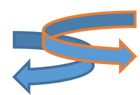
FIRST EDITION

THE LAW ON PROFESSIONAL MAL PRACTICE IN UGANDA

AN APPRAISAL ON WHEN AND HOW TO SUE YOUR MEDICAL PRACTIONER, ADVOCATE, ENGINEER AND RELIGIOUS LEADER

ISAAC CHRISTOPHER LUBOGO



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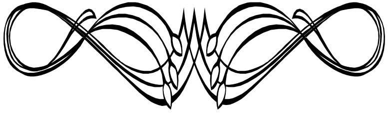

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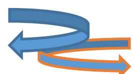

THE LAW ON PROFESSIONAL MALPRACTICE IN UGANDA

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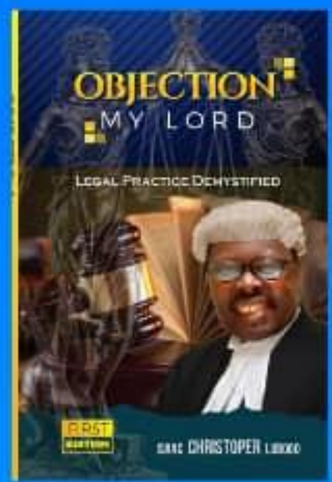
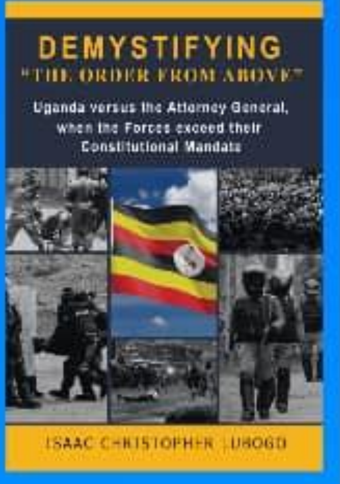
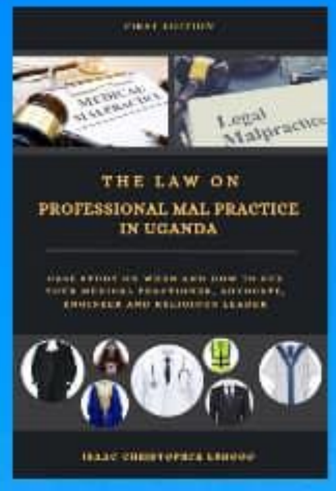
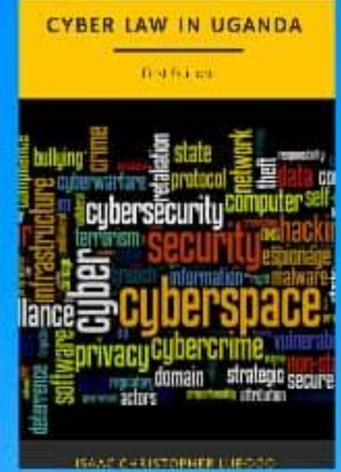
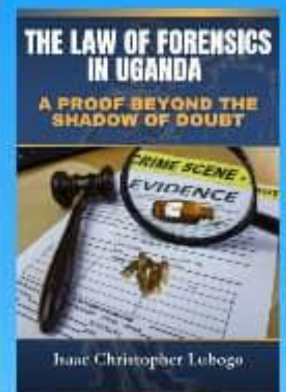
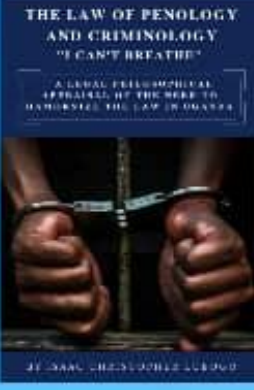


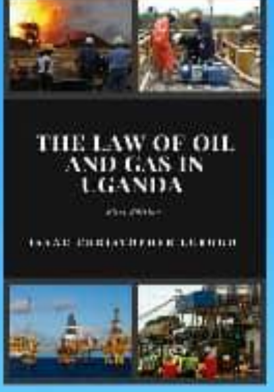


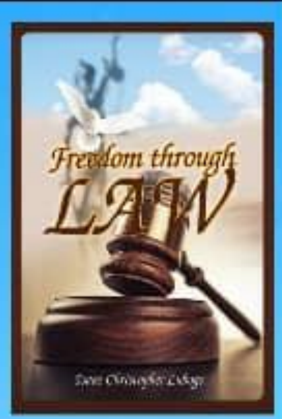


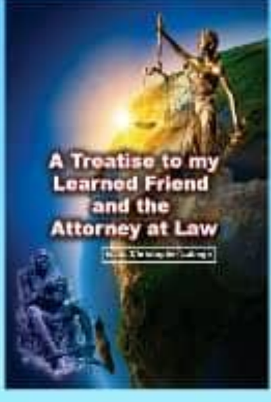


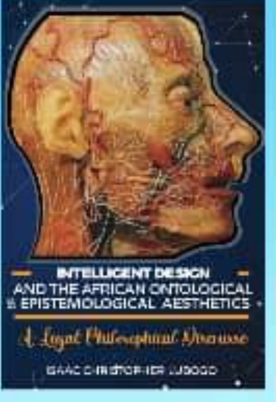


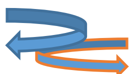




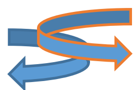


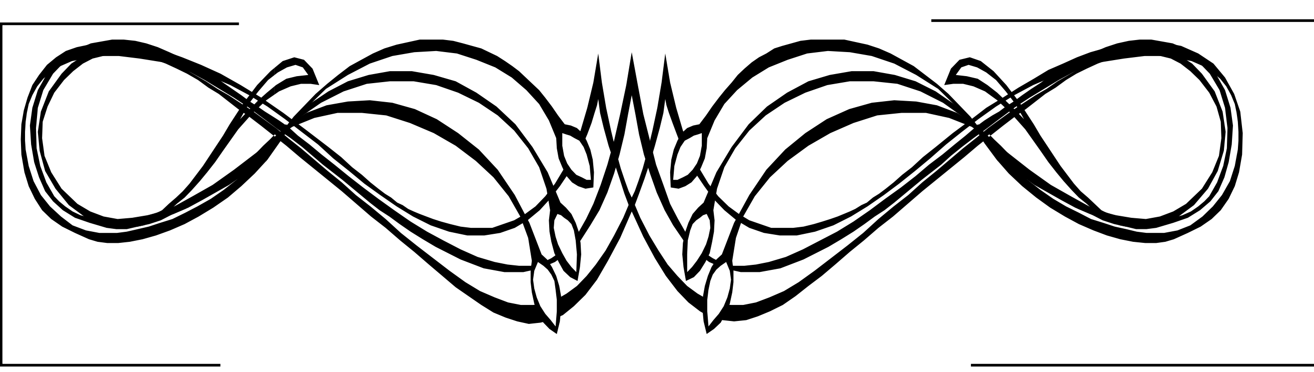






To The Lord Who Breathes Life And Spirit On Me … Be My Guide Oh Lord Of The Entire Universe.





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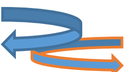

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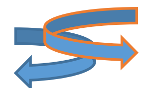

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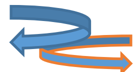

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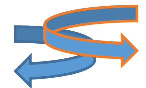

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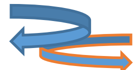

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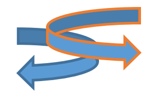

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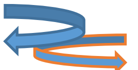

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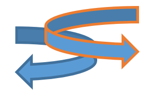

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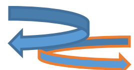

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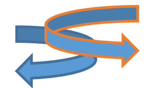

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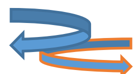

CHAPTER ONE

INTRODUCTION AND ORIGIN OF ETHICS

Introduction of key terms.

Professional Malpractice refers to negligence or misdeeds by many professionals such as doctors, dentists, chiropractors, optometrists, nurses architects, engineers. Professional misconduct seems to be a topic in daily news headlines.

Malpractice law provides the rules and procedures for holding professionals responsible for the harm that results from their carelessness. People depend on lawyers, pastors, judges, accountants and engineers, traditional medical practitioners, doctors and all other experts to perform their jobs prudently. They are entrusted with the sacred duty of preserving virtues of life, promoting justice for the oppressed, protecting health, offering penance to those who repent. However, these people instead act contrary and thus the term Professional misconduct. States governed by their various laws provide solutions to the violations conducted by these professionals. The law of Professional Misconduct aims at addressing professional negligence, creating a forum for redress mechanisms, promoting accountability, fostering patient safety and providing quality services.

Meaning of Professional.

The word Professional means practicing of a learned art in a characteristically methodological, courteous manner.[1] It should be noted and recorded that the every profession is guided by a code of conduct of ethics and headed by an overall or regulatory body. The conduct of conduct sets the standard of minimally accepted conduct within their profession. They act as a guide to ensure right and proper conduct in the daily practice of the profession.

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[1] Bryan Garner, the editor, Black's law Dictionary ,9th edition, West Publishing Company limited.

Key terms in Professional malpractice.

Negligence. Negligence means failure to perform up to the standard of care which causes injuries to a patient or client.

Standard of care. Standard of care is the quality of professionalism which is expected from a person executing his profession.

Medical Malpractice. A medical malpractice suit is a type of personal injury suit against a health care professional when the provider has injured a patient.

Plaintiff. A plaintiff is a person who initiates a law suit.

Defendant. Defendant is a person sued by the plaintiff. That is a person whom the case is against.

Damages. Damages means compensatory money obtained in a suit.

Settlement. It is a sum of money the plaintiff accepts instead of going to court.

Ethics:

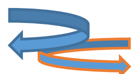
There is no universal accepted definition of ethics because the word ethics is too complex to define. The word ethics is understood to include nobility, honesty, accountability, trust, truth, hard-work and openness. Ethics are principles and values with rules of conduct and laws that regulate human beings or a profession. These principles affect how a person lives his or her life and makes decisions. Every profession is guided by its own ethics.

Professional ethics in the literal meaning means a body of moral principles. Professional ethics and conduct constitutes a set of rules and behaviors which facilitates effective interaction on professional matters. Ethical rules are like laws or standards that govern social and professional standards and deals with respect for one's colleagues and for their rights.

Sources of ethics include the constitute, statutes, professional codes, case law, court rule books, common law and doctrines of equity. Areas covered by ethical standards include

-Independence, honesty and integrity.

-Competence which encompasses academic qualifications, training and meeting other practicing requirements such as holding a valid license or even practicing certificate in case someone is a lawyer.



ORIGIN OF ETHICS

Ethics comes from a Greek term ethos which means 'custom' or character. The Greek philosopher Aristotle used it to refer to a person's character. Ethics is a branch of philosophy concerned with human character and conduct. It is the science of ideal human character expressed through moral action, conduct, motive, containing a right or befitting. It involves systematizing, defending and dealing with the concepts of right and wrong behavior. These principles affect how a person lives his or her life and makes decisions. Ethics are principles and values which together with rules of conduct and laws, regulate a profession. They act as an important guide to ensure right and proper conduct in the daily to day activities of the professionals.

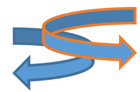
The term ethics is used in three different but related ways, signifying *(1) a general pattern or "way of life," (2) a set of rules of conduct or "moral code," and (3) inquiry about ways of life and rules of conduct.* In the first sense we speak of Buddhist or Christian ethics; in the second, we speak of professional ethics and of unethical behavior. In the third sense, ethics is a branch of philosophy that is frequently given the special name of "*metaethics.*" The present discussion will be limited to the history of philosophical or "meta" ethics, for two reasons. First, because it is impossible to cover, with any degree of thoroughness, the history of ethics in either of the first two senses. Practices and the codification of practices are the threads out of which all of human culture is woven, so that the history of ethics in either of these senses would be far too vast a subject for a brief essay. Second, although ethical philosophy is often understood in a broad way as including all significant thought about human conduct, it can well be confined within manageable limits by separating purely philosophical thought from the practical advice, moral preaching, and social engineering that it illuminates and from which it receives sustenance. This distinction, while somewhat artificial, makes sense of the common opinion that philosophy in general, and ethical philosophy in particular, was invented by the Greeks.

According to the Black's Law Dictionary[2], something *"ethical"* is one *Of or relating to moral obligations that one person owes another; esp., in law, of or relating to legal ethics <the ethical rules regarding confidences. In legal ethics, it is something in conformity with moral norms or standards of professional conduct.*

Values or morals; a view by Dr. R. Wilfred

It is observable that Ethics is largely premised on what is moral and good. The central questions of philosophical ethics are: What do we or should we mean by "good" and "bad"? What are the right standards for judging things to be good or bad? how do judgments of good and bad (value judgments) differ from and depend upon judgments of value-neutral fact? It is important to mention that anything considered "good" is usually good, yet something moral, is subjectively dependent upon personal judgment. Similary, what is moral depends on who gives the judgment.

[2] Bryan A Garner- Black's Law Dictionary, 9th Ed. pg. 632



I have come to learn that much as doing something good is more achievable and easily appreciated, something moral will depend on so many factors surrounding the individual and their society. Am well inclined to the meaning in the words expressed by *Dr. Wilfred Rajul* in his article *"Ethical Challenges in Uganda"* whereupon writing about 'values,' noted that;

In Uganda today, values are turned upside down. When an individual struggles to earn his/her wealth genuinely and takes a long time to make any big financial gains, he/she is termed foolish, dull and not enterprising. On the other hand, wealth gained overnight through fraudulent ways, thus exalting the financial status of that individual, such a person is considered successful, serious, a hero etc.

According to Dr. Rajul, he relates the wrong attitude to a misguided interpretation of the Holy Scripture, that;

When Jesus called a repentant thief a good thief because he repented and acknowledge his mistakes by asking for mercy and help from Jesus, some Ugandan would call a person who misappropriates the public wealth and invests that wealth in Uganda a good thief. He thus opine that the *misinterpretation of the scriptures* is responsible for the moral down-warp today where. *People who amass wealth from dubious sources are considered successful, enterprising and therefore have become models for our young people to immolate.* In his opinion, he deems this *a great ethical challenge in Uganda.*

Ethics is a great attribute of Greeks owing to their serious input into formalizing concepts relative to good ethical living and which today have been repeated by present day authors. Take for instance the today's common phrase; *"a healthy mind in a healthy body"* is a creation as old as ages in the times of Socrates.

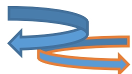
Greek Ethics

Ethical philosophy began in the fifth century BCE, with the appearance of Socrates, a secular prophet whose self-appointed mission was to awaken his fellow men to the need for rational criticism of their beliefs and practices.

Henry Sidgwick put it that;

This emergence of an art of conduct with professional teachers cannot thoroughly be understood, unless it is viewed as a crowning result of a general tendency at this stage of Greek civilization to substitute technical skill for traditional procedure…. If bodily vigor was no longer to be left to nature and spontaneous exercise, but was to be attained by the systematic observance of rules laid down by professional trainers, it was natural to think that the same might be the case with excellences of the soul.[3]

[3] Henry Sidgwick (Outlines of the History of Ethics, p. 21)



Early Greek thinkers drew frequent comparisons between medicine and ethics, describing ethics as the "art of living" and the "care of the soul." Socrates' motto, *"A sound mind in a sound body*," suggests the *medical image of ethics as mental hygiene*. Many thinkers took a special interest in medicine, and, recognizing the interdependence of mind and body, they practiced a rudimentary psychiatry. Protagoras, Gorgias, and Thrasymachus taught methods of self-advancement and of attaining virtue. They stressed the difference between subjective values and objective facts, arguing that good and evil are matters of personal decision or social agreement (nomos) rather than facts of nature (phusis).

Socrates

Socrates stood midway between the unexamined, traditional values of the aristocracy and the skeptical practicality of the commercial class. Like the Sophists, he demanded reasons for rules of conduct, rejecting the self-justifying claim of tradition, and for this reason he was denounced as a Sophist by conservative writers like Aristophanes. But unlike the Sophists, he believed that *by the use of reason man could arrive at a set of ethical principles that would reconcile self-interest with the common good and would apply to all men at all times.*

The central questions of ethical philosophy were raised for the first time by Socrates and the Sophists, but only Socrates realized the difficulty, bordering on impossibility, of finding adequate answers. In this respect, Socrates may be regarded as the first philosopher, in the strictest sense of the term.

The Socrates of the early dialogues raises questions about the meaning of ethical terms, such as "*What is justice?"* (Republic), *"What is piety*?" (Euthyphro), "*What is courage*?" (Laches, Charmides), "*What is virtue*?" (Protagoras). The answers offered by others to these questions are then subjected to a relentless cross-examination (Socratic dialectic), exposing their vagueness and inconsistency.

Although Socrates did not separate judgments of value from judgments of fact, the negative results of his line of questioning suggest a distinction that was made explicit only in modern times by David Hume and G. E. Moore. All the ethical theories developed since Socrates may be considered as alternative explanations of the relation between facts and values, naturalistic theories stressing their interdependence and non-naturalistic theories stressing their differences. Socrates, in demanding rational grounds for ethical judgments, brought attention to the problem of tracing the logical relationships between values and facts and thereby created ethical philosophy.

Plato

Plato's thought may be regarded as an endeavor to answer the questions posed by Socrates. From the Republic on through the later dialogues and epistles, Plato constructed a systematic view of nature, God, and man from which he derived his ethical principles. The objects of ethical

knowledge are even less visualizable than geometrical forms and numbers—they are concepts and principles ultimately unified under the all-encompassing concept of the Good.

Although Plato suggests in this and other passages that ethical truths can be rigorously deduced from self-evident axioms, and thus introduces the mathematical model of knowledge that has guided many philosophers ever since, he does not employ a deductive procedure in his discussions of specific ethical problems, perhaps because he did not feel that he had yet attained an adequate vision of the Good that would supply him with the proper axioms from which to deduce rules of conduct. Plato's main goal in his ethical philosophy is to lead the way towards a vision of the Good.

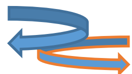
The Socratic-Platonic ethical theory identifies goodness with reality and reality with intelligible form and thus concludes that the search for value must lead away from sense perception and bodily pleasure. In the Protagoras and Symposium, Socrates argues for rational control over the body for the sake of greater pleasure in the long run, but he does not oppose pleasure as such. In the Symposium the unity of body and mind is a luminous thread throughout the discussion. He also stated that;

"Love is regarded as a search for the pleasure that consists in possession of what is good, and it is shown to exist on many levels, the lowest being that of sexual desire and the highest that of aspiration toward a vision of eternity."

By this view, he seems to connect with the Christian biblical view of *"bodily sanctity"* thus *"...the body is not for sexual immorality but for the lord and the lord is for the body"* (*1 Cor. 6.13)* and the other being that; *"...do not be deceived...the sexually immoral...will not inherit eternity*." (Emphasis mine *per Rev. 22:9-10)* it is funny how an atheist like Socrates writes secular views but which are in line with biblical and Christian values.

While still under the influence of Socrates, Plato distinguishes noble pleasures from base pleasures, rather than condemning pleasure in itself. The image he draws of Socrates is of a man who eats and drinks heartily and enjoys himself on all levels of experience, but in rationally controlled proportions. *Socrates enjoys the wine at the symposium as much as anyone else, but unlike the others he remains sober to the end.* While the poet Agathon becomes drunk with his own rhetoric, Socrates employs richly sensual language and metaphor in a way sufficiently controlled to make a philosophical point and so remains master of his rhetoric as well as of his body. Through the *bodily pleasure* analogy, Socrates writes on the ethics of anyone as a tool of control over one's body and behavior[4]. He insinuates the importance of exercising body control as relative to moral

[4] Plato has Socrates say, in the Philebus, "no degree of pleasure, whether great or small, was thought to be necessary to him who chose the life of thought and wisdom" (translated by B. Jowett, New York, 1933, Para. 33).



He proposed, in the Laws, a ruthless system of punishments and the propagation of ideologically useful myths that would preserve social harmony and class distinction. Yet despite his support of severe punishment for social transgressions, Plato followed Socrates in holding, in the Protagoras, Timaeus, and Laws, that evil is due only to ignorance or madness and that "no man is voluntarily bad," a paradox that Aristotle later tried valiantly to resolve. Plato was the fountainhead of religious and idealistic ethics, while Aristotle engendered the naturalistic tradition.

Aristotle

Throughout the subsequent history of Western civilization, ethical views that looked to a supernatural source, such as God or pure reason, for standards of evaluation stemmed from the metaphysics of Plato, while naturalistic philosophers who found standards of value in the basic needs, tendencies, and capacities of man were guided by Aristotle.

Aristotle's ethical writings aimed to define the subject matter and methodology of philosophical ethics. In doing so, he both drew upon and revised the beliefs and values of the Greek society of his time. Aristotle begins his study by searching for the common feature of all things said to be good and, in contrast with Plato, who held that there is a Form of Good in which all good things "*participate,"* Aristotle concludes that there are many different senses of "good," each of which must be defined separately for the limited area in which it applies. Each such "good" is pursued by a specific practical art or science, such as economics, military strategy, medicine, or shipbuilding. But the ends of these particular disciplines can be arranged in order of importance, so that the supreme good can be identified with the goal of the most general practical science to which the others are subordinate. On an individual level, this all-inclusive science is ethics; on a social level, it is politics. The end of ethics is personal happiness and that of politics is the general welfare, and since the good of the whole ranks above that of the part, personal ethics is subordinate to politics. However, this principle does not entail, for Aristotle that the individual must sacrifice his interests to those of the community, except under unusual conditions such as war, because he assumed that the needs of both normally coincide.

Aristotle identifies the supreme good with *"happiness,"* which he defines as the exercise of natural human faculties in accordance with virtue. His next task is to define virtue as a skill appropriate to a specific faculty, and he distinguishes two classes of virtues—intellectual and moral. There are five intellectual faculties, from which arise art, science, intuition, reasoning, and practical wisdom. He offers a long list of moral virtues, defining each as the mean between the extremes of either emotion or tendencies to action. For instance, courage is the mean between the excess and the deficiency of the emotion of fear, temperance is the mean between the tendencies to eat and drink too much or too little, justice is the mean with respect to the distribution of goods or of punishments.

Summary: Socrates, Plato, and Aristotle

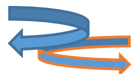
Returning to the central problems of ethical theory, one may hazard an estimation of the contributions of Socrates, Plato, and Aristotle to their clarification. Socrates was the first to recognize the importance of analyzing the meaning of good, right, just, and virtuous, and of articulating the standards for ascribing these properties. Plato charted a spiritualistic direction for finding the answers in a realm of timeless ideals, while Aristotle located the answers in the scientific study of biology, psychology, and politics. Good, for Plato, means resemblance to the pure Form, or universal model of goodness, which serves as the standard for all value judgments. Actions are right, laws are just, and people are virtuous to the degree to which they conform to the ideal model. For Aristotle, good means the achievement of the goals at which human beings naturally aim, the balanced and rational satisfaction of desires to which he gives the name "happiness." Right action, just laws, and virtuous character are the means of achieving individual and social well-being. All three philosophers agree in identifying individual good with social good and in defining moral concepts such as justice and virtue in terms of the achievement of good.

Moral responsibility

The concept of moral responsibility that acquired crucial importance in later Christian thought was only obliquely considered by Plato and more fully, although inconclusively, dealt with by Aristotle. Plato, who identified virtue with philosophical understanding, concluded that *"no one does evil voluntarily,"* so that wrong action is always due to intellectual error. Aristotle recognized that intellectual error must be distinguished from moral vice, since the former, unlike the latter, is involuntary. In order to distinguish punishable evil from innocent mistakes, he explained vice as due to wrong desire as well as poor judgment. The will, for Aristotle, is rationally guided desire, formed by moral education and training. But since even voluntary action is determined by natural tendencies and early training, Aristotle searched for an additional factor to account for the freedom of choice necessary for moral responsibility. He thought he found that factor in deliberation, the consideration of reasons for and against a course of action. The further question, as to whether, when an agent deliberates, he has any choice of and consequently any responsibility for the outcome of his deliberation, was not considered by Aristotle and remains an unsettled issue between determinists and libertarians. In general, the concepts of free will and moral responsibility did not become matters of great concern until the rise of Christianity, when people became preoccupied with otherworldly rewards and punishments for moral conduct.

Hellenistic and Roman Ethics

During the two millennia from the death of Aristotle in the fourth century BCE to the rise of modern philosophy in the seventeenth century CE, the interests of ethical thinkers shifted from theoretical to practical ethics, so that little advance was made in the clarification of the meanings



of ethical concepts, while, on the other hand, new conceptions of the goals of human life and new codes of conduct were fashioned. The philosophical schools of Skepticism, Stoicism, Epicureanism, and Neoplatonism that set the ethical tone of Hellenistic and Roman thought offered a type of intellectual guidance that was more like religious teaching than like scientific inquiry and paved the way for the conquests of Christianity. The popular conception of philosophy as an attitude of indifference to misfortune applies best to this period, in which philosophy and religion were nearly indistinguishable.

The subtlety of Socrates' thought is attested to by the variety of schools that developed out of his teaching. Plato and, through Plato, Aristotle probably represent the Socratic influence most completely. But the Stoics, Epicureans, and Skeptics also owed their guiding principles to Socrates. Aristippus of Cyrene, at first a disciple of Socrates, founded the school of Cyrenaicism, which followed the simple hedonistic principle that pleasure is the only good. Antisthenes, another Socratic disciple, founded the Cynic school on the apparently opposite principle that the good life is one of indifference to both pleasure and pain. The Cynics, of whom Diogenes was the most renowned, rejected the comforts of civilization and lived alone in the forests, like the dogs after whom they named themselves. Cyrenaicism developed into Epicureanism, and Cynicism into Stoicism. Soon after the death of Aristotle, Pyrrho of Elis initiated the philosophy of Skepticism, influenced by both the Sophist and the Socratic criticisms of conventional beliefs. According to Skepticism, no judgments, either of fact or of value, can be adequately proved, so that the proper philosophical attitude to take toward the actions of others is one of tolerant detachment, and toward one's own actions, extreme caution. In the second century BCE, the leaders of Plato's Academy, Arcesilaus and Carneades, adopted Skepticism, and Carneades developed a theory of probability that he applied to ethical judgments. During this period, the Peripatetic school at Aristotle's Lyceum continued the Aristotelian tradition until it merged finally with Stoicism.

Epicureanism

Epicurus (c. 341–270 BCE) founded one of the two dominant philosophical schools of the era between the death of Aristotle and the rise of Christianity.

He assumed that freedom of choice of action is incompatible with the deterministic principle that all events are necessary results of antecedent causes. But this identification of freedom with pure chance seems to entail that a capricious person is more free than a rational and principled person, and such a conclusion would contradict Epicurus's own vision of moral life. For Epicurus's main difference with his Cyrenaic predecessors lay in his conviction that, by the use of reason, one could plan one's life and sacrifice momentary pleasures for long-run benefit. Like the Cyrenaics, Epicurus held that pleasure is the single standard of good. But he distinguished "natural pleasures," which are moderate and healthful, from "unnatural" satiation of greed and lust. His name for moderate and natural pleasure was ataraxia, gentle motions in the body that he regarded as the physiological explanation of pleasure. He proposed, as the ideal way of life, a relaxed, leisurely

existence, consisting in moderate indulgence of the appetites, cultivation of the intellect, and conversation with friends, which is how Epicurus himself lived and taught in his famous garden.

Stoicism

Stoicism was by far the most impressive intellectual achievement of Hellenistic and Roman culture prior to Christianity, providing an ethical framework within which metaphysical speculation, natural science, psychology, and social thought could flourish to such a high degree that Stoicism has not unjustly been identified in the public mind with philosophy itself, that is, with the distinctively "philosophical" attitude toward life. Like every great tradition, Stoicism evolved through many stages and thus comprehends a great variety of specific beliefs. Historians generally distinguish three main stages of its development:

With the Stoics, the **concept of duty** acquired a central place in ethics, as conformity to moral rules that they identified with laws of human nature. Indeed without doubt it is that usually along duty lines is liability placed upon a professional for their conduct whether such fulfils a duty or breaches the duty.

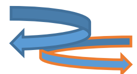
The later Roman Stoics developed this doctrine into the theory of natural law on which Roman jurisprudence was largely based. No wander today, even tortious liability is rested upon existence of a duty. Most of the Stoics were materialists, yet imbued with natural piety and were fatalists, maintaining that man can control his destiny only by resigning himself to it, a principle that contrasted vividly with their emphasis on rationality and self-control. They sought to reconcile this extreme determinism with freedom and moral responsibility by means of the Aristotelian distinction between external and internal causation, thus suggesting that the free man is one who, in understanding the necessity of what befalls him, accepts it and thus freely chooses it, a solution echoed in modern thought by G. W. F. Hegel's definition of freedom as the recognition of necessity.

(2) The middle Stoics, notably Panaetius and Posidonius, brought Stoicism to Rome, shaping the doctrine to the political-mindedness of the Romans by modifying its extreme individualism and stressing the importance of social duties.

(3) The late Stoics, Seneca, Epictetus, Marcus Aurelius, and, to some extent, Cicero—who accepted only certain parts of Stoic doctrine—developed the ideal of a "cosmopolis," or universal brotherhood of man, in which all men would be recognized as having equal rights and responsibilities, an ideal that Christianity absorbed into its conception of the "City of God" and which, in the modern age, Immanuel Kant made the cornerstone of his system of ethics.

Medieval Ethics

The rise of Christian philosophy, out of a fusion of Greco-Roman thought with Judaism and elements of other Middle Eastern religions, produced a new era in the history of ethics, although one that was prepared for by Stoicism and Neoplatonism. The Stoic concern with justice and self-



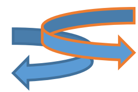
mastery, and the Neoplatonic search for reunion with the source of all being, were combined in early Christian philosophy with the Judaic belief in a personal God, whose commandments are the primal source of moral authority and whose favor is the ultimate goal of human life. Two sources of ethical standards, human reason and divine will, were juxtaposed in one system of ethics, and the tension between them was reflected in conflicting sectarian interpretations of theological principles.

From the second to the fourth century, Christianity spread through the Roman Empire, offering the poor and the oppressed a hope for otherworldly happiness in compensation for their earthly suffering, and thus a way of life with which the more pessimistic and intellectualist schools of philosophy could not compete. By the fourth century, Christianity dominated Western civilization and had absorbed the main ideas and values of the secular schools of thought, as well as rival religions such as Manichaeism, Mithraism, and Judaism. Having converted the masses, it was time to win over the intelligentsia, and doing this required the hammering out of an explicit and plausible system of metaphysical and ethical principles. This task was performed by the Church Fathers, Clement of Alexandria, Origen, Tertullian, Ambrose, and, most completely and authoritatively, by Augustine.

Augustine

St. Augustine (354–430), born near Carthage, the son of a pagan father and a Christian mother, was first a Manichaean and later became converted to Christianity. He rose in the church to become bishop of Hippo and helped to settle the doctrinal strife among the many Christian sects by constructing a system of theology, ethics, and theory of knowledge that soon became the authoritative framework of Christian thought, modified but not supplanted by subsequent church philosophers. Augustine's major works, Confessions, The City of God, Enchiridion, and On Freedom of the Will, wove together threads of Stoic ethics, Neoplatonic metaphysics, and the Judeo-Christian doctrine of revelation and redemption into a many-colored fabric of theology. With Augustine, theology became the bridge between philosophy and revealed religion, the one end anchored in reason and the other in faith, and ethics became a blend of the pursuit of earthly well-being with preparation of the soul for eternal salvation.

Like the Neoplatonists, Augustine rejected almost entirely the claims of bodily pleasures and community life, maintaining, as St. Paul had done, that happiness is impossible in this world, which serves only as a testing ground for reward and punishment in the afterlife. Augustine inherited the Neoplatonic conception of virtue as the purgation of the soul of all dependence on material comforts in preparation for reunion with God. Against the Stoic and Aristotelian reliance on reason as the source of virtue, Augustine maintained that such apparently admirable traits as prudence, justice, wisdom, and fortitude—the four cardinal virtues identified by Plato and stressed by Stoics and Christians—are of no moral worth when not inspired by Christian faith. With the pessimistic view of life characteristic of an era of wars, political collapse, and economic decline—a view already apparent in the Stoic, Epicurean, and Neoplatonic modes of withdrawal from social



responsibilities—intensified by his personal sense of guilt and worthlessness, Augustine saw life on Earth as a punishment for Adam's original sin. "For what flood of eloquence can suffice to detail the miseries of this life?" he laments in The City of God.

Nature

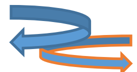
The tension between natural and supernatural values in Augustine's ethical thought shows itself most clearly in his ambivalent attitude toward nature. Nature, as God's creation, must be unqualifiedly good. Natural evils are only apparently evil, and in the long run they contribute to the fulfillment of divine purpose. Natural evil is simply imperfection that makes variety possible and thus, when viewed on a cosmic scale, does not exist at all. On the other hand, since man must be held morally responsible for his sins, human sin cannot be so easily explained away as incompleteness that promotes the cosmic good. Moreover, it is man's bodily desires that tempt him to sin. Without the aid of divine grace, the promptings of human nature, whether impulsive or rational, lead only to vice and damnation. Augustine resolves this paradoxical view of human nature by holding that man, unlike other natural species, was endowed by his Creator with free will and thus with the capacity to choose between good and evil. Through the original sin of Adam he has chosen evil, and it is for this reason, rather than because of any flaw in his original construction, that he is irresistibly inclined to further sin.

Free will and divine foreknowledge

If Augustine's dual conception of nature is explained by his concept of free will, the latter contains new difficulties. The problem of free will is critical in Christian ethics, which emphasizes responsibility and punishment. The Greek ideal of practical reason ensuring physical and mental well-being was supplanted by the ideal of purification of the soul through suffering, renunciation, and humble obedience to divine will.

Where the practice of virtue produces well-being as its natural consequence, as in the Greek view, virtue carries with it its own reward in accordance with the causal processes of nature, so that causal necessity and moral desert are not merely compatible; they normally coincide. But in the Christian view, causal necessity and moral responsibility seem incompatible, for the choice between good and evil is made by the soul, independently of natural processes, and its reward or punishment is independent of the natural effects of human actions. Man is punished or rewarded to the degree to which he voluntarily obeys or disobeys the commands of God. In the Greek view, man suffers from the natural consequences of his mistakes, but in the Christian view, no matter what the natural consequences of his actions, he is held to account for the state of his soul. It is his motives and not his actions that count in assessment of his moral responsibility, and the primary motive is his desire for, or his turning away from, God.

Responsibility is thus transferred from the consequences of a person's actions to the state of his soul. Yet if the soul is created by God, and not subject to its temporary owner's control, then in



what sense can man be said to have freedom of choice between good and evil? Augustine describes the soul that chooses evil as "defective," but if so, is not the Creator of the defective soul responsible for its deficiency? In absolution of God, Augustine argues that a defect is not a positive entity, thus not a created thing and not attributable to a creator—a terminological escape that is vulnerable to the objection that, on such grounds, a man who stabs another produces in his victim a deficiency rather than a positive state and therefore is not responsible for his "nonexistent" product.

Augustine's concept of free will is further complicated by his support of the theological principle of divine omniscience, which entails foreknowledge by God of human decisions. The term predestination, used by later theologians and notably by the Protestant reformers, suggests a determinism that Augustine rejects in his criticism of fatalism. For Augustine, God knows what man will choose to do and makes it possible for man to act on his free choices but does not compel him to any course of action. To the obvious question of how God can know in advance what has not been destined or causally necessitated, Augustine replies by means of his subtle analysis of time. God has knowledge, not of what we are compelled to do but of what we freely choose to do, because his knowledge is not the kind of advance knowledge that is based on causal processes but is due to the fact that, in the mind of God, we have already made our decisions. All of past and future time is spread out in the specious present of the divine mind, so that what, from our limited standpoint, would be prediction of the future is, for God, simply direct awareness of contemporaneous events.

Distinctions among ethical concepts

While Augustine's ethical writings are mainly concerned with the substantive problem of how to achieve redemption, rather than with the clarification of ethical concepts, much of his writing is philosophical in our strict sense, in that it suggests solutions to conceptual or meta-ethical problems of meaning and method. Augustine opposed the classical tendency to define the moral concepts of rightness and virtue in terms of individual and social well-being and interpreted moral right and virtue as obedience to divine authority. The concept of good is split into a moral and a practical sense. Good as fulfillment of natural tendencies is subordinated to eternal beatitude, the fulfillment of the aspirations of the virtuous soul. Freedom and responsibility are interpreted as internal states of the soul and as excluding, rather than (as for Aristotle) presupposing, causal necessity.

Fourth To Thirteenth Centuries

From Augustine in the fourth century to Peter Abelard (1079–1142) in the eleventh century, Christian, Islamic, and Judaic philosophy was dominated by Neoplatonic mysticism and preoccupied with faith and salvation. The outstanding figure of this period was John Scotus Erigena (c. 810–c. 877), whose conception of good was the Platonic one of approximation to timeless being and whose view of life as issuing from and returning to God bordered on heretical pantheism.

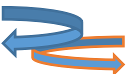
By the eleventh century, interest in rational philosophical speculation had revived, and even those Schoolmen like Bernard of Clairvaux (1090–1153), who continued to defend religious mysticism and denounced reliance upon reason as inimical to faith, nevertheless employed philosophical arguments to refute contrary opinions. Augustine had asserted that one must "believe in order to understand," and St. Anselm (1033–1109) took this to mean that faith is not incompatible with reason but, rather, prepares the soul for rational understanding. The main issues among philosophers of this time were the relation between faith and reason, and the nature of universals.

Abelard, however, an extraordinarily original and independent thinker whose vibrant personality reveals itself in his philosophical writings, rediscovered some of the unsolved problems of ethical philosophy. Abelard brought into clear view the distinctive features of Christian ethics implicit in Augustine's work, in particular, the split between moral and prudential concepts that sharply separates Christian ethics from Greek ethics. Abelard held that morality is an inner quality, a property of motive or intention rather than of the consequences of one's actions, a principle that was later stressed by the Reformation and attained its fullest expression in the ethical system of Kant. A somewhat heretical corollary follows from Abelard's principle, namely that, as Étienne Gilson put it, "Those who do not know the Gospel obviously commit no fault in not believing in Jesus Christ," and it seems clear from all this that Christian faith need not be the foundation for moral rules. Abelard concluded that one can attain to virtue through reason as well as through faith.

Thomas Aquinas

The towering figure of medieval philosophy is, of course, Thomas Aquinas (c. 1224–1274), whose philosophical aim was to reconcile Aristotelian science and philosophy with Augustinian theology. The way to this achievement had already been prepared by the revival in western Europe of interest in Aristotle, whose thought had been preserved and elaborated by Muslim and Jewish scholars such as Avicenna, Averroes, and Maimonides and had been brought to the attention of Christendom by the commentaries of Albert the Great. It remained for Aquinas to prove the compatibility of Aristotelian naturalism with Christian dogma and to construct a unified view of nature, man, and God. This he undertook with remarkable success in his Summa Theologiae and Summa Contra Gentiles.

To a large degree, Aquinas's union of Aristotelianism with Christianity consisted in arguing for the truth of both and in refuting arguments of his predecessors and contemporaries that purported to show their incompatibility. Aristotle's ethics was relativistic, rational, and prudential; Augustinian ethics was absolutist, grounded on faith, and independent of consequences. Now one of these views is totally misguided, or else there must be room for two different systems of ethical concepts and principles. Aquinas adopted the latter alternative and divided the meaning of ethical concepts into two domains, "natural" and "theological." Natural virtues, adequately accounted for by Aristotle, can be attained by proper training and the exercise of practical reason, while



theological virtues—faith, hope, and love—require faith and divine grace. Similarly, he distinguished two highest goods, or paramount goals of life, worldly happiness and eternal beatitude (which has precedence); the former is achieved through natural virtue and the latter is achieved through the church and its sacraments. Aquinas thus expressed a considerably more optimistic attitude than did Augustine toward the possibility of improving man's lot on earth through knowledge of nature and intelligent action. This helped to prepare the climate for the rebirth of natural science, whose first stirrings were felt in the thirteenth century.

Natural law

At the center of Thomistic ethics was the concept of natural law. The medieval doctrine of natural law, stemming from Aristotle's teleological conception of nature and from the Stoic identification of human reason with the Logos, was a fusion of naturalistic Greek ethics with monotheistic theology. On this view, the promptings of informed reason and moral conscience represent an inherent tendency in the nature of man, and conformity to this nature fulfills both the cosmic plan of the Creator and the direct commands of God revealed in the Scriptures. Natural law is the divine law as discovered by reason, and therefore the precepts of the church and the Bible, and scientific knowledge of the universal needs and tendencies of man, provide complementary rather than competing standards of ethical judgment. Where conflicts between science and religious authority arise, they must be due to inadequate understanding of science, since church authority and dogma are infallible.

The Thomistic unification of scientific and religious ethics in the doctrine of natural law—further elaborated in subtle detail by Francisco Suárez and other legalists—was an effective way of making room, within the religious enterprise of achieving salvation, for the practical business of everyday living in pursuit of personal and social well-being. The ideological supremacy of theology was maintained, but the doctrine of natural law purported to guarantee reliable knowledge of nature, psychology, and political economy. The weakness in this system was that it placed religious barriers in the way of scientific advance, tending to sanctify and render immune from revision whichever scientific principles seemed most congenial to theology, such as instinct theory in psychology, vitalistic biology, and geocentric astronomy.

Free will

Aquinas's account of freedom and moral responsibility was, in general form, similar to that of Augustine, maintaining the compatibility of free will with predestination or divine foreknowledge. Aquinas also maintained the compatibility of free will with causal determinism, thus dealing with the problem on the level of prudential ethics as well on as the theological level of grace and salvation. Aquinas's solution makes effective use of Aristotle's analysis of choice and voluntary action in terms of internal causality and deliberation, and it identifies free will with rational self-determination rather than with the absence of causal influences. On the other hand, Aquinas's

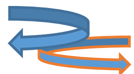
concept of freedom is, as a result, more relativistic than Augustine's, and, while it explains the conditions under which an agent may be held responsible for his actions—namely, the conditions of desire, knowledge, and deliberation—it does not meet the further issue of whether these faculties that determine action are within the control of the agent, that is, whether a person can freely choose the habits and desires that determine his actions. Later writers, particularly Protestant theologians, tended to interpret Augustine as stressing predestination and Aquinas as stressing free will, but it may be argued to the contrary, that Augustine's conception of free will as an inexplicable and supernatural thrust of the soul allows the agent more independence of his formed character than does Aquinas's, but by that very token, Aquinas's account is more congenial to a scientific view of man.

Subsequent scholastic philosophy, from the fourteenth to the seventeenth centuries, added little to the clarification of metaethical problems, but it probed further into the relation between intellect and will as sources of human and divine action. John Duns Scotus (c. 1266–1308), William of Ockham (c. 1285–1349), and Nicolas of Autrecourt (c. 1300–after 1350) developed the voluntaristic doctrine that the will is free in a more absolute sense than that accounted for by Aquinas, in that it is independent both of external causality and of determination by the intellect—that is, by the agent's knowledge of what is right and good. Their view in one way strengthened the case for religious faith as against scientific reason, at least in matters of ethical judgment, but, in another way, it helped stimulate an attitude of individualism and independence of authority that prepared the ground for the secular and humanistic ethics of the modern age.

Early Modern Ethics

Philosophy seems to flourish best in periods of rapid social transformation, when the conceptual framework of a culture crumbles, requiring a re-examination of basic concepts, principles, and standards of value. The sixteenth and seventeenth centuries, which saw the demise of medieval feudalism and ushered in the modern age of industrial democracy, were, like the fifth and fourth centuries BCE, a period of intense philosophical ferment. In both cases, the preceding century witnessed the demolition of traditional beliefs, while the succeeding century was one of systematic reconstruction. The development of commerce and industry, the discovery of new regions of the world, the Reformation, the Copernican and Galilean revolutions in science, and the rise of strong secular governments demanded new principles of individual conduct and of social organization.

In the sixteenth century, Francis Bacon demolished the logic and methodology of medieval Scholasticism. Desiderius Erasmus, Martin Luther, and John Calvin, while attempting to strengthen the bond between religion and ethics, undermined the elaborate structure of canon law based on the moral authority of the medieval church, and Niccolò Machiavelli dynamited the bridge between religious ethics and political science. The task of reconstruction in philosophy was performed in the seventeenth century by René Descartes, Thomas Hobbes, Gottfried Wilhelm Leibniz, Benedict de Spinoza, and John Locke.



Hobbes

Modern ethical theory began with Thomas Hobbes (1588–1679). The advent of Galilean natural science had challenged the traditional notions, supported by authority, of purpose, plan, and value in the physical world; it cast into doubt the doctrine of natural law and nullified the anthropomorphic assumptions of theology. New standards of ethical judgment had to be found, not in the cosmic plan of nature or in scriptural revelations of the divine will but in man himself, either in his biological structure, or in his agreements with his fellow men, or in the social and political institutions that he creates. Thus were born, simultaneously and to the same parent, the ethical philosophies of naturalism, cultural relativism, and subjectivism, respectively.

Born in a time of international and domestic strife, Hobbes regarded the preservation of life as the paramount goal of human action and constructed his system of ethics and political science in his major work, Leviathan, with the principle of self-preservation as its cornerstone. His enthusiasm for Galileo Galilei's physics and his conviction that all fields of knowledge could be modeled on this universal science (following the method of Euclid's geometry) may have suggested to him that the drive to self-preservation is the biological analogue of the Galilean principle of inertia. Hobbes conceived of man as a complex system of particles in motion and attempted to deduce ethical laws from the principle of self-preservation. He offers, however, two formulations of this principle, the first of which is his foundation of ethics, while the second is, in effect, the repudiation of ethics.

The tendency to self-preservation, according to Hobbes, expresses itself in the quest for social harmony through peacekeeping institutions and practices or, alternatively, in the aggressive drive toward power over one's fellow men. Thus he formulates his "first and fundamental" principle in two parts, the "law of nature" to the effect that "Every man ought to endeavor to peace as far as he has hope of obtaining it," and the "right of nature," that "when he cannot obtain it, he may seek and use all the helps and advantages of war." Which of these two forms of the principle of self-preservation should be applied depends, for Hobbes, on whether the agent finds, himself in a well-organized society or in a "state of nature" in which he cannot expect cooperative behavior on the part of his fellow men. Thus, the concept of ethical law applies to social agreements and commitments, while that of rights applies to the exercise of natural powers. In the state of nature one has a right to do whatever one has the power to do.

From his fundamental law of nature, Hobbes derives a number of specific rules that prescribe the means of establishing and maintaining a peaceful society, the primary means being the willingness to make or, if already made, to maintain the social contract in which individual rights or powers are surrendered to a sovereign in return for the guarantee of personal security. The state is thus the artificial creation of reasonable men, a "Leviathan" that maintains peace by means of power relinquished to it by its citizens. Once such a commonwealth has been established by contract or conquest, other general rules of conduct follow in accordance with Hobbes's theory of psychology. To restrain the natural human tendencies to envy, mistrust, self-aggrandizement, and aggression, the virtues of accommodation, gratitude, clemency, obedience to authority, and respect for the

equal rights of others are recommended by "laws of nature" as effective means of ensuring social harmony.

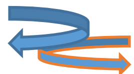
Reason and ethical laws

Hobbes's use of the term "laws of nature" in referring to ethical principles is to be distinguished sharply from the medieval concept of natural law that he rejected. There is, for Hobbes, no moral order in the cosmos, nor any natural prompting toward justice and sympathy for others in human nature. Man, like the rest of nature, is a system of particles perpetually moving and colliding in accordance with physical laws whereby direction and intensity of motion are determined solely by preponderance of force. Yet reason plays a role in human action that distinguishes man from the rest of the world machine. Ethical rules are "precepts, found out by reason, by which a man is forbidden to do that which is destructive of his life or taketh away the means of preserving the same."

In his mechanistic physiology, Hobbes explained reason as a mechanical process in the brain consisting in the combining and separating particles that serve as representations of objects and qualities; thus, cognitive processes are a special type of physical process, governed by the same laws. But on this mechanistic view of man, it is difficult for Hobbes to account for the prescriptive character he attributes to ethical laws as distinguished from physical laws. Throughout his discussion, Hobbes vacillates between a conception of ethics as a branch of physical science that describes the behavior of human mechanisms and the quite different conception of ethics as rational advice on how to get along with one's fellow men by consciously restraining one's aggressive impulses. Both sides of the nomos-phusis controversy between the Sophists and Plato are represented in Hobbes's thought, and he cites both social authority and prudential reason as sources of ethical obligation. Moral virtue consists in conformity to custom and law, in opposition to the natural aggressiveness that equips a man for survival in the state of nature, yet the "precepts found out by reason" provide a natural basis for the establishment of customs and laws.

Desire and will

Hobbes's account of desire and will is designed to bridge the gap between rational directives and physical laws. He defines "good" as "any object of desire" and desire as the motion toward an object that results from physiological processes ("endeavors") within the body. To act rationally does not entail freedom to act contrary to one's physiological impulses, since rationality or deliberation is simply the mediating processes of the central nervous system. The will is not a supernatural power controlling desires but simply the last stage of deliberation that eventuates in overt action, and thus is itself a neurological process governed by laws of physics. Freedom of the will from causal influences is, for Hobbes, a senseless combination of concepts; freedom is the "absence of external impediments" to the will. It is the person who is free or unfree, and not his will, since his freedom consists in the determination of his overt actions by his will rather than by



external forces. Yet this mechanistic account of the will seems in paradoxical contrast with his subjectivist account of civil law as deriving its obligatory force from the arbitrary will of the sovereign, an account that comes dangerously close to the Aristotelian and Augustinian notions of the will as a "first cause."

Naturalism and non-naturalism

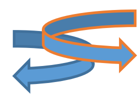
The importance of Hobbes to modern ethical theory is inestimable. In freeing ethics from bondage to revealed theology and its anthropomorphic view of nature, Hobbes brought philosophy back to the problems with which it had begun to wrestle in the time of Socrates and the Sophists, and of which it had lost sight for a millennium. At the same time, he raised the understanding of these problems to a higher level, profiting both from the Christian insight that moral principles have an obligatory force and from the refinements of scientific method introduced by Bacon, Galileo, and Descartes.

If ethics was to become a body of reliable knowledge, it must be grounded on objective laws of psychology and biology, rather than on tradition, sentiment, and church authority. On the other hand, if nature and its scientific description are ethically neutral, then ethics is to be contrasted with science and purged of references to nature, just as natural science must be purged of references to ethical values. In that case, ethical principles must be understood as subjective expressions of emotion and desire, and not as objectively verifiable laws. This dilemma has plagued philosophy ever since, and, if it was not resolved by Hobbes, at least his thought was not completely impaled on either horn but only a bit on both.

Early intuitionists

Locke

John Locke (1632–1704) is generally regarded as the founder of modern utilitarianism, although his applications of utilitarian ethics to social and political theory were more influential than his analysis of standards of individual conduct. He combined the mathematical model of ethical judgment suggested by Descartes and the Cambridge Platonists with a hedonistic theory of psychology according to which pleasure is the goal of all human action and consequently is the fundamental standard of evaluation. In his Essay concerning Human Understanding, Locke criticizes the doctrine of innate ideas of Descartes and Leibniz, in defense of the principle that all knowledge is founded on experience; he then, somewhat paradoxically, offers an account of ethics as a deductive science in which specific rules of conduct are derived "from self-evident propositions, by necessary consequences as incontestable as those in mathematics." The appearance of paradox dissolves, however, on noting that, for Locke, the formation of the ideas of goodness and justice is due to the sensations of pleasure and pain, and thus ethical concepts are derived from experience although their logical relations are then discoverable by reflective analysis.



Locke follows Hobbes in defining good as the object of desire, but then, assuming that the only property of things which provokes desire is their tendency to produce pleasure or reduce pain, he also defines good as "what has an aptness to produce pleasure in us." Again, like Hobbes, Locke defines moral virtue as conformity to custom and law, but he differs from Hobbes in maintaining that custom and law can in turn be evaluated by the more fundamental standards of utility and natural rights. It is in terms of these more basic standards that Locke justifies representative government and civil liberty.

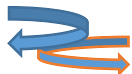
Locke's main contribution to the clarification of the meaning of ethical concepts was in his distinction between "speculative" and "practical" principles. Speculative knowledge is independent of action, while practical principles (including ethical principles) can be said to be believed and known to be true only insofar as they are acted upon. This distinction accounts for the obligatory force of ethical principles and eliminates the need for a supernatural agency, "free will," to translate belief into action, although it makes it difficult to explain why, if practical principles are "self-evident propositions," we do not all behave in a morally impeccable way. Like Hobbes, Locke ridicules the notion of free will as a semantical absurdity similar to the questions "whether sleep be swift or virtue square." Will is the power of the mind to decide on action, and freedom the power to carry out one's decisions, that is, to get what one wants.

Moral-sense theories

The seventeenth-century philosophers found the connection between self-interest and morality in the threat of punishment—divine, natural, or civil—that coerces the individual to be moral for the sake of self-interest. But it was soon noticed that this connection breaks down wherever the expected benefit to the individual of immoral conduct outweighs the likelihood of punishment and that, if morality is grounded in psychology, then human nature cannot be as aggressively self-centered as the apostles of self-preservation and pursuit of pleasure maintained.

The third earl of Shaftesbury (1671–1713) and Francis Hutcheson (1694–1746) proposed that moral obligation has its source in benevolent affections, such as love and pity, that are as natural and universal as the more aggressive tendencies ("self-affections"), such as envy, greed, and the impulse to self-preservation. Moreover, there is a "moral sense" in man that finds unique satisfaction in actions directed toward the common good. This moral sensibility turns us from the pursuit of pleasure toward the performance of duties toward others and explains our admiration of self-sacrifice independently of external reward or punishment.

Bernard Mandeville (c. 1670–1733), in The Fable of the Bees, defended egoistic psychology against this attack and ridiculed the concept of moral conscience as a hypocritical device for maintaining social privileges, a view later echoed by Baron d'Holbach, Karl Marx, and Friedrich



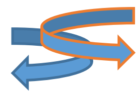
Nietzsche. Bishop Joseph Butler (1692–1752), whose sermons in defense of Christian morality against the cynicism of Hobbes and Mandeville reveal extraordinary analytical power, argued that benevolence and conscience are as deeply rooted in human nature as is self-love. In adding conscience or intuition of duty to benevolence as the psychological source of moral obligation, Butler lessened the stress of earlier moral-sense theorists on emotion and gave more recognition to the role of rational judgment. Moral-sense theory, refined further by David Hartley (1705–1757) and Adam Smith (1723–1790), who applied utilitarian ethics to economic theory, achieved its most persuasive formulation in the writings of David Hume.

David Hume

David Hume (1711–1776), like Hartley and Smith, combined an emotional account of morality with a utilitarian theory of good. Hume's discussions of ethics in the third part of his A Treatise of Human Nature and, more fully, in his An Enquiry concerning the Principles of Morals are attempts to answer the metaethical questions of the meaning of good, right, justice, and virtue; by what standards they are attributed to persons and actions; how it is psychologically possible for men to admire and cultivate morality at the expense of self-interest; and by what rules ethical disputes can be decided in favor of one judgment against another. Despite the clarity and good sense that Hume brings to bear on these topics, his discussion shifts inadvertently from one type of question to another, particularly from questions of meaning to questions of motivation, a shift characteristic of moral-sense theories.

Hume begins his studies of ethical judgment with a search for the meanings of ethical terms. Finding no observable facts or logical relations that answer to our concepts of goodness, justice, and moral virtue, Hume concludes that the function of ethical terms is not to denote qualities or relations but to convey a "sentiment of approbation," so that their meaning is to be found in the feelings of the judge rather than in the object judged. We call things good for the same reason that we call them beautiful: because we find them agreeable. An object is good if it is immediately pleasant, or if it is a useful means for attaining something else that is pleasant. Virtues are qualities that render a person agreeable or useful to himself or to others, whether they are "natural virtues" such as talent, wit, and benevolence or "artificial virtues" like honesty and justice. While judgments as to what is useful in producing pleasure, insofar as they rest on knowledge of causal facts, are within the competence of reason, nevertheless they depend, for their distinctively ethical import, on feeling or taste, since rational knowledge alone is "not sufficient" to produce any moral blame or approbation. "Utility is only a tendency to a certain end; and were the end totally indifferent to us, we should feel the same indifference toward the means. It is requisite a certain sentiment should here display itself" (Enquiry concerning the Principles of Morals, Appendix I).

Thus, according to Hume, there are two possible grounds or standards of evaluation, utility and feeling, the one objective and subject to rational confirmation, the other subjective and personal.



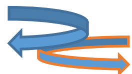
The objective standard, unfortunately, applies only to instrumental values and not to ultimate ends. However, the subjectivity of feelings is not cause for despair about achieving agreement on ethical judgments, since the sentiment that motivates them, the disinterested pleasure and approval that we feel in contemplating actions directed toward the welfare of others, is, for Hume as for Butler, a universal tendency in human nature.

Moral reasons and psychological motives

In common with Hobbes and Locke, who justified moral conduct by the fear of punishment, and the earlier moral-sense theorists, who explained moral obligation in terms of the benevolent affections, Hume identifies the psychological motives that influence and often prejudice moral judgments with the logical grounds or reasons for moral judgments. From the premise that, were it not for our natural benevolence, we would not care enough about moral issues to make moral judgments, Hume draws the non sequitur that the only evidence which supports such judgments lies in the feeling of approval or disapproval that motivates them.

Hume tends to equate moral virtue with the artificial quality of justice, artificial because it is required only for the protection of property rights in a society in which goods are neither too scarce nor sufficiently abundant. The importance for social harmony of strict conformity to laws renders it dangerous and undesirable to make exceptions in the name of expediency. Consequently, the utility of strict justice outweighs the utility of any possible exceptions. But Hume realized that this rather abstract utilitarian consideration can hardly explain our sense of moral obligation and our admiration for those who demonstrate high moral character. He therefore supplements this account with the notion of "disinterested interest" that resembles the rational moral sense appealed to by Butler, Richard Price, and Thomas Reid.

However, Hume is not positing any occult faculty, for he explains disinterested moral approbation as a combination of the natural quality of sympathy for others (pain at witnessing another's pain) and the habit of following rules. Since natural sympathy alone would lead us into injustices and considerations of utility alone would seem to justify exceptions to general rules, we come to agree on general principles of conduct and transfer to these principles the sentiment of approbation that we originally felt toward the happiness or release from pain usually produced by following such principles. Thus arises the sense of moral duty and the capacity for disinterested approval. Here again, Hume offers a psychological description of the motivating processes that cause us to approve of moral virtue as an answer to the question of what criteria we use to judge persons and actions to be worthy of moral approval. Once this identity of psychological motive and logical ground is presupposed, it becomes impossible to distinguish between correct and incorrect moral judgments. The question as to whether action that meets with general approbation actually merits such approbation cannot even be raised, since merit has already been identified with the mere fact of approbation.



Freedom

On the issue of free will and its relation to moral responsibility, Hume argued persuasively that responsibility presupposes the causal efficacy of threat of punishment. He developed further the arguments of Hobbes and Locke that freedom is not a quality of the will but a relation between desire, action, and environment, such that a man is free when his actions are caused by his own desires and unimpeded by external restraints, a view that William James later baptized "soft determinism."

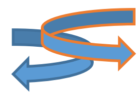
The French enlightenment

Ethical thought in eighteenth-century France paralleled developments in Great Britain, although the French philosophers failed to establish as strong traditions as their British contemporaries. French thought subsequent to the eighteenth century added little to moral philosophy as compared with that of Germany and Great Britain. Due to their intense involvement in political issues, the French writers placed rhetorical effectiveness above clarity and consistency as a standard of philosophical value.

Voltaire (François-Marie Arouet, 1694–1778) and Jean-Jacques Rousseau (1712–1778) led the revolt against Cartesian rationalism as well as against political and religious superstition, so transforming philosophy into ideology that idéologue became a popular French synonym for philosophe. Voltaire employed acid satire in attacking religious and philosophical obscurantism in Candide, Zadig, and his Philosophical Dictionary, while Rousseau inaugurated the romantic style of soul-stirring emotional intensity, in place of detached analysis and rigorous argument. Denis Diderot (1713–1784) raised philosophical writing to the highest level of literary grace and subtlety since Plato, criticizing conventional morality and religious beliefs in his remarkable essay-novels Le neveu de Rameau, Jacques le fataliste, and Rêve de d'Alembert. Yet while appreciating their extraordinary intellectual qualities and the permanence of their place in Western culture, it must be noted that they provided few new concepts and principles on which later ethical philosophers could build.

Rousseau

Rousseau's celebrated exaltation of untutored human nature in his two Discourses attributed genial and cooperative tendencies to man's innate disposition and aggressively self-serving tendencies to the harmful influence of civilization. This coincided with the British moral-sense theorists' attacks on Hobbesian egoism. However, unlike Hume (his friend and benefactor prior to their notorious public quarrel), Rousseau considered custom and law to be arbitrary restraints on natural impulses rather than rational methods of channeling self-interest toward the common good. Whatever justification can be given for control of the individual by social institutions lay, for Rousseau, in their claim to represent the "general will," that is, the desires of the majority, independently of whether what is so desired is good. While Rousseau argued forcefully, in The Social Contract, for



popular sovereignty and the right of revolution, he justified the use by the state of extremely repressive measures, such as the death penalty for atheism. His rather mystical notion of the state as the embodiment of the general will helped to inspire the overthrow in France of absolute monarchy in favor of representative government, yet half a century later it was employed by Johann Gottlieb Fichte, and a century after that by V. I. Lenin, in the justification of authoritarianism.

Although Rousseau's religious mysticism and his preference for feeling over rational prudence were contrary to the general tone of the Enlightenment, his most lasting contribution to ethical philosophy was his insistence that good and evil tendencies are due to social causes, a principle that he shared with baron de Montesquieu, Voltaire, and the Encylopedists. The soundness of this principle is subject to question, but there can be no doubt that it served as a useful guide in the reform of social institutions.

Montesquieu

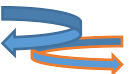
Charles Louis de Secondat, baron de la Brède et de Montesquieu (1689–1755), in The Spirit of the Laws founded the relativistic conception of moral and political principles as grounded in the traditions of particular societies. The "spirit of the laws" is the system of social practices in relation to which new laws are to be evaluated. Western European governments require a division of functions and compensating checks and balances to fulfill the partly republican, partly monarchical values of European society. In treating values as historical and sociological facts, rather than as divine principles or natural laws, Montesquieu developed further the scientific approach to ethics and politics begun by Machiavelli and Hobbes.

Nineteenth-Century Ethics

Nineteenth-century ethical thought became a battleground for two rival traditions. Utilitarianism, stemming from Locke, Hume, and the French Encyclopedists, dominated British and French philosophy, while idealistic ethics was supreme in Germany and Italy. Both traditions took root in the United States, with idealism appealing to the religious vision of Ralph Waldo Emerson and Josiah Royce, while utilitarianism answered to the developing faith in technology that found philosophical expression toward the end of the century in the pragmatic ethics of James and John Dewey.

Utilitarianism

Christian ethics based on divine authority and natural law was given a utilitarian interpretation by William Paley (1743–1805) in his Principles of Moral and Political Philosophy. The source of

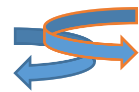


moral obligation, he agreed with Hobbes, lies in the "violent motive resulting from the command of another," while the ground of goodness is pleasure or utility. But moral duty and self-interest coincide because God, as the paramount authority, commands us through the Scriptures and the promptings of conscience to seek the general good as well as our own happiness. Moral obligation is supported both by natural pleasure in the welfare of others and by the fear of divine punishment that provides the selfish but rational person with a good reason to sacrifice his pleasure for the common good. Paley's psychological account of morality, like that of earlier moral-sense theories, failed to explain why anyone who lacks natural benevolence ought to have it. His alternative justification of morality in terms of the fear of divine punishment equally fails to explain why such punishment would be just and why a nonbenevolent nonbeliever in Christian theology can nevertheless be expected to behave morally.

Bentham

The mainstream of utilitarian thought was anticlerical. Jeremy Bentham (1748–1832) and James Mill (1773–1836) formed a political movement that helped bring about legislative reforms by criticizing social institutions in terms of their utility in producing "the greatest happiness for the greatest number." In his influential Introduction to the Principles of Morals and Legislation, Bentham formulated a theory of ethics and jurisprudence remarkable for its clarity and consistency. The great appeal of Bentham's theory lay in its apparent simplicity and ease of application, although these virtues may have been more apparent than real. Bentham attempted to make ethics and politics scientifically verifiable disciplines by formulating quantitative standards of evaluation. He began with the psychological generalization that all actions are motivated by the desire for pleasure and the fear of pain: "Nature hath placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do. On the one hand the standard of right and wrong, on the other the chain of causes and effects, are fastened to their throne" (Principles, London, 1823, p. 1). From this equation between ethical obligation and psychological necessity, Bentham derived the general principle of utility that "approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question," happiness being understood as the predominance of pleasure over pain.

The most original but also the most dubious part of Bentham's theory is his "hedonic calculus" for measuring pleasures and pains, in computing the overall value of alternative policies. If such a procedure were feasible, ethical judgments would be as scientific as meteorological forecasts, even though both are subject to considerable error, due to the complexity of the factors involved. But Bentham's ideal of a science of ethics runs afoul of two internal difficulties, the resistance of pleasure to measurement and the impossibility of predicting the long-range consequences of actions. Aside from these internal defects, there remains the general objection that pleasure, unlike pain, is not a bodily sensation but a favorable response to an object grounded on the perception of value in the object, as Thomas Reid had argued. To conclude that an object is good from the fact



that it pleases us involves the circular reasoning that it is good because it is judged to be good, a principle too vacuous to provide a guide to ethical judgment. If, on the other hand, pleasure is understood in a more narrow, technical sense as desirable bodily sensations, then Bentham's identification of happiness and welfare with pleasure is unacceptable because it reduces human experience to the level of animal existence. The plausibility of Bentham's theory may be due to the ease with which he shifts inadvertently from one of these senses of pleasure to the other.

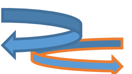
Despite its theoretical defects, Benthamite utilitarianism, which was more socially oriented than that of Locke and Hume, had a salutary effect on social legislation. His analysis of pleasures into factors of intensity, duration, propinquity, certainty, fecundity, and "extent" (number of persons affected) offered reasonable criteria by which alternative social programs and laws can be evaluated and was a marked improvement over the sanctification of existing laws and customs by which Hobbes, Locke, and Hume had made the transition from self-interest to morality. But there is a missing link in Bentham's chain of reasoning that may not be reparable within the confines of his hedonistic psychology, namely, the link that should connect the desire for one's own pleasure with the willingness to consider "extent" or pleasure of others in deciding on a course of action. Is desire for the pleasure of others also a "sovereign master under which nature hath placed us?" If so, then desire for one's own pleasure cannot be sovereign as well. If not, then on what ground are we required to consider the factor of extent?

Idealist ethics

Kant's distinction between man as noumenon, legislating and obeying "laws of freedom," and man as phenomenon, governed by laws of nature, was incorporated into new ethical systems by later German idealists, who assimilated the phenomenal side of the distinction to a part of the noumenal side, making natural science subordinate to ethics. Johann Gottlieb Fichte (1762–1814) extended the noumenal will into a universal force that creates the material world out of its own force and expresses itself partially in the free rational will of the individual conscience but more fully in social institutions and laws. The individual thus achieves self-realization in identifying himself with the universal will and voluntarily accepting his Beruf (vocation) as part of the social order.

Hegel

G. W. F. Hegel (1770–1831) developed Fichte's social basis of ethics further and in more historical terms. For Hegel value, morality, and law are among the highest forms of self-realization of absolute spirit. The Enlightenment doctrine of abstract rights is only the first stage in the development of ethical consciousness. A higher stage is reached in the Kantian sense of moral duty, which recognizes the conflict between individual rights and social responsibilities, subordinating the former to the latter. But the highest stage of self-realization of "objective mind" involves the incorporation of rights and duties in a rational system of social and political



institutions which the individual citizen recognizes as the embodiment of the national will. The perfect freedom that consists in rational self-determination is achieved when individual conscience coincides with custom and law, so that will and reason, subjective motivation and objective necessity, become identical. But this is possible, according to Hegel, only in the modern age of the national state, Christian conscience, and constitutional law. In earlier stages of human history, whatever was necessary for historical progress was, for that age, necessary and therefore right, as, for example, the institution of slavery was necessary and right in ancient Greece. "World history," he declared, "is world justice."

Post-Hegelian Theories

The impact of Darwin's theory of natural evolution produced naturalistic echoes of Hegelian historical relativism in the utilitarian "survival of the fittest" doctrine of Herbert Spencer (1820–1903), the Marxist philosophy of class conflict, and the cultural elitism of Nietzsche.

Marx

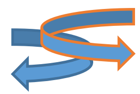
Karl Marx (1818–1883) transformed Hegel's theory of the dialectical self-realization of mind into a doctrine of dialectical development of history through class conflict. In the Marxist theory, moral principles represent the sanctification of the interests of the ruling class at each stage in the development of progressively superior modes of economic organization. Marx criticized both utilitarian and Kantian ethics as variant expressions of bourgeois marketplace procedures. Subordinating rules of individual conduct to the historical imperatives of "revolutionary praxis," the Communist Manifesto of Marx and Friedrich Engels called for revolutionary action to achieve a classless society in which "the free development of each is the condition for the free development of all," a society that would require neither the internal repressions of conscience nor the external repressions of laws and punishments. Both morality and the state would "wither away."

British Idealism and Intuitionism

In the last quarter of the nineteenth century the vitality of idealism began to attract even the sober British intellect, and the ethics of self-realization became a powerful rival to utilitarianism through the influence of Thomas Hill Green, Bernard Bosanquet, and F. H. Bradley.

Sidgwick

Henry Sidgwick (1838–1900) combined the social utilitarianism of Mill with the intuitionism of Butler and Kant. In The Methods of Ethics (1875), a work described by C. D. Broad as "the best



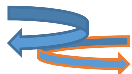
treatise on Moral Philosophy that has ever been written," Sidgwick raised ethical analysis to a new level of precision and logical rigor. Setting aside practical moralizing as not the business of objective philosophical analysis, Sidgwick interpreted the task of moral philosophy to be the clarification of the logic of moral judgment, a conception of philosophy that was continued by the contemporary British school of linguistic analysis.

Sidgwick held that there are just three approaches to ethics worth philosophical consideration: egoistic hedonism, utilitarianism, and intuitionism. He pointed out that neither the self-centered ethics of Hobbes and the French Encyclopedists nor the socially oriented ethics of Bentham and Mill can justify the step from psychology to ethics, that is, from the description of human motivation to judgments of moral obligation. Even those who declare that one ought to pursue one's own interests must justify their use of ought, and this cannot be done on the grounds of psychological facts alone. Sidgwick therefore insisted on distinguishing psychological hedonism from ethical hedonism and grounding the latter on intuition. His argument is reminiscent of Hume's claim that values cannot be deduced from facts, and it anticipates G. E. Moore's later analysis of the "naturalistic fallacy."

All three "methods of ethics" rest, according to Sidgwick, on principles held to be self-evident, and thus intuitionism is, to some extent, inescapable. The egoist must assume the self-evident rightness of pursuing one's own pleasure, and the social utilitarian must assume the rightness of maximizing the common good. Intuitionists differ from utilitarian and egoists only in holding many principles and duties to be self-evident as well, and thus they expose themselves to inevitable counter instances. The more numerous and specific the rules claimed to be self-evident, the more subject to exception and vulnerable to disproof. Sidgwick concludes that social utilitarianism offers the correct standard of moral judgment but that this standard is in turn grounded on direct awareness of moral obligation. Thus at least one, and probably at most one, moral intuition is essential for moral judgment.

Sidgwick could not finally decide between the conflicting claims of self-interest and social utility. He leaned toward the latter as definitive of moral duty, but he recognized that one's self-interest rightly carries a special weight, other things being equal. Perhaps he would have been able to reconcile these two "intuitions" more easily had he considered utilitarianism in a somewhat weaker form, as the principle that one ought always to refrain from causing unnecessary suffering, rather than the stronger claim that one ought always to aim at maximizing happiness. For while one's own welfare seems naturally to outweigh that of others, it is very close to being self-evident to any morally sensitive person that he ought not to pursue his interests at the cost of substantial suffering to others.

It would appear from our brief glance over the history of ethics through the nineteenth century that philosophers failed to find any conclusive ethical truths and merely argued, more persuasively and

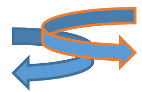


with a more impressive display of learning than most, for whatever way of life and standards of conduct they happened to prefer. In some respects this impression would be justified, and it serves to remind us of the differences between scientific knowledge and ethical wisdom. The perennial character of the problems, the lack of general agreement on proposed solutions, and the return of later doctrines to principles advanced by earlier ones all contrast strikingly with the irreversible progress of scientific discovery. It has been suggested by some contemporary philosophers that the endless disputability of ethical issues is rooted in the very nature of ethical language, so that it is not a defect of philosophy to have failed to achieve general agreement on ethics. As W. B. Gallie put it (Philosophy and the Historical Understanding, New York, 1964), ethical concepts are "essentially contestable." It is essential to their meaning that they evoke continual disputes as to the correct standards for their application. But if we cannot find historical progress in the form of final settlement of issues, we can at least discern some degree of gradual, if irregular, advance toward greater clarity in the formulation of the issues.

On the central issue of the logical relation between facts and values, ethical theories have provided increasingly clear and sophisticated statements of two fundamental positions, naturalism and non-naturalism (sometimes called teleology and deontology). Naturalistic theories relate values to facts by defining "good" and related concepts in terms of observable criteria, such as fulfillment of natural tendencies (Aristotle), satisfaction of desire (Hobbes and Spinoza), production of pleasure for the greatest number (utilitarianism), conduciveness to historical progress (Spencer and Marx), or efficiency of means to ends (Dewey). Non-naturalistic theories stress the fact that the meaning of ethical terms goes beyond the observable facts on which ethical judgments are grounded, and they locate the additional component of meaning outside nature. Plato located it in a realm of abstract Forms, Christianity in the will of God, the intuitionists in the direct recognition of the quality of rightness, the moral-sense theorists in the feeling of approbation. Each of these accounts of value and moral right has revealed an additional dimension of the complex logic of ethical judgment. Naturalistic theories have brought to light various ways in which ethical judgment is grounded on the fulfillment of biological and social needs, while non-naturalistic theories have revealed prescriptive aspects of moral concepts that are independent of prudential considerations. The main effort of twentieth-century ethical philosophy was to weave together in a consistent pattern all the threads, both naturalistic and non-naturalistic, that constitute our philosophical heritage.

Contemporary Non-naturalism

In much of the English-speaking world G. E. Moore's Principia Ethica (Cambridge, U.K., 1903) is taken to be the starting point of contemporary ethical theory. But it is important to recognize that this primacy is to a considerable degree local and distinctive of the tradition of analytical ethics. On the Continent and in Latin America the work of Max Scheler and Franz Brentano has been a preeminent influence. For much of American thought until about the mid-twentieth century,



the work of John Dewey or Ralph Barton Perry provided the starting point. But, for all that, it is reasonable to begin with G. E. Moore.

Moore

It is the critical side of Moore's work in ethics that has had the most lasting effect. His delineation of the subject matter of ethics and his very careful effort to show that any form of ethical naturalism involves a fundamental conceptual mistake—the work of the first three chapters of Principia Ethica —has been the part of Moore's work that has deeply affected contemporary ethical thought. However, Moore's own positive non-naturalistic cognitivism, with its reliance on non-natural characteristics, has found few adherents. Most philosophers—C. L. Stevenson and R. M. Hare are typical—who have been convinced that in essence Moore's case against naturalism is sound have not followed Moore's lead but have adopted some form of non-cognitivism.

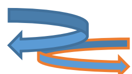
It was Moore's belief that if moral philosophers simply interest themselves in good conduct, they are not really starting at the beginning, for we cannot know what good conduct is until we know what goodness is. Moore's concern was with a "general enquiry into what is good." Our first question must be "What is good and what is bad?" Such knowledge of good and evil, Moore claims, is the "goal of ethical investigation"; but, he stresses, "it cannot be safely attempted at the beginning of our studies, but only at the end." First we must consider how "good" is to be defined.

Moore clearly is not interested in giving a stipulative definition of "good," and from his disclaimers in Principia Ethica about being interested in a merely verbal point, it would seem that he is not interested in a lexical definition either. What he is after, in seeking a definition of "good," is just this: what property or set of properties is common to and distinctive of anything that could conceivably be properly called intrinsically good, for instance, "answering to interests." Moore thinks "good" stands for a property, and he seeks to determine what it is. Moore's answer, which he is aware will cause discontent, is that "good" is not definable. All we can finally say correctly is that good is good and not anything else. "Good," like "red," is, in the appropriate sense, indefinable. Good is a simple, unanalyzable, nonnatural characteristic. We are either directly aware of it or we are not, but there is no way of defining it or analyzing it so as to make it intelligible to someone who is not directly aware of it.

Such a radical claim on Moore's part would have little force if he could not thoroughly refute naturalistic and metaphysical theories that do purport to give the kind of characterization of intrinsic goodness that he takes to be impossible.

Moore's case against naturalism

Let us consider Moore's case against ethical naturalism. An ethical naturalist holds that moral judgments are true or false empirical statements ascribing an empirical property or set of properties to an action, object, or person. "Good" is defined in terms of this property or set of properties. But,



Moore argues, we will not come to know what good is simply by "discovering what are those other properties belonging to all things which are good." Those who commit what Moore calls the naturalistic fallacy think that when they have "named those other properties they were actually defining good; that these properties, in fact, were simply not 'other,' but absolutely and entirely the same with goodness." But to identify good with any other property is to commit the naturalistic fallacy. The naturalists confuse the question of the meaning of the concept of good with the quite different question of what kinds of things are good.

In a famous argument, which has been dubbed the open-question argument, Moore points out that for whatever naturalistic value we substitute for the variable x in a proposed definition of "good," we can always significantly ask if it is good. If a man says "Happiness is good," or "Self-realization is good," or "The object of any interest is good," we can always significantly ask "Is happiness good?," "Is self-realization good?," "Is the object of any interest good?" Even though we agree, let us say, that happiness is good, it is an evident fact of language that these questions are not without significance. But they would be without significance if "good" did mean "happiness," or "self-realization," or "the object of any interest," just as it is pointless to ask if a father is a male parent or a puppy is a young dog. For whatever naturalistic definitions we offer—whatever naturalistic values replace the variable x —it always makes sense to ask if that thing is good. Since this is so, these naturalistic definitions can be seen to be inadequate.

This can be seen in another way as well. If a statement like "The satisfaction of desire is good" were a definition of the sort Moore was searching for, it would be analytic and it would be self-contradictory to assert "This satisfies desire but it is not good." For whatever naturalistic definition one proposes, however, one can assert without self-contradiction "This is x but it is not good," but if x meant the same as "good" this would be impossible, for "X is good" would then be analytic. But since this is possible it is clear that the proposed statement is synthetic.

Moore's influence

The above arguments of Moore's, together with his famous argument in Chapter 3 of Principia Ethica against Mill's alleged naturalism, have provided the background for much of the controversy in contemporary ethical theory. While few have accepted all the details of Moore's case against ethical naturalism, it has been felt by many that Moore's essential case is well taken. R. M. Hare in his The Language of Morals (Oxford, 1952), P. H. Nowell-Smith in his Ethics (Harmondsworth, U.K., 1954), and A. C. Ewing in his Second Thoughts in Moral Philosophy (London, 1959) try to restate these Moorean insights in such a way as to present a decisive case against ethical naturalism.

It should be noted, however, that the reception of Moore's case against naturalism, even on the part of such eminent nonnaturalists as A. N. Prior and E. W. Hall, has not been that favorable. It is generally thought now that (1) the naturalistic fallacy is not, strictly speaking, a fallacy but is at

best a mistake and (2) that it is not really distinctive of naturalism but should be called the definist fallacy, that is, the belief that moral terms are capable of definition in nonmoral terms.

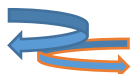
Criticisms of Moore

It is easy to see that someone, though at a certain price, could be a consistent ethical naturalist and that Moore's naturalistic fallacy would not really point to anything necessarily fallacious in such a naturalist's reasoning. An ethical naturalist who is also a hedonist could argue: By "intrinsic good" I am just going to mean "pleasure." This is a stipulative definition on my part and I am making no claim that it squares with ordinary usage, but it will give a clear and consistent definition of "good" that fits well with my preanalytic insight that pleasure and pleasure alone is intrinsically good. It is indeed true that on my theory "Pleasure is good" is a tautology and "Is pleasure intrinsically good?" is a self-answering question. Still, there is a normatively vital question that I can and do ask with perfect conceptual propriety. The vital open question is this: Should an individual seek pleasure and only pleasure as the thing that, morally speaking, he ought always to do? If a man takes this position, Moore's arguments, given above, do not show anything fallacious in his thinking, that is, he has committed no formal or informal fallacy, though it can be shown by some additions to Moore's arguments that he has said something that is mistaken.

There is a further criticism of Moore that can be made with considerable plausibility. Though it is indeed true that good taken in isolation cannot be defined, the term good is in reality always used in specific contexts, with context-dependent meanings and with such riders as "good at" and "good for." But in such a context good can be defined. "A good car," "good teacher," "good at ballet," or even "good man" can be naturalistically defined, even though good sans phrase cannot. Finally, and perhaps most importantly, it has been pointed out that the open-question and noncontradiction arguments are not conclusive. At best they show why all the naturalistic definitions hitherto proposed do not work. They do not show that naturalistic definitions are impossible.

Emotive theory

The noncognitive view, which has subsequently been called the emotive theory, received its first formulation in 1911, when the Swedish philosopher Axel Hägerström drew the outlines of such a theory in his inaugural lecture, "On the Truth of Moral Propositions." In 1917 Hägerström developed his ideas with particular attention to the concept of duty in his Till Frågan om den Gällande Rättens Begrepp (Uppsala, 1917). Similar statements of the emotive theory have been developed in Scandinavia by Ingmar Hedenius and Alf Ross. Independently of its Scandinavian formulation, the emotive theory was first stated in the English-speaking world by I. A. Richards and by Bertrand Russell, but it was developed in the Anglo-Saxon world by A. J. Ayer and by Charles Stevenson. There have also been interesting if somewhat atypical statements of it by Richard Robinson, Rudolf Carnap, and Hans Reichenbach.



The emotivists were convinced that moral statements are not a subspecies of factual statement, and they were further convinced that it was impossible to derive a moral statement from a set of purely factual statements. As Hägerström put it, "There is no common genus for the purely factual and the 'ought.' By using the predicate 'ought to happen' we refer an action to an altogether different category from the factual. That an action 'ought to be done' is regarded as something which holds true altogether without reference to whether it actually is done or not." The whole notion that there is a determinate character of an action that would make a moral statement true or false is, Hägerström argues, an illusion. There is nothing there for an "unmoved spectator of the actual" to observe that would either confirm or disconfirm his moral statements. Moral statements characteristically take a declarative form, but they actually function not to assert that so-and-so is true but to express an attitude toward an action or a state of affairs.

The emotive theory developed as a via media between intuitionism, on the one hand, and ethical naturalism, on the other. Both of these ethical theories displayed crucial difficulties. "Nonnatural qualities" and "nonnatural relations" were obscure, fantastic conceptions, to say the least, and the notion of intuition remained at best nonexplanatory. Furthermore, it was plain that moral judgments are closely linked to one's emotions, attitudes, and conations. But, as Moore in effect showed, neither "A cup of tea before bed is good" nor such general utterances as "Pleasure is good" and "Self-realization is good" are empirical or analytic.

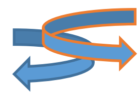
The function of ethical statements

The emotivists maintained that while the grammatical function of a sentence like "A swim before bed is good" is indicative, its actual logical function is much closer to that of an optative or imperative utterance, such as "Would that we could go swimming before bed" or "Swim before bed." Because of this, emotivists have claimed that it is misleading to say that ethical sentences can be used to make statements: They do not function to assert facts.

Similarly, it is a mistake to treat all words as simply functioning to describe or designate some characteristic or thing. Some words so function; but there are other words, like nasty, saintly, graceful, and wise, that function primarily or in part to express the attitudes of the utterer or to evoke reactions on the part of the hearer. The emotivists claim that good, ought, right, and the like are also emotive words. This gives them their normative function.

Ethical argument

Hägerström and Ayer contend that the fact that there are no moral facts carries with it the corollary that there can be no genuine moral knowledge. There are no moral facts to be learned; there is no moral information to be gained or forgotten. It makes clear sense to say "I used to know the difference between a pickerel and a pike, but by now I've forgotten it," but what is meant by "I used to know the difference between right and wrong, but by now I've forgotten it"? The word forgotten could hardly do its usual job here. The utterance is so deviant that without explanation and a very special context, we do not understand it. Considerations of this sort bring us to the



realization that moral utterances are not used to state facts or assert truths; their essential role is a noncognitive one. They typically express emotions, attitudes, and conations and evoke actions, attitudes, and emotional reactions.

Because of this fact about the logical status of moral utterances, it always remains at least logically possible that two or more people might agree about all the relevant facts and disagree in attitude—that is, disagree about what was desirable or worth doing.

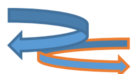
We do, however, as Ayer and Stevenson stress, give reasons for moral judgments. If I say "MacDonald did the right thing in killing Janet," it is perfectly in order to ask me to show why this is so. If I say "I don't have any reasons. There aren't any reasons, but all the same I just know that MacDonald did the right thing," I am abusing language. I am saying something unintelligible, for we cannot "just know" like that. The person who claims that an action is right must always be prepared to give reasons for his moral claim.

Ayer and Stevenson grant all that. This is indeed how we do proceed when we are being reasonable about a moral disagreement. But Ayer says: "the question is: in what way do these reasons support the moral judgments? They do not support them in a logical sense. Ethical argument is not formal demonstration. And they do not support them in a scientific sense either. If they did, the goodness or badness of the situation, the rightness or wrongness of the action, would have to be something apart from the situation, something independently verifiable, for which the facts adduced as the reasons for the moral judgment were the evidence." But this is just what we cannot do. There is no procedure for examining the value of the facts, as distinct from examining the facts themselves.

If we cannot demonstratively prove or inductively establish fundamental moral claims, then what can it mean to say that a factual statement F is a good reason for a moral judgment E ? The emotivist's answer is very simple: If F causes the person(s) to whom E is addressed to adopt E, to share the attitude expressed by E, then F is a good reason for E. It is Ayer's and Stevenson's claim that whatever in fact determines our attitudes is ipso facto a good reason for a moral judgment.

Criticisms of emotive theory

It has been argued by many moral philosophers (W. D. Falk, Richard Brandt, Errol Bedford, Paul Edwards, and Kai Nielsen, among others) that so to characterize what is meant by "a good reason" in ethics is persuasively to redefine "a good reason" in ethics. As Bedford has well argued against the emotive theory, "we do use logical criteria in moral discussion, however inexplicit, unanalyzed, and relatively vague these criteria of relevance may be." Remarks like "It doesn't follow that you ought to" or "That's beside the point" are just as common and just as much to the point in moral argument as elsewhere. There is no reason to think that these remarks about relevance differ in any essential way from their use in nonevaluative contexts. We don't just seek agreement when there is a moral dispute, but we try to justify one claim over another and we rightly reject persuasion as irrelevant to this task of justification.



Stevenson has replied that to answer in this way is in effect to confuse normative ethical inquiries with metaethical ones. Good and relevant are normative terms and have their distinctive emotive force. To say that such and such are good reasons is to make a moral statement. Making such a statement involves leaving the normative ethical neutrality of metaethical inquiry. One answer to this is that to say what is meant by "good reasons" in ethics is to mention "good reasons" and not to use them.

Existentialism

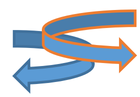
Non-cognitivism is not limited to emotivism. The existentialists do not call themselves noncognitivists, nor do they write metaethical treatises. But reasonably definite metaethical assumptions are implicit in their writings. Their contention that "men create their values," their stress on decision, commitment, and the impossibility of achieving ethical knowledge, strongly suggests a noncognitivist metaethic. We shall limit the examination here to two major figures, Albert Camus and Jean-Paul Sartre.

Camus

Unlike Sartre, Albert Camus wrote no technical philosophy, but in his Myth of Sisyphus (Paris, 1942), The Rebel (Paris, 1951), and his plays and novels he did articulate an ethical view that has been called the ethics of the absurd. To read Camus is to be immediately thrown into normative ethics via what has been called philosophical anthropology. We are immediately confronted with a picture of man and man's lot. Man is divorced from the world yet is paradoxically thrust into it. The world as we find it—given our hopes, our expectations, our ideals—is intractable. It is incommensurate with our moral and intellectual demands. Life is fragmented. We seek to discover some rational unity amidst this diversity and chaos. We discover instead that we can only impose an arbitrary unity upon it. L'homme absurde, as distinct from l'homme quotidien, sees clearly the relativity and flux of human commitment and the ultimate purposelessness of life. Yet man has a blind but overpowering attachment to life as something more powerful than any of the world's ills or any human intellectualization. But the world is ultimately unintelligible and irrational, and man's lot in the world is absurd.

Given this situation, all moral commitments are arbitrary. There is no escaping this: Reason will only show us the arbitrariness of human valuations, and a Kierkegaardian leap of faith in the face of the absurd is evasive. It is evasive because it is to consent to absurdity rather than to face up to it, recognizing it for what it is. Man's dignity comes in his refusing to compromise. His very humanity is displayed in his holding on to his intelligence and in recognizing, contra Kierkegaard, that there is no God and, contra Karl Jaspers, that there is no metaphysical unity that can overcome the absurdity of human existence.

Yet paradoxically, and some would claim inconsistently, in his novel The Plague (Paris, 1947), and in his essays, collected and published in English under the title Resistance, Rebellion and Death (New York, 1961) Camus writes with passion and conviction in defense of human freedom



and intelligence. Camus's rationale for this is that we become engagé because we see that life has no ultimate meaning and that, finally free from a search for cosmic significance, we can take the diverse experiences of life for what they are in all their richness and variety. Yet beyond that and perhaps because of that, Camus, as a humanist, is espousing the cause of man. By this is meant, as is very evident in Resistance, Rebellion and Death, that Camus repeatedly defends human freedom, equality, and the alleviation of human misery and deprivation. We must become involved, but in this involvement Camus urges a reliance on human intelligence in facing the problems of men.

What might be taken to be a conflict between the more theoretical side of Camus's thought and his more directly normative ethical side comes out in his fourth "Letter to a German Friend." Camus agrees with his "German friend" that the world has no ultimate meaning, but he does not and will not conclude from this, as his "German friend" did, "that everything was equivalent and that good and evil could be defined according to one's wishes." Camus then goes on to remark that he can find no valid argument to answer such a nihilism. His only "answer" is "a fierce love of justice, which after all, seemed to me as unreasonable as the most sudden passion." Camus felt he could only resolutely refuse to accept despair and "to fight against eternal injustice, create happiness in order to protest against the universe of unhappiness." Camus concludes with a cry of the heart that while "the world has no ultimate meaning … something in it has a meaning, namely man because he is the only creature to insist on having one."

Recent Views on Moral Discourse

Linguistic philosophy

As has frequently been noted, there are at least superficial resemblances between the existentialists and the otherwise very different, self-consciously metaethical theories of such linguistic philosophers as R. M. Hare, P. H. Nowell-Smith, Bernard Mayo, Alan Montefiore, and John Hartland-Swann.

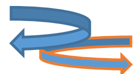
There is, indeed, this much similarity between these linguistic philosophers and the existentialists. All of the former make the following contentions, all of which would be welcome to the latter:

Moore was essentially right about the naturalistic fallacy. That is to say, moral statements cannot be deduced from any statement of fact, whether biological, historical, psychological, sociological, or religious.

No moral choice or question of value can ever be guaranteed by logical rules.

We are free, as far as language or logic is concerned, to apply evaluative or prescriptive terms to anything we wish to commend or condemn, criticize or approve, prescribe or forbid.

Moral utterances are generalizable decisions, resolutions, or subscriptions.



Given that a man accepts certain moral principles, other moral principles can, together with certain factual statements, be derived from the above principles. But like Ayer and the existentialists, these linguistic philosophers hold that there must be some moral principles which are not derived from any other principles—moral or otherwise—and, being fundamental moral principles, they are not even verifiable in principle. They express moral commitments and can have no rational ground, for what is deemed worthy of acceptance ultimately depends on the very commitments (generalizable decisions, resolutions, or subscriptions) an agent is willing to make.

Many people have thought that such a view of morality is either directly or indirectly nihilistic—that both the linguistic philosophers and the existentialists espouse what is in effect an irrationalism that would undercut the very possibility of a rational normative ethic. If we consider a reply linguistic philosophers typically make to such criticisms, we will become aware of a crucial dissimilarity between them and the existentialists and a fundamental defect in existentialist ethics.

Linguistic philosophers have frequently claimed that the existentialists have merely dramatized a logical point. That moral principles are expressions of commitment or choice, that man cannot simply discover what is good or evil or know a priori that a certain thing must be done but must "create his own values," is not a worrisome fact about the human predicament; it is a conceptual truth concerning the nature of moral discourse. It is not a fact of the human condition that man is born into a world alien and indifferent to human purposes. What is a fact is that the phrases "the universe has a purpose" and "value and being are one" are unintelligible phrases. To say "man creates his own values" is in reality only to say in a dramatic way that a judgment of value is an expression of choice. This statement, it is argued, is not an anguished cry of the human heart but is merely an expression of a linguistic convention.

To say "If x is a judgment of value, then x is an expression of choice" is not to say "Any choice at all is justified," "Anything is permissible," or "All human actions are of equal value." These latter statements are themselves value judgments and could not follow from the above-mentioned statement, for it is not itself a statement of value but a nonnormative metaethical statement about the meaning of evaluative expressions, and, as Sartre himself stresses, one cannot derive an "ought" from an "is." In general, Hare and Nowell-Smith, as well as Ayer and Stevenson, stress the normative neutrality of metaethical statements.

Hare

R. M. Hare in two very influential books, The Language of Morals (Oxford, 1952) and Freedom and Reason (Oxford, 1963), developed a very closely reasoned metaethical analysis of the type that has been discussed. In The Language of Morals, Hare views moral utterances as a species of prescriptive discourse, and he feels that we can most readily come to understand their actual role in the stream of life if we see how very much they are like another form of prescriptive discourse, namely, imperatives. Imperatives tell us to do something, not that something is the case. Moral utterances in their most paradigmatic employments also tell us to do something. Imperative and

moral utterances do not, as the emotivists thought, have the logical function of trying to get you to do something. Rather, they tell you to do something. Furthermore, there are logical relations between prescriptive statements, just as there are logical relations between factual statements.

Moral judgments are viewed as a kind of prescriptive judgment but, unlike singular imperatives, moral judgments (as well as all value judgments) are universalizable. Hare means by this that such a judgment "logically commits the speaker to making a similar judgment about anything which is either exactly like the subject of the original judgment or like it in the relevant respects."

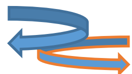
Hare stresses that while almost any word in certain contexts can function evaluatively, good, right, and ought almost always so function. The evaluative functions of these terms are distinct from their descriptive functions and are an essential part of their meaning. In fact, the distinctive function of all value words is that they in one way or another commend or condemn. But while good is a general word of commendation, the criteria for goodness vary from context to context and are dependent on what it is that is said to be "good."

The meaning of good or any other value term is never tied to its criteria of application. There is nothing in the logic of our language to limit the content of a moral judgment. As far as logic is concerned, any universalizable prescription that expresses a deep concern or commitment is ipso facto a moral prescription, and we can decide without conceptual error to do anything that it is logically or physically possible to do. If we treat the resulting decision as a decision of principle, that is, a universalizable prescription, then it is a value judgment that is in good logical order. As Nowell-Smith has well put it in discussing Hare's theory, "Nothing that we discover about the nature of moral judgments entails that it is wrong to put all Jews in gas-chambers."

Criticism of Hare

Probably the most persistent dissatisfaction with Hare's theory has resulted from the belief that it makes moral reasoning appear to be more arbitrary than it actually is. To say "Nothing that we discover about the nature of moral judgments entails that it is wrong to put all Jews in gas-chambers" is, it will be argued, a reductio of such a position. Hare would reply that to argue in such a way is to fail to recognize that he is talking about entailment, and that he is simply making the point that from non-normative statements one cannot deduce normative ones.

Hare argues that his thesis about the logical status of moral utterances does not commit him to the position that there can be no rational resolution of basic conflicts in moral principle. Returning, in Freedom and Reason, to a stress on decisions (though with a new attention to inclinations), Hare contends that to have a morality we must have freedom. Specifically, we must have a situation in which each man must solve his own moral problems. (This is not to moralize about what we should do but to state a logical condition for the very existence of moral claims.)

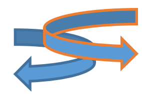


Philosophers who have criticized Hare, including someone as close to him as Nowell-Smith, have suggested that Hare still has a far too Protestant conception of moral discourse. He fails really to take to heart the Wittgensteinian claim that here, as elsewhere in human discourse, we must have public criteria for what could count as a logically proper moral claim. As F. E. Sparshott—whose book An Enquiry into Goodness (Chicago, 1958) deserves more attention than it has received—notes: Hare's individualism leads him to neglect the fact that a morality, any morality, will necessarily incorporate "those rules of conduct that seem necessary for communal living." It is not the case that just any universalizable set of prescriptions can constitute a morality or a set of moral judgments.

The good-reasons approach

The last metaethical theory we shall discuss has been dubbed the good-reasons approach. Stephen Toulmin, Kurt Baier, Henry Aiken, Marcus Singer, Kai Nielsen, A. I. Melden, A. E. Murphy, and John Rawls may be taken as representative figures of this point of view. It is an approach that obviously has been deeply affected by the philosophical method that we have come to associate with the work of the later Ludwig Wittgenstein. These philosophers have centered their attention on the logic of moral reasoning. Their central question has been "When is a reason a good reason for a moral judgment?" Accordingly, the crucial problems center on questions concerning the nature and limits of justification in ethics. These philosophers agree with the noncognitivists that moral sentences are used primarily as dynamic expressions to guide conduct and alter behavior. And they would also agree with ethical naturalists that moral utterances usually, at least, also make factual assertions. But they believe that the primary use of moral utterances is not theoretical or just emotive but practical. Hare and Nowell-Smith are right in stressing that they are designed to tell us what to do.

Yet while moral utterances typically tell us what to do, language with its complex and multifarious uses does not neatly divide into "the descriptive" and "the evaluative," "the constative" and "the performative," "the cognitive" and "the noncognitive." These are philosophers' specialized terms, and they do not help us to understand and clearly characterize moral discourse but actually distort our understanding of it. There can be no translation of moral terms into nonmoral terms, and the ancient problem of bridging "the is-ought gulf" is a muddle, for there is no clear distinction between such uses of language and no single function that makes a bit of discourse normative. Some moral utterances indeed bear interesting analogies to commands or resolutions, but they cannot be identified with them. It is a mistake to think ethical judgments are like scientific ones or like the judgments of any other branch of objective inquiry; yet cognitivist metaethicists were correct, not in pressing this analogy but in maintaining that there is a knowledge of good and evil and that some moral claims have a perfectly respectable objectivity. No matter how emotive or performative moral utterances may be, when we make a moral judgment, it must—logically must—satisfy certain requirements to count as a moral judgment. In making a moral judgment, we must be willing to universalize the judgment in question, and it must be possible to give factual reasons in support of the moral claim.



The advocates of the good-reasons approach in the general tradition of the later Wittgenstein did not take it to be incumbent on the philosopher to translate moral utterances into some clearer idiom. They did not believe that there was some other favored discourse or form of life that moral discourse or morality should be modeled on. What was expected of the philosopher was that he should describe morality so as to perspicuously display the living discourse at work. In particular, philosophers should concern themselves with a conceptual cartography of the nature and limits of justification in ethics. Before we can reasonably claim that moral judgments are at bottom "all subjective" or that no moral claim can be "objectively justified," we must come to understand what can and what cannot count as a good reason in ethics and what the limits of moral reasoning are.

The religion of law.

Philip Woods in his book, *"The fall of Priests and Rise of Lawyers"* has attempted to give law a staunch relation with morals and religious sentiments. He links so much the origin of today's legal tradition with early Christian practice and religious sentiments. Intriguingly Wood includes Moses and Jesus Christ in his list of great heroes of the law. According to Wood "these men were among the first great lawyers. They formulated principles of moral behaviors, effectively basic rules of law, the foundation of legal systems."[5] He must however not consider these "basic rules of law" really to be law because he also asserts that "the contribution to the law by the Christian bible (about 50 to 100 CE) and by the Koran (about 650 CE0 was small.[6]" At least in relation to the Christian Bible's contribution to the Western legal tradition this statement is clearly false. As Patrick Parkinson has explained:

Christianity was to the formation of the Western legal tradition as the womb is to human life. The history of western law cannot be understood in isolation from religious influences, for at every level of society, and in every aspect of social and political life these influences were pervasive [21]

Berman also made a similar statement to this. He stated thus;

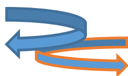
The centrality of law may...be traced to the origins of the western legal tradition. The Church was governed by law. Indeed, it has been said that "it was the Church that first taught western man what a modern legal system is like.[7]

In Parkinson's view:

[5] 19 Wood above n2, 238 20 Wood above n2, 22

[6]

[7] Berman H, *The Interaction of Law and Religion* (SCM Press, London, 1974) 59



The moral authority of the law may also be traced to its history. The close relationship between law and theology in the formation of the western legal tradition, the belief in law as ultimately given by God, and the idea that there were natural laws which governed human relations meant that law was imbued with a certain aura of sacredness.[8]

According to Wood *"our societies may decide that they can do without religion, but they can't do without law."*[9] Again this mis-conceptualises religion for most of the world.

In affirming the importance of law, Woods opines that, *"without law, there would be no democracy or safety from tyrants, no security from violence or theft, no protection of women from sexual attack, no property."*[50]

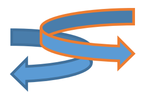
Wood correctly upholds the importance of religion as framing the ethics and morals of a nation, much easier and quicker than today's law and that in an instance where the religious sanctions fail, a big vacuum is left which the law itself cannot cure. He stated thus; "If the sanctions of religion no longer have influence on people's private moral conduct then we have a vacuum unfilled.[10]"

Though still, Woods recognizes that the law as an instrument to govern our conduct is sufficient for survival if properly framed and administered and that properly framed and administered legal systems would substantially fill the necessary gaps if religions ceased to be a force at all.[53]

[8] Parkinson above n11 [2.290] 64

[9] Wood above n2, 12

[10] BOOK REVIEW: PHILIP R WOOD, THE FALL OF THE PRIESTS AND THE RISE OF THE LAWYERS, (Hart, 2016) 273pp - Professor Michael Quinlan*



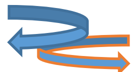
CHAPTER TWO

THE LEGAL PROFESSION

"Persons belonging to the legal profession are concededly the elite of the society. They have always been in the vanguard of progress and development of not only law but the polity as a whole. Citizenry looks at them with hope and expectations for traversing on the new paths and virgin fields to be marched on by the society. The profession, by and large, till date has undoubtedly performed its duties and obligations and has never hesitated to shoulder its responsibilities in larger interests of mankind. The lawyers, who have been acknowledged being sober, task-oriented and professionally responsible stratum of the population are further obliged to utilize their skills for socio-political modernization of the country. The lawyers are a force for the perseverance and strengthening of the Constitutional Government as they are guardians of the modern legal system. After independence, the concept of social justice has become a part of our legal system. This concept gives meaning and significance to the democratic ways of life and of making the life dynamic. The concept of welfare state would remain in oblivion unless social justice is dispensed with. Dispensation of social justice and achieving the goals set forth in the Constitution are not possible without the active, concerted and dynamic efforts made by the person concerned with the justice dispensation system. The prevailing ailing socio-economic-political system in the country needs treatment which can immediately be provided by judicial incision. Such a surgery is impossible to be performed unless the Bench and the Bar make concerted effort. The role of the members of the Bar has, thus, assumed great importance in the post-independent era in the country."

Justice Sethi[11] in ***Ramon Services v. Subhash Kapoor*.**

[11] In the Indian Supreme Court: The question was- "*should a litigant suffer penalty for his advocate boycotting the court pursuant to a strike call made by the association of which the advocate was a member*"?



Introduction

In Uganda the legal profusion is vast and wide it is one of the most prestigious professions in Uganda and considered to be one of the most regulated professions. The legal Profession is under the ministry of justice and constitutional affairs which is regulated by the judicial service commission, Uganda law society and the law council. All the above bodies except the ministry of justice and constitutional affairs are under the judiciary provided for under the 1995 constitution of Uganda.[12] It also regulated by the law council as under the Advocates Act (Professional Conduct Regulations). Any intending advocate must first of all attend undergraduate degree in Law from a recognized faculty of law followed by a post graduate diploma in law (bar course) From Law Development Center. Just like any one may know how to drive a vehicle but only one who possesses a driving permit is allowed to drive along the road, so is it with practicing law in court. It is until to obtain a permit/license that you qualify to practice law at the bar. This permit is obtained from the Law Development Center.

The legal profession is basically comprised of two major divisions:

1. Lawyers/Advocates

2. Justices/judges/magistrates.

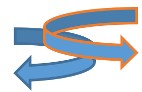
Lawyers and advocates.

A lawyer is a person who has attained a law degree from any recognized university. It is important to note that the basic difference between a lawyer and an advocate is that a lawyer is one who has attained a law degree. He may be called a lawyer by profession just after attaining a law degree however and advocate has to qualify as an advocate by fulfilling the Advocates Act[13]'s requirements as prescribed and then he or she is eligible to represent clients in courts of law.

An advocate according to the Advocates Act[14] is;

Any Person whose name is dully entered upon the roll and for the purpose of ***section 19 (2***) and part VI of the Act include any person mentioned in section 6. This section means that an advocate

[12] Chapter eight
[13] Cap 267
[14] Cap 267 section one



is one who has been enrolled after having met all the requirements and it's after he or she is enrolled to practice in Uganda as an advocate of the high court that one is rightly called an Advocate.

The following are the steps or various ways of entering the legal profession as an advocate of the high court of Uganda.

Section 8(a) of the Advocate's Act cap 267 provides that an advocate may be that one who has attained a law degree in a university in Uganda or a degree in law or other legal qualification s granted by or obtained from such other university or institution outside Uganda as may be recognized by the law council by regulations made for the oppose of the section.

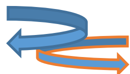
The interpretation of this section is that one to be admitted or enrolled is to have attained a law degree in any Ugandan university or any other university outside Uganda but recognized by Uganda. It is on this note that a prerequisite to attain a law degree is irrefutable, however after the law degree; one must also attain a postgraduate diploma in legal practice at law development center.

Usually in Uganda any person with two principle passes in any combination is eligible to apply for law at any university except some university that require one to first attain some grades before subjecting such students to a pre-entry examination.

It is important to note that in Uganda, there are two ways one may pass through to attain a law degree. First by completion of the Uganda Advanced level where a Uganda advanced certificate of education (UACE) is awarded

Secondly, one may also attain a law degree through passing various steps if he or she has not attained the UACE. Where one has stopped in secondary 4, he or she may apply for a certificate in law at any university in Uganda. After attaining this, he or she becomes eligible to apply for a diploma at any university and institution like the law development center. It is after all this that one now becomes eligible to apply for a law degree at any university.

In Uganda, a law degree is often four years of study and after this, one is supposed to seat pre entry exams for him or her to be eligible to apply for the post graduate diploma at Law development center. At the law development center, one studies for nine months to attain a post graduate



diploma in legal practice .It is after this as shown by the Advocates Act that one is eligible to apply to be enrolled as an advocate of the high court of Uganda.

Judges and the magistrates

A judge is an advocate as defined under the advocates Act[15] and is eligible to be appointed as a judicial officer of the high court.

Article 143 of the 1995 constitution of Uganda outlines the qualification for appointment of the judicial officers specifically, article 143(e) states

(1) A person shall be qualified for appointment as—

(e) judge of the High Court, if he or she is or has been a judge of a court having unlimited jurisdiction in civil and criminal matters or a court having jurisdiction in appeals from any such court or has practiced as an advocate for a period not less than ten years before a court having unlimited jurisdiction in civil and criminal matters.

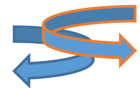
In simple terms an advocate can be eligible to be appointed as a judge only after they have been in legal practice for 10 years or have been working in any court of unlimited jurisdiction.

Duties and Ethical guidelines for judges.

Some of the judge's duties and ethical guidelines include the following;

- A judge should preside over both criminal and civil matters
- He or she should grant prerogative remedies to whoever seeks they as they deem fit
- A judge should maintain and enforce high standards of conduct and should personally observe those standards, so that the integrity and independence of the judiciary may be preserved. The provisions of this Code should be construed and applied to further that objective.
- A judge should respect and comply with the law and should act at all times in a manner that promotes public confidence in the integrity and impartiality of the judiciary.
- A judge should not allow family, social, political, financial, or other relationships to influence judicial conduct or judgment.
- A judge should not hold membership in any organization that practices invidious discrimination on the basis of race, sex, religion, or national origin.
- A Judge should perform the duties of the office fairly, impartially and diligently and can engaged in extrajudicial activities that are within obligations of judicial office.

[15] Section 1 cap 267



- A judge should be faithful to, and maintain professional competence in, the law and should not be swayed by partisan interests, public calmer, or fear of criticism.
- A judge should not act as a leader or hold any office in a political organization;
- Should not make speeches for a political organization or candidate, or publicly endorse or oppose a candidate for public office; solicit funds for, pay an assessment to, or make a contribution to a political organization or candidate, or attend or purchase a ticket for a dinner or other event sponsored by a political organization or candidate.
- A judge should resign the judicial office if the judge becomes a candidate in a primary or general election for any office.

Magistrates.

A magistrate is one who presides over cases in a magistrate court. He can only become eligible to be appointed as one after he or she has attained a degree in laws and has a practicing license after he or she has been enrolled to practice as an advocate of the high court of Uganda.

He has almost similar functions like those of a judge however he does not grant prerogative remedies.

It is also important to note that there are various kinds of magistrates. For example;

Chief magistrates who reigns in the chief magistrate's courts

Grade one magistrate in grade one magistrate's court

Grade 2 magistrates in grade two magistrate's court.

The dress code of magistrates and judges is a robe and a black suit then a silk wig.

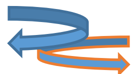
The Robe means or represents the respect of court as a holly ground; the same applies to the wig.

The black suit represents the somber mood in court or a mood or morning.

Historical development of the Legal Profession.

The legal profession has its origin in England during the Medieval times.[16] The laws regarding the inappropriate handling of Clients has its origin in ancient Greece and Rome. In Greece, it was forbidden to take payment for pleadings the cause of another, the rule was widely flouted. During the reign of Emperor Claudius, the legal profession was legalized and even allowed lawyers also known as advocates to charge a limited fee. After the time of Emperor Claudius, the lawyers could openly practice law although their remuneration was limited. A skilled and regulated profession developed gradually during the late Roman Empire and the Byzantine Empire. Advocates acquired more status and a separate class of notaries appeared. The legal profession continued to evolve and

[16] Roscoe Pound ,The Lawyer from Antiqury To Modern Times 78 (1953)



became official in ancient Rome. The profession also became highly regulated by laws and ethics that were expected from an ideal lawyer.

The Legal Profession is guided by ethics and code of conduct in which lawyers are compelled to conduct themselves legally, professionally and regularly. The work of a lawyer cannot be underestimated in society. In order to fulfill their work, they are guided by the legal ethics. The Legal Profession is guided by ethics and code of conduct in which lawyers are compelled to conduct themselves legally, professionally and regularly.

Legal ethics means the standards of minimally accepted conduct within the legal profession. It comprises of the rules that govern the advocate's duties owed to the court, to their client, fellow counsel and to the public[17] .

Uganda was declared a British protectorate in **1894. The** English Legal System was introduced in Uganda, by the virtue of the **reception clause of the Order In Council (article 20**). The English legal system was introduced in Uganda. In **1904,** the Legal practitioners rules were introduced to govern the legal profession in Uganda. The Courts, procedure of administration were enrolled and disciplinary controls of lawyers.[18] The first Ugandan lawyers were under rules of barristers and solicitors from England, Scotland, and Ireland and then pleaders from India. From the Year **1911 to 1913**, the rules were amended to expand the categories of people that could practice. In **1956,** the Advocates Ordinance was passed and consolidated the law relating to Advocates. The act was amended in **1963** to establish the council of legal education in Uganda. The Act was repealed by the **1970 Act** which made significant changes in lawyer qualifications and control of advocates.

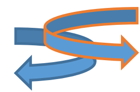
The Advocates Act was later replaced by the **Advocates Act amendment Act 2005.**

The conduct of an Advocate.

Under conduct both the language and the general character of lawyer or an advocate is put in to consideration. An advocate must have a courteous language in and outside court. This is a language that is more of polite and calm. For example a lawyer is not supposed to address a magistrate by his own names in court. He or she is supposed to refer to him or her as your worship and he is supposed to address a judge in the courts of record as "My lord"

A lawyer is not supposed to attack another advocate, and he is not to speak while the other advocate is submitting. An advocate's demeanor also matters a lot. This is in other wards the conduct in

[17] Black's law Dictionary ,Bryan Garner, seventh edition ,page 409
[18] B.J ODOI , A guide to the legal Profession.



court. He is to be genital and humble towards court. All this is rooted in the old English history of court where the court room was like a church.

The dress code of lawyers in the legal profession

Since Uganda was colonized by the Brittan is from this that even most of our laws by virtual of the 1902 order in council are the same as the law of England.

Uganda took over the culture of the common law courts because of the Uganda being a British protectorate and accepting to follow the British laws. Ugandans advocate dress just like British Advocates. English Advocates (whether barristers or solicitors) who appear before a judge who is robed must also be robed and the same principle applies in Uganda.

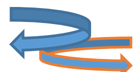
All male Advocates in Uganda wear a white stiff wing collar with bond (two strip of linen about 5/13 cm by 11/25 mm hanging down the front of the neck) They also wear dark double breasted suits (or with waist coat if single –breasted) or a black coat and waist coat and black or grey morning dress striped trousers. This is simply interpreted to mean a black suit and a wing then a black morning rob the same applies to women only that they put on a dark suit to.

An advocate in Uganda performs several duties and under these includes the following;

- Represent clients in court
- Lawyers have a duty to implement the law;
- They also have a duty to interpret law, rulings and regulations for individuals or lay men;
- Lawyers are officials of court. It is important to note that generally, the advocates have a duty to themselves, fellow Advocates, to the client and to the courts of law which is summarized as hereunder;

Duties of an advocate to a Client

- Don't take cases where the lawyer has to be a witness
- Never withdraw service halfway
- Don't refuse a brief
- Give client top priority
- Don't try to tamper with the evidence or suppress it
- Act according to the client's instructions
- Fees adjustment as per liability is a strict no
- Bidding for purchasing property arising of legal proceeding is a strict no



- Don't take undue advantage of the client's trust
- Variation in charges depending upon the success of the case is a strict no
- Proper accounting of everything is important
- Absolute clarity about things with the client is necessary

Duty of a Lawyer To Court

- Respecting the court. In ***Batchelor v. Partisan Mackers***[19] court stated that; "*an advocate in undertaking he conduct of a case in this court takes upon himself/herself an office in the performance of which he/she owes a duty, not to his or her client only but also to the court, to the members of his or her own profession and eh public. "*
- The advocate also has a duty to follow the appropriate dress code for his/her profession
- Don't take up cases of clients who insist on use of unfair means such as influencing the layer to act unreasonably or deviate from the path of justice.
- An advocate should have a dignified behavior

Duty of an advocate to a fellow advocate

- A lawyer should not promote unauthorized practice
- Avoid advertisement and solicitation of work and any related form of touting to attract clients.
- He or she must avail to the opposing advocate all the documents on which he or she bases his or her pleadings and while in court, to give due respect to his or her opponent.

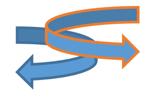
ETHICS IN THE LEGAL PROFESSION

Lawyers throughout the world are specialized professionals who place the interests of their clients above their own, and strive to obtain respect for the Rule of Law. They have to combine a continuous update on legal developments with service to their clients, respect for the courts, and the legitimate aspiration to maintain a reasonable standard of living.[20]

The fundamental aim of legal ethics is to maintain the honour and dignity of the law profession, to secure the spirit of friendly cooperation between the Bench and the Bar in the promotion of higher standard of justice. The legal profession is not a business but a profession created by state for public good.

Principle 26 of the **UN Basic Principles on the Role of Lawyers** states that; *"Codes of professional conduct for lawyers shall be established by the legal profession through its appropriate organs, or by legislation, in accordance with national law and custom and recognized international standards and norms."*

[19] R (Ct. of Sess) 514
[20] International Bar Association's International Principles on Conduct for the Legal Profession



Ethics are principles and values, which together with rules of conduct and laws, regulate a profession, such as the legal profession. They act as an important guide to ensure right and proper conduct in the daily practice of the law

Ethics in the legal profession are most concerned with;

- Independence, honesty and integrity.
- The lawyer and client relationship, in particular, the duties owed by the lawyer to his or her client. This includes matters such as client care, conflict of interest, confidentiality, dealing with client money, and fees.
- The lawyer as an advocate, in particular, a lawyer's duties to the court.
- Competence, which encompasses academic qualifications and training, and meeting other practicing requirements such as holding a valid practising certificate or licence.
- A lawyer's duties to persons other than a client.
- A lawyer's duties to other lawyers.
- Advertising of legal services.
- Human rights and access to justice

Independence, Honesty, and integrity. The legal profession needs independence in order to exercise their duty of promoting justice. Independence is key to providing unbiased advice and representation to a client. Lawyers must maintain the highest standard of honesty, integrity, and fairness towards a client, court, other lawyers and members of the public. The ***Advocates Act (Professional Conduct) Regulations; Reg 30*** forbids an advocate from engaging in a trade or profession, either society or with any other person, which in the opinion of the law council is unbecoming of the dignity of the legal profession.

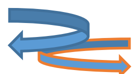
Maintaining lawyer-client relationship.

An advocate must not act unprofessionally before their client but must at all times respect the latter and himself/herself. Disrespect and unprofessionalism exhibited before a client may discourage them from hiring the advocate’s legal services again or from recommending future clients. It may also result into disciplinary proceedings against the advocate under the law council.

Conflict Of Interest

Principle 15 of the UN Basic Principles on the Role of Lawyers states that; “*Lawyers shall always loyally respect the interests of their clients.”*

It is well settled that a solicitor has a fiduciary duty to his or her client. That duty carries with it two presently relevant responsibilities. The first is the obligation to avoid any conflict between his duty to his client and his own interests - he must not make a profit or secure a benefit, at the expense of his client's expense. The second arises when he endeavors to serve two masters and requires.... full disclosure to both. A conflict of interest may arise in the following instances;



- The lawyer owes separate duties to two or more clients in relation to the same or related matters, and those duties conflict, or there is a significant risk that those duties may conflict. This could also encompass a client who the lawyer acted for in the past. The lawyer's duties towards that client (in particular, the duty of confidentiality) continue, even when the case has completed.
- The lawyer's duty to act in the best interests of any client in relation to a matter conflicts, or there is a significant risk that it may conflict, with the lawyer's own interests with regard to that or a related matter. In these situations, a lawyer should inform his or her client, or clients, of the conflict or potential conflict of interest. In most cases, it is better to refuse to act for the client where a conflict of interest has been identified. In some cases, a lawyer cannot act where there is a clear conflict of interest. For example, a lawyer cannot represent both parties in the same or related litigation.[21]

Conflicts of interest have given rise to a number of legal and disciplinary actions. It is an area that is commonly identified by lawyers as a problem in legal practice. Conflicts of interest are not all that easy to resolve because some interests will require that the lawyer not act for the person while other conflicts may still allow for the lawyer to act for both parties.

It is also an area that requires the balancing of two public interests; namely the interest in clients having full confidence in their lawyers, including the protecting of their confidences, and on the other hand, the interest in the freedom of a lawyer to take instructions and for the client to be represented by the lawyer of his or her choice.

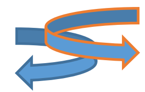
Also, there is the case that the lawyer has divided loyalties - owing a duty to the court while at the same time owing a duty to the client. On occasions, these duties will be in conflict. In these cases, the lawyer is obliged to fulfil his or her obligations to the court. This is not generally understood by clients, or by some lawyers who carry the notion of the duty to the client too far and engage in practices that are unethical and that go to defeat the interests of justice.

Making an allegation of fraud in circumstances where there is no evidence to support the claim is an example. Other examples include deliberately delaying proceedings, perhaps in order to force a settlement from the opposing client who is concerned about increasing costs; or issuing writs without their being any proper legal or factual foundation.

This is where legal ethics comes in. A commitment to legal ethics involves a commitment to the introduction of Codes of Ethics or Standards of Professional Practice. An example is the standards reflected in the International Bar Association General Principles of Ethics. However, not all jurisdictions have Professional Codes and not all of those that do give sufficient attention to their enforcement. In any case, the lawyer who acts in accordance with a professional code of ethics may still be engaging in unethical practice.

In ***Chandra Shekhar Soni v. Bar Council of Rajasthan and Ors (1983)***, an advocate who was representing one party in a criminal case switched sides and began representing the opposite party.

[21] Booklet on Ethics for lawyers accessed at https://www.thehorizoninstitute.org/usr/library/documents/main/booklet-on-ethics-for-lawyers.pdf on 30 December 2021



It was held by the Supreme Court that it is not in accordance with professional etiquette for an advocate while retained by one party to accept the brief of the other. It is unprofessional to represent conflicting interests except by express consent given by all concerned after a full disclosure of the facts. Counsel's paramount duty is to the client, and where he finds that there is conflict of interests, he should refrain from doing anything which would harm any interests of his client.

A lawyer when entrusted with a brief is expected to follow the norms of professional ethics and try to protect the interests of his client in relation to whom he occupies a position of trust. The Supreme Court upheld his being found guilty of malpractice by the Bar Council of India in disciplinary proceedings, and he was suspended from practice for the period of one year.

The consequences of a conflict of interest situation for the lawyer can be severe and costly. For example, acting with a conflict of interest can result in civil liability for professional malpractice as well as disciplinary action. Some very serious consequences also flow from a proven claim in contract, tort or equity, including:

Being scrapped from the roll of advocates in accordance with ***section 20(4) (c)*** of the **Advocates Act[22].** The advocate may face disqualification from representation of one or more clients;

Forfeiture of fees charged; the inability to charge for work in progress and other time invested;

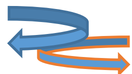
Embarrassment, inconvenience and aggravation of defending a malpractice claim or investigation;

Lost time spent on defending a malpractice claim or investigation.

Thus, it is clear that lawyers have to be very careful while dealing with potential and current clients, so as to ensure that a conflict of interest situation does not arise. When such a situation does arise, the best plan of action is to request the new client to seek other representation so that the interests of the current client are not adversely affected.

However, if a lawyer is already representing two different clients, and a potential conflict of interest situation arises, he may choose to disclose the relevant non-confidential aspects of the potential conflict to both of them and seek their express written consent to his continued representation of them, provided that it is clear that he can represent the interests of one client without adversely affecting the interests of the other. If, however, the two interests are directly conflicting ones, the advocate will have to remove himself from the matter rather than face action for professional negligence or malpractice, the consequences of which have already been outlined above.

[22] Cap 267



The rule against champerty.

The case of ***Elizabeth Kobusingye v. Annet Zimbiha***[23] defined champerty as a bargain between a stranger and a party to a suit by which the sarnger pursues a party's claim in consideration of receiving part of the judgment proceeds. In "*Tritel on the Law of Contract- 12th Ed." Thomson Sweet and Maxwell – Champerty* agreements are classified as illegal; they define Champerty as a contract by which one person agrees to finance another's litigation in return for a share in the proceeds, the former having no genuine or substantial interest in the outcome. In the recent decision of ***Shell (U) Ltd & 9 Ors v. Rock Petroleum & 2 Ors***[24]**,** the high court held that champertous agreements and maintenance as is known among lay persons as buying another's lawsuit and also means sharing in the spoils of litigation; the law always regards champerty as unlawful and prohibited. Court noted in this matter that it seems the applicants were worried that the champerty agreement will be rendered unenforceable with the change of advocate and that eh same is illegal and cannot be enforced by any court of law.

It was a case concerning loss of professional confidence in an advocate who connived with some of the employees/applicants and spent 33.3% of the money awarded to clients by an industrial court. As a result, 53 of the 153 applicants withdrew their instructions from Mukuve Advocates and gave instructions to another counsel, *Rwamboka Advocates.* the Mukuve Advocates and his clients (the applicants) applied to court seeking an order that Rwamboka Advocates (the respondents) were not given instructions, they should quit the matter and that this was in violation of the ***Advocates Act (Professional Conduct Regulations) Reg. 2 (1)*** which states that;

No advocate shall act for any person unless he or she has received Instructions from that person or his or her authorized agent.

Amid the proceedings, it came to court's notice that a champerty had existed between the applicants, an agent and Mukuve Advocates.

The learned ***justice Musa Ssekana*** stated that; *in a perfect world, every matter a lawyer handles for a client would come out to a timely, successful and profitable conclusion. Sometimes however, it becomes necessary to withdraw from an engagement before the world is done or the matter comes to an end. Withdrawing from an engagement that has become problem at can be an effective risk control measure eliminating an impermissible conflict or neutralizing a dispute with a client before it takes on a life of its own.*

Court held that the respondent is a liberty to represent the plaintiffs who have revoked the powers of attorney to the applicants and that a party to a litigation has a right to decide which lawyers to represent them in court as per ***Nareeba Dan & 5 Ors v. Joseph Bamwebembeire & 4 ors.***[25] This case is very important to any client who feels aggrieved by the unprofessional conduct or professional misconduct of their lawyer. It also shows an instance of where you can sue your

[23] HCCS no. 295 of 2014
[24] HCMA No. 645 of 2010
[25] HCMA No. 45 of 2009

lawyer for anything not properly done. In relation to the latter, The facts herein where that some of the applicants had sued Mukuve advocates in the law council. This is a right reserved by any client who feels aggrieved by the conduct of their lawyer according to *Reg. 31,* to sue them in the law council.

ADVERTISING OF LEGAL SERVICES.

The ethics act as an important guide to ensure right and proper conduct in the daily practice of the law. According to ***Principle 26 of the United Nations Basic Principles on the Role of Lawyers,***[26] codes of Professional conduct for lawyers shall be established by the legal profession through its appropriate organs or by legislation in accordance with national law and custom recognized international standard and norms.

In fulfillment of the above, United Nations Document, Uganda has promulgated different laws and regulations to govern the ethical behavior of practicing advocates. The sources of professional legal ethics are the various Ugandan legislations, case law decision from Uganda and other common law jurisdiction and International treaties ratified by Uganda.

The ***International Code of Ethics*** was adopted in 1956, and a ***copy of its 1988 edition*** was incorporated in the ***East Africa Law Society Codes of Legal Practice, Conduct, Ethics and Etiquette in East Africa.***

The *Constitution of Uganda*[27] *the Advocates Act* [28]*, the Advocates (Professional Conduct) Regulations*[29] *Statutory he Uganda Law Society Act Cap 267-4*[30]*, the Advocates (Professional conduct) Regulations*[31] are some of the legislations enacted to promote ethics in the legal Profession.

In particular *Regulation 25 of the Advocates (Professional Conduct) Regulations*[32] *is prohibits advocates from advertising his or name.*

Regulation 25(1) of the Regulations prohibits advocates from using their name or the fact that she is an advocate to be used in any commercial advertisement.

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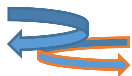
[26] Principle 26 of the United Nations Basic Principles on the Role of lawyers.
[27] Constitution of Uganda 1995 as amended,
[28] The Advocates Act Cap 6 ,
[29] The Advocates (Professional Conduct)Regulations Statutory Instrument 267, The Uganda Law Society Act Cap 267-4.
[30] The Uganda Law Society Act Cap 267-4.
[31] Regulation 25 of the Advocates (Professional Conduct) Regulations Statutory Instruments Number 267-2
[32] Regulation 25 of the Advocates (Professional Conduct) Regulations Statutory Instruments Number 267-2



Regulation 25(2) bars advocates from using their names or name of their law firms or using the fact that they are advocates to be inserted in heavy or distinctive type or in any directory or guide and in particular a telephone directory.

Regulation 25(3) provides that an advocate shall not cause or allow his or her name to be inserted in any classified or trade directory or section of such directory.

Advertising is the act of drawing attention to a product, service, or event through the mass media to promote its awareness, sale or attendance.

It should be noted that the rules relating to legal advertising can be traced in the 1800's in England. The 'esquires' of the day saw themselves as part of a public calling, rather than members of a crassly commercial production. A lawyer that was seen marketing his practice to the general public was seen as unseemly and unprofessional. In 1908, the American Bar Association adopted prohibition of advertising and solicitation as part of its Canons of Professional Ethics. The Canon tolerated business cards but held open the possibility that they could be scrutinized by local bar officials by calling them 'not per se improper'. Lawyers were prohibited from soliciting business through fliers, or advertisement and the prohibition extended to indirect forms of advertising such as commenting on newspaper articles. Until the 1970's, most states prohibited advertising. It should however be noted that in the case of ***Bates V Arizona State Bar*** in which the Supreme Court rejected the argument by Arizona Bar that attorney advertising was inherently misleading and[33] tarnishing the image of the legal profession. The court noted that lac of advertising could be viewed as profession's failure to reach out and serve the community. After this judgement some countries maintained the restriction on advertising and other countries legalized advertising.

Common forms of advertising by lawyers can be by their *dress code, television and radio advertisements, billboards, direct mail marketing[34], law firm websites, participation in telephone directories, commercial directories and referral services and through indirect online advertising on social media.* Many law firms have official websites that provides for information about the law firm. The page contains the words 'About Us, Practice Areas, Lawyers and Contact information.' This means that if one went on google he would find information about that particular law firm. The development of social media has created an incentive for some lawyers to move away from the traditional ways that pioneered the career of simply waiting for clients to show up.

The first major case law on advertising is the case of ***Bates V Arizona State Bar*** in which the Supreme Court rejected the argument by Arizona Bar that attorney advertising was inherently misleading and[35] tarnishing the image of the legal profession. The court noted that lac of advertising could be viewed as profession's failure to reach out and serve the community.

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[33] Bates V Arizona State Bar 433 US 350(1977

[34] Spahn Thomas E. , Lawyer Marketing ;An Ethics Guide, Mc Guire Woods LLP accessed …

[35] Bates V Arizona State Bar 433 US 350(1977

It is necessary to prohibit the law on advertisement for various reasons.

Advertising In **Sharma Advocate V State of Haryana** [36]the High court of India held that an advocate is an officer of court and that the legal profession is not a trade or business but a noble profession and so advocates have to strive to secure justice for their clients within legally permissible limits.

Advertising would raise legal fees which are now not affordable to many.

Advertisement promotes deception. Many lawyers would end up advertising themselves that they are experts in certain fields and yet they are not. A lawyer could tout himself to be an expert in for example family law and yet in reality he does not.

Importance of ethics to the Legal Profession.

The fundamental aim of legal is to maintain the honor and dignity of the profession, to secure a spirit of friendly co-operation, to establish honorable and fair dealings of the counsel with his client, opponent and witnesses, to establish the spirit of brotherhood in the bar itself and to ensure that lawyers discharge their responsibilities to the community generally.[37]

Ethics promote rule of law and access to justice. **The preamble to the United Nations Basic Principles on the Role of lawyers,** provides that an independent legal profession is integral to upholding rule of law. It further that whereas adequate protection of human rights and fundamental freedoms to which all persons are entitled be they economic, social, cultural or civil and political, requires that all legal persons have effective access to legal services provided by an independent legal profession.

If lawyers do not adhere to, and promote, principles of justice, fairness and equity, the law itself is brought into disrepute and public confidence in law will be undermined thereby hindering access to justice.

Legal Ethics maintain the reputation of the legal profession. The reputation of lawyers is closely linked to how public views the administration of justice. Where there is no public confidence in the legal profession, trust in the justice system itself is undermined.

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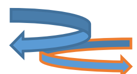
[36] Sharma Advocate V State of Haryana (2003)

[37] https://www.legalserviceindia.com/legal/article-3962-legal-profession-and-ethics.html accessed on 30th December 2021



Principle 12 of the **UN Basic Principles on the Role of Lawyers** states that*; "Lawyers shall at all times maintain the honor and dignity of their profession as essential agents of the administration of justice."*

Legal ethics promote accountability. Lawyers' accountability can be judged from their conduct. In order to achieve proper accountability, it is important to ensure adherence to the rules of ethics.

Importance of the legal profession to society

The Legal Profession plays an important role in the administration of Justice. The Lawyers are considered to be the center of the administration of justice. Lawyers are the one who are related to the parties, they listen to the party and collect all the relevant legal materials relating to the case and argue the case in court, thus helping the Judge to arrive at the correct and fair judgment. Without the assistance of lawyers it would be a superhuman task for the Judge to come at the satisfactory judgment. **Justice P.N. Sapru** has stated that:

"justification for the existence to the counsel is that each side to the controversy should be in a position to present its case before an impartial tribunal in the best and most effective manner possible.[38]"

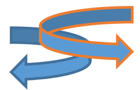
The Lawyers play important role in the upholding **rule of law**. The Preamble to the UN Basic Principles on the Role of Lawyers states that; *"…an independent legal profession is integral to upholding the rule of law. Whereas adequate protection of human rights and fundamental freedoms to which all persons are entitled, be they economic, social and cultural, or civil and political, requires that all persons have effective access to legal services provided by an independent legal profession."*

It is through upholding rule of law that law and order are achieved. Learned **C.L. Anand** has rightly stated that the advocates share with the judges the responsibility for maintaining order in the community. They do not promote stripes but settle them. They stand for legal order which is one of the noblest functions in the society.

The order which the advocates seek is not of grave but based on justice. It is the foremost function of the advocates to fulfil the desire of their clients by providing them Justice. It is the desire of every human on the earth.

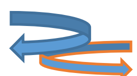
Lawyers also play a very important role in law reform also. By reason of the experience gained in daily application and interpretation of laws, lawyers are best aware of the imperfection, of the legal system and constitute the most competent class of men to advise on law reform and to promote

[38] The Art of Advocacy, edited by Chief Justice Dr. B. Malik, p 325



popular enthusiasm and support for it. The most difficult part of the process of legislation is drafting of its provisions and no one is better fitted to give guidance on this than the lawyers.

Thus, it can be said that the legal profession is a profession of great honour. This is made for public welfare, for public good. This is not for making money but to provide Justice to the right person. An advocate is an officer of the Court and is required to maintain towards the Court a respectful attitude bearing in mind that the dignity of the judicial office. The Supreme Court has rightly observed that the legal profession is a partner with the judiciary in the administration of justice.



LEGAL PROFESSIONAL NEGLIGENCE

Professional negligence refers to failure to do what a reasonable person of the profession doing the same profession would have done or doing something which a reasonable person would not do. Professional negligence causes harm, injury or even death.

Every person enjoys the right to petition courts of law for their rights or the rights of their counterparts. **Article 50 of the constitution** is an open floodgate for all to approach the alter of justice as tritely known that equity aids the vigilant not the indolent. The meaning that once you sleep on your rights, your rights slip off. Therefore judicial remedies are available for only those who make way to demand for them either individually, jointly or through a next friend.

Article 50 of the constitution of Uganda[39] provides that any affected person whose rights have been infringed can seek redress**. Article 50(2) of the constitution**[40] also recognizes that any other person or groups of persons can sue in case some one else's rights are being violated hence the legal concept of Public interest litigation. The affected persons are therefore entitled to seek for remedy from competent court or tribunal.

Public interest litigation was defined in the case of **Mtikila V Attorney General**[41]**,** as where a person or a spirited group of persons come to obtain redress due to infringement of other people's rights. Court emphasized in the same case that such people ought to be heard in court.

Access to justice is an important principle that governs society and very useful in conflict resolution. It is useless to have laws and not to judge their implementation to make hallow warnings without an iron hands of implementation. Courts of law through various laws have implemented various remedies to those who are afflicted given that the range of potential victims of professional misconduct and professional malpractice.[42]

[39] 1995 as amended.

[40] 1995 as amended.

[41] Highcourt civil suit 5 of 1993

[42] R. Venkata Rao - Importance of Legal Ethics in the Legal Profession - National Law School of India University, India

Legal Professional malpractice *vis-a-viz* professional negligence

The traditional view has been that as long as a lawyer does not mislead the court, he is entitled to do his best for furthering his client's interests. Senior Counsel Ram Jethmalani, an Indian Lawyer stated in an interview that;

"the duty of every lawyer is to ensure that the presumption of innocence in criminal proceedings, and the burden of proof in civil proceedings are not subverted. The legal system based on adversarial foundations can function only when the interests of both sides are adequately and fairly represented."

In practice, lawyers are faced with a challenge and sometimes a dilemma in representation; whether to represent justice or money. Take for instance, a bomb explosion in the city center which claims very many lives and a tape recording shows the accused's actual involvement at the scene of the crime. As an officer of court to defend justice, is it proper and ethical for a lawyer to represent the accused?

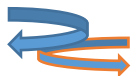
These competing interests result in what Dr Freedman calls a "trilemma" facing any legal professional. It is very well summarized by Mr David O'Donnell[43], who says,

"By the very nature of the adversarial system, the lawyer is required to represent his or her client's interest as zealously as possible. In order to do this, the lawyer must make every effort to find out everything from his client concerning the case. It would be unreasonable to expect the client to know what information is vital and/or relevant and what is not. Accordingly, the client is expected to tell the lawyer everything he or she knows. Some of this information may be detrimental to the client's interests and therefore, the only way the client can be expected to give the lawyer all the information is by assuring the client that everything that passes between him or her and the lawyer will be confidential and will always remain so. However, the lawyer in the adversarial system is also an "officer of the court".

Earlier, issues relating to legal ethics arose more often in criminal proceedings. However, with the commercialization of the legal profession, self-help also is an interest which lawyers need to keep themselves away from. In an article written by Mr Danovi about the implications of the Parmalat collapse on the legal profession in Italy, he observes,

Certainly, it is sometimes not easy to distinguish between the lawful performance of a lawyer providing advice to its client, and the unlawful performance committed by the client - so in many cases it is only the knowledge of facts or the knowledge of the crime that allows one to draw conclusions. For example, a lawyer could easily not know that the constitution of a new company in a tax free haven is being used by its client as a vehicle for carrying out massive fraud, and, in such circumstances, it is not possible to blame the lawyer for the fraudulent acts of the client ... To

[43] Paper presented at the IALS Conference on "Teaching, Legal Education and Strategic Planning" organized by International Association of Law Schools at the University of Buenos Aires, Argentina 2** Vice Chancellor, NLSIU, Bangalore,



us, it is important to confirm that within legal consultation - as in tax consultation or accounting - one must not lose autonomy and independence towards the client. This is the only means of guaranteeing regularity of contact and the honesty of behaviour that provides a shelter from the disaster that can result from the confusion of roles between client and adviser.

Upon discussing the veracity of legal ethics: what important question is what consequences should follow from the conclusion that there has been a breach of legal ethics? One obvious answer is that the relevant professional body is empowered to take the action its charter authorizes it to, and indeed, that is the most common way in which the problem is addressed. However, with the rapid growth of commercial litigation in India over the past decade, we must ask whether it is possible for a *civil claim* to be brought against a lawyer by one wronged by his breach of ethics. It is clear that this claim cannot be brought in contract, unless of course it is the case that the lawyer's breach of ethics is vis a vis his client, and in a way that is connected with the contract. In the more common case of breach of ethics vis a vis the court or the opposition or a third party or the public at large, the question remains whether those affected entities may move a civil court to claim damages in *tort*.

One is reminded immediately of the classic statement of principle of Chief Justice Cardozo, who said that cases giving rise to *economic loss* are especially difficult in the law of tort, because they lead to potentially the imposition of '*liability in an indeterminate amount, for an indeterminate time, to an indeterminate class*.' The implications of economic loss cases thus pose challenges completely different to those of pecuniary loss. It is important to note that a large number of economic loss cases involve huge claims, which is inherent in the nature of economic loss itself. Social policy and economic considerations weigh against the imposition of such liability. The result is that it might be desirable not to compensate certain types of foreseeable damage.

The **concept of foreseeability** is critical to understanding and appreciating the complexities of economic loss. It is common knowledge that Lord Atkin's seminal speech in ***Donoghue* v. *Stevenson*** established the now famous 'neighbourhood principle', which states that there is a duty on people to avoid acts or omissions which they can reasonably foresee would harm their 'neighbours'. Lord Atkin did not refer to neighbours in the literal sense, or proximity in the physical sense. His Lordship defines neighbour as one who is closely and directly affected by the act in question that the defendant ought to have had him in contemplation at the time the act was committed. This is the genesis of the principle of foreseeability. It was immediately realized that applying the principle of foreseeability would lead to unfortunate results in cases of economic loss. It is pertinent to reiterate that liability is indeterminate in economic loss cases, such as the negligent preparation of an audit report. The auditor has absolutely no idea as to who might rely on his report for what purpose and to what extent. However, it is entirely foreseeable that potential investors or creditors might refer to the audit report prior to making investment or lending decisions, as the case may be.

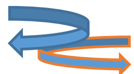
It is at once apparent that the case of a lawyer who acts in breach of his ethical duties is perhaps different to the extent that the nature of *liability* may not be indeterminate, even if the

extent and the class of people to which it is owed are indeterminate. Ought that to make a difference? The roots of an answer lie in the classic development of the doctrine of "assumption of responsibility" in English common law and especially in what is perhaps the most famous case in the common law over the past fifty years or so – ***Hedley Byrne v Heller & Partners*****.**

The genesis of that case itself lies in ***Candler v. Crane, Christmas & Co***., where the Court of Appeal held that a duty of care is *not* owed to a third party with whom the professional man did not have a contractual or fiduciary relationship. Lord Denning wrote a strong dissenting judgment in that case, which later gained widespread approval and was to prove extremely influential. In ***Hedley Byrne*****,** the House of Lords adopted Lord Denning's reasoning to hold that a third party who relied on a negligent misstatement, to his detriment, could sue even in the absence of privity, subject to certain conditions. Thus, Lord Reid stated that there is good reason for holding that mere misstatements will not give rise to any liability to a third party, and that there must be something more. Further, it was held that persons uttering statements owed a duty of care to any third person with whom a 'special relationship' existed. *Candler* was therefore overruled. The House of Lords spoke in terms of 'assumption of responsibility,' to constitute the sufficient condition for liability. Lord Reid stated that a professional making a statement without any qualification will have to assume some responsibility for it. As Lord Griffith pointed out, 'assumption of responsibility' merely refers to situations where the law will impose a responsibility on the maker of the negligent statement for damage caused by it, irrespective of the actual intention of the parties, depending on the facts and circumstances of the case. It does not indicate under what circumstances the law will impose this 'assumption of responsibility.' A similar situation had arisen in ***Glanzer v. Shepherd***. The defendants were held not liable, solely because they had disclaimed responsibility. In ***Home Office* v. *Dorset Yacht Co. Ltd***., it was suggested that the time had come to regard the neighbour principle as a general principle to determine the existence of a duty of care in any situation. This is precisely what *Anns* v. *Merton London Borough* did, introducing for the first time the test of foreseeability to determine the nature and scope of the duty to third parties.

Predictably, *Anns* led to unfortunate results. In ***JEB Fasteners, Ltd.* v. *Marks Bloom & Co***., JEB Fasteners (JEB) acquired all of the shares in a private company, relying on an unqualified audit report produced by accountants, Marks Bloom. The financial statements contained numerous errors and thus JEB acquired overvalued stock. Although the auditors did not know about any specific takeover bidder during the audit, they later discovered the identity of the bidder, and contacted him to supply relevant information. JEB sued the auditors for damages, claiming Marks Bloom provided negligent auditing services. Naturally, the loss was purely economic. Strictly on the duty of care issue, the High Court found the auditors owed JEB a duty of care. Mr. Justice Woolf (later Lord Woolf MR and Lord Chief Justice Woolf) relied on both *Anns* and ***Scott Group, Ltd.* v. *McFarlane*****,** in concluding the plaintiffs could derive duty from foreseeability alone. *Scott* was a New Zealand case where the facts were similar to *Caparo*.

This change in policy culminated in *Caparo*. The House of Lords unanimously held that an auditor of a public company, in the absence of special circumstances, owes no duty of care to an outside investor or an existing shareholder that buys or sells stock relying on a statutory audit. The

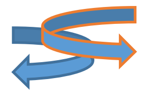


duty of care is limited to the shareholders as a collective body. The House was greatly influenced by what Lord Bridge termed the masterly analysis of Lord Denning in *Candler*. Lord Denning had suggested that the auditor must be aware of, *inter alia*, the purpose the accounts are required for. This is a far better test to constitute special relationship than the 'assumption of responsibility' used in *Hedley Byrne*, which was liberally interpreted since it was divorced from the actual intention of the parties. Two cases just preceding *Caparo* greatly influenced it. ***Smith* v. *Eric S Bush*** and ***Harris* v. *Wyre*** *Forest District Council* were heard together. In the case of Harris the mortgagees were the local authority who employed a member of their own staff to carry out the inspection and valuation. His report was not shown to the plaintiff, but the plaintiff rightly assumed from the local authority's offer of a mortgage loan that the property had been professionally valued as worth at least the amount of the loan. In both cases the terms agreed between the plaintiff and the mortgagee purported to exclude any liability on the part of the mortgagee or the surveyor for the accuracy of the mortgage valuation.

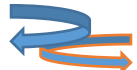
The position in another great common law jurisdiction – Canada – is similar. The leading Canadian authority, ***Haig* v. *Bamford*,** resembles *Hedley Byrne*. The Supreme Court of Canada held that there must be actual knowledge of the limited class that will use and rely on the statement. The most important factor taken into consideration in reaching that decision was the statement's purpose. The court balanced the need to protect the public against the need to protect accountants from indeterminate liability essentially by adopting Lord Denning's dissent in *Candler*. In *Haig*, the financial statements were actually used for the purpose for which the accountants intended, namely, for decision-making by a lending institution and potential investors. However, by holding that knowledge of the specific investor is unnecessary, the Supreme Court of Canada left open the possibility of applying the foreseeability test. However, Canada followed the UK in widening the scope of liability and almost adopted verbatim the *Anns* test in ***Kamloops* (*City of*) v. *Nielson*.** However, Justice McLachlin (later Chief Justice McLachlin), in ***Canadian National Railway* v. *Norsk Pacific Steamship***, characterized the *Kamloops* approach as an incremental approach, which is more sensitive to excessive liability. Still, this created a fear of indeterminate liability.

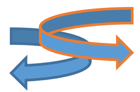
A recurrent theme in the analysis above is the importance of policy considerations in limiting the liability of auditors. A lot of these considerations are common to economic loss cases. By 1990, Canadian accountants faced over 100 lawsuits, a substantial increase in a short period of time, and claims of around C$ 1.2 billion were pending against Canadian accountants by 1994. In the UK, the 'Big 6' accounting firms faced 627 outstanding cases, claiming damages of £20 billion, by mid-1994. Moreover, by 1999, changes were affected to the procedural law that swung the pendulum in favour of plaintiffs. There are now compelling incentives for a defendant to settle early rather than risk going to trial. The pressure to settle increases the longer the case runs. As a result, UK's largest accounting firms spend as much as 8 percent of their auditing and accounting income on professional liability insurance. The total estimated amount of negligence claims brought against Australian accountants accumulated to approximately A$8 billion.

These are challenges to which there are no easy answers. Indeed, when faced with two unattractive questions – must a victim of unethical behavior be left without a remedy, or must law firms and lawyers be saddled with prohibitive and economically inefficient professional liability



insurance costs – the law will fall short no matter what it chooses. The best lesson is this: there was a time in England, and in India, when a barrister would walk out of court and accept whatever fee his client chose to pay him. It is no doubt unrealistic to expect that such practices ought to continue unaffected by the march of time – and yet, apocryphally, perhaps there lies a clue that will allow the Ugandan legal system to avoid having to make this Hobson's choice, and promote a culture based on internal regulation. History will bear witness to the choice it makes, although those who make it will not.





CHAPTER THREE

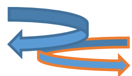
ENGINEERS

Engineering is similar to other professions such as legal and medical profession. They have a professional code of conduct and are supposed to abide by it. They have specialized knowledge, the privilege of self-regulation and are obliged to respect the public under the duty of care in exercising their mandate.

Professional ethics of engineers are not just personal preference established and governed by an individual engineer but rather a set of philosophical modes to govern the profession and prevent professional misconduct.

Professional misconduct among engineers is seen by engineers stealing raw materials, charging very exorbitant fees and constructing substandard buildings that can quickly collapse. Engineers are also liable under professional misconduct for negligence or any other violations. Assigning professional responsibility for harm in negligence cases often crucially depends on what is reasonable to expect from members of a given profession. Reasonableness is a concept which embodies the notions of what is proper and rationally prudent from a person to do in a given set of circumstances.

It is also thought that the professional should conform to hat any prudent person would deem reasonable. Thus if the standard operating procedures of an entire profession are deemed unreasonable in the light of common prudence, then merely living up to those standards is no defense against a charge of negligence. The standard of conduct expected of a contractor in 1900 cannot be the same as what is expected of them in 2021. Take for instance, in the 1930's a court ruled that because radios reduce the probability of collisions, it was negligent of captains not to have them on their ocean-going tugs. Merely conforming to professional standards did not



guarantee that these captains had discharged their duty of due care. In general, the duty of due care is not automatically met simply by following professional norms.[44]

In ***Inman v. Binghamton Housing Authority, 1957*** involving an issue of assigning responsibility for remote harmful consequences concerned a faulty architectural design. The city of Binghampton, New York, contracted to have a housing complex constructed within it's cty limits. Following the plans and designs of an architect named Lacey, Smith's Construction Company completed the buildings in 1948. In 1954 a two year old child was injured at the housing complex by falling off the stoop of his parents' house. The stoop was a single step but it was the height of two normal steps along part of its length with no railing around it. The step leading from the stoop to the sidewalk was in the center of the porch and did not extend along its entire length. Furthermore, the rear door opened outward in such a way as to require the person using it to step back dangerously close to the edge of the porch. The parents of the injured child, the In-mans, contended that the injury resulted from a design defect. The architect should have known that the children would use stoop and should have made it a two step stoop or at least put a railing around it. Clearly the harmful consequence is remote from the actions of the architect,

MODELS OF ENGINEERING ETHICS.

Malpractice or minimalist Model.

In general, we are held responsible not only for the harmful consequences of our actions but also for the harmful consequences of our omissions if the actions which we omit to do are ones that could be reasonably expected of us.

This is the minimalist model in which professional conduct is concerned with only with meeting standards and requirements of the profession and any other law or codes that apply. This model looks to find fault when problems or accidents arise from someone's failure to meet a requirement.

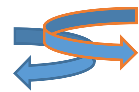
Reasonable care- due care Model.

A model of engineering practices in which the engineer is expected to take reasonable precaution of care in the practice of his profession. The model strives to prevent harm, and it appeals to a standard of reasonableness seen by a normal prudent non-professional.

Good works model.

A model of engineering practice in which engineers go beyond the basics of what is required by standards and codes and do what they ought to do to improve product safety, social health or social well-being.

[44] Prosser 1964, p. 170



CLAIMING AGAINST A NEGLIGENT ENGINEER

A Professional Engineer is negligent if he/she fails to use the skill and care that a reasonably careful professional engineer would have used in similar circumstances. If an engineer is sued, there are two grounds for liability: contract liability and professional negligence. "negligence" is defined as an act or omission in carrying out a practitioner's work that constitutes a failure to maintain the standards that a reasonable and prudent practitioner would maintain in the circumstances.

The requirements/ elements to prove when instituting a claim against a negligent engineer are almost similar in all aspects as those in common tort. If you've lost out financially because an engineer acted negligently, you may be able to bring a professional negligence claim against them.

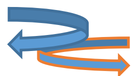
- The claim against an engineer may take the form of the following;
- Costs incurred in purchasing new building materials
- Failing to problem solve on construction projects
- Incorrect drawing and design plans
- Incorrect structural calculations in building projects.
- Negligent engineering advice
- The engineer failed to follow industry standards
- Unfinished projects
- This is by no means a comprehensive list of examples and there are many other actions that could fall under the category of negligence.

Any aggrieved person by an economic loss as a result of negligent engineering works, may make a complaint to the firm in question through its own complaints handling procedure. If you are considering bringing a claim for professional misconduct or professional negligence then you have six years from the date of the event of the negligence, or three years from the date you first realised negligence had occurred, in which to make a claim. If you're planning to pursue a professional negligence claim against your engineer, you'll need to demonstrate at least three things:

- You were owed a duty of care by the engineer
- The engineer in question breached that duty of care
- The engineer's negligent actions caused you a financial loss of some kind.

These were cited out in the case of ***B.C. Rail v. CP Consulting***, the contract had a provision that reasonable skill, care and diligence must be made in providing the services. the plaintiff sought damages for both breach of contract and for negligence (a liability in tort). For liability in tort, one must demonstrate the three elements as listed above.

If an engineer is sued, there are two grounds for liability: contract liability and professional negligence. In the case of contract liability, contracts contain various terms that impose contractual obligations and standards on the engineer. If a contract fails to express the same, our legal system implies that engineering services shall be provided to a standard that would protect the integrity



and purpose of the contract. If the contracted or implied obligations are not met, the engineer may be sued for breach of contract.

If there is no written or verbal contract for the engineering services, then a claimant must sue the engineer in tort, which is a system of law that allows recovery from those whose actions have resulted in damages. For professional negligence to be established, three conditions must be met. First, the engineer owed the claimant a duty of care. Second, the engineer's conduct breached the duty of care by falling below the standard of care. Third, the engineer's conduct caused loss to the claimant.

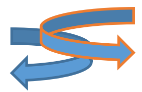
Often times, people face challenges with engineers in relation to the quotation price where engineer or contractor at the conclusion of the contract, seeks more money than originally agreed. This often places the other contracting party in an unduely influenced position since much as the work get more expensive than expected, they would gladly need it finished. Such cases often lead to civil action in courts of law wherein some instances turn out to be fundamental breaches.

The concept of fundamental breach was considered in ***Harbutt's Plasticine Ltd. v. Wayne Tank and Pump Co. Ltd*.** where the defendant used "thoroughly" and "wholly" unsuitable for is purpose. The concept of fundamental breach has not been overruled; however, in the case of ***Hunter Engineering Company Inc. v. Syncrude Canada Ltd*.**, the decision was to accept the freedom of contract and true "construction approach". In this case, the equipment provided by Rock Crusher did operate even if only at 17% of the guaranteed efficiency and therefore would be unlikely that the concept of a fundamental breach would be applicable here and therefore the limitation of liability would likely be upheld by the courts and ACE would be responsible for the $50 000 over-and-above the original contract costs of $400 000.

Regardless of whether the legal action is in contract or tort, the standard of care is central in determining if the engineer's conduct should attract legal culpability. If the standard of care is breached, the engineer will be found to have "negligence" and may be at fault for providing inadequate services.

The standard of care is the threshold used to determine if the engineer's conduct should attract legal culpability. It is an objective standard that begs the hypothetical question of "whether other persons exercising the same profession or calling and, being men of experience and skill therein, would or would not have come to the same conclusions as the Defendants" as visible in ***Chapman v. Walton.***[45] In other words, if an engineer with similar experience and skill would have come to similar conclusions and provided similar services, then no liability would be found. The standard of care differs from profession to profession, but there are some common principles. Past legal decisions and precedents tell us the following about the standard of care:
Standard: A professional is held to a higher standard than a lay person according to ***Hilton Canada v S.N.C.*** [46] and in measuring negligence on lines of competence, the standard is of a professional

[45] (1983) 10 Bing, 57, cited in Building Contracts 4th Ed. Keating, 1978).
[46] Lavalin Inc. (1999, N.S.J. No.188));



with average professional competence A professional should not be compared to the most skilled person in the field and the same professional should not be held to a standard of perfection as held in ***Trizec Equities Ltd. V. Ellis-Don.***[47]

According to ***Lapointe v Hopital Le Gardeur***[48]***,*** An error or mistake does not result in liability if others in the field would have acted in the same manner. In handling such matters, Courts often distinguish between conduct that is incompetent and an "error in judgment". Not every error in judgment will result in negligence. The standard of care expected of a professional engineer for instance, may increase if a professional represents special skills or expertise in a contract or verbal and written communication as was held in ***B.C. Rail Ltd. v C.P. Consulting Services Ltd***[49].

In Uganda, the minimum standards for engineering, construction are set out in the ***Building Control Act, 2013.*** *(find attached in the appendix).* Registration of engineers follows the procedure set out in ***the Registration of Engineers Act cap 271.*** Other laws governing the engineering profession include;

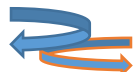
1. *Architects Registration Act, Cap. 269*
2. *Public Finance and Accountability Act, 2003*
3. *Surveyors Registration Act, Cap. 275*
4. *Uganda National Bureau of Standards Act, Cap. 327*

In final conclusion, the engineering profession is yet another profession subject to ethical codes and good behavioral practices in the course of its operation. Common law, statutory law and case law is evident to impute liability upon the actions of engineers, contractors, builders, surveyors, architects and all members of the profession but of course their great contribution to society building cannot be under estimated.

[47] (1998, A.J. No. 179));

[48] (1992, 90 D.L.R. (4th) 7);

[49] (1990, 41 C.L.R. 89).



CHAPTER FOUR

THE CLERICS PROFESSION

The code of Conduct for Christian leaders is established in **the Code of Ethics for those in leadership in Church.** The code of Conduct is based on four foundational principles which should guide the conduct of all human person, Justice and Integrity, Humility and love, mutual ministry.

The foundational Principles.

The dignity of the Human Person.

This is based on the reasoning that human beings are created in the image of God, with a clear recognition in scripture that each person is of unique value. Christian leaders are obliged to respect, encourage, nurture and guide the children of God under their guidance recognizing the dignity of all people since they are all created in God's image.

Justice and Integrity.

Christian leaders must treat people equally with respect, consideration and honesty towards all people. They must fight for justice of people in cases of oppression and bring people to the truth in case of deceit.

Humility and love.

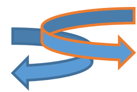
Christian leaders are called and empowered by the Holy spirit to pattern their leadership on example of Jesus Christ. Jesus was humble in his ministry, he accepted to die for our sins, he was tempted, he got hungry, people mocked and insulted him, he lived a life of a humble servant.

Religious leaders must therefore live exemplary lives, they must not fight for recognition and privileges.

Mutual ministry.

Christian leaders must do their work, exercise all particular responsibilities according to their giftedness for which they are held accountable to the body of Christ.

According to the **introduction for the Code of ethics for those in leadership in church,** Christian leaders exercise a special role within the community and the state at large. They have a responsibility to their peers, local community of faith, to the wider church and to the society.



Principle 2 of the Code of Ethics for Christian Leaders emphasizes that Christian leaders should not exploit their flock spiritually, emotionally, financial reasons. However, a lot of exploitation against members of the congregation is being practiced today by religious men and women as I shall discuss herein.

FACTUAL SCENARIOS OF UNPROFESSIONALISM AMONG CLERICS IN UGANDA.

There is no uniform code of conduct for all religious ministers all over the world although there is a uniform book of laws and guidelines for all Christians and Christian religious; which directs their conduct and relations between one another and within it, has specific commandments or laws given by God. Therefore, this means that attaining uniformity of conduct for the religious i.e. both Christians and Islamists is made more possible with the existing Holy Bible and the Holy Qur'an respectively. With particular regard to this and in my well considered opinion, I appreciate that the guidelines in ***Psalms: 15*** of the Holy Bible are sufficient to supplement the 10 commandments in providing a code of ethics for all religious Christians. That for instance; the ministers regarded with good ethical conduct are; ...

2 The one whose walk is blameless, who does what is righteous,

who speaks the truth from their heart;

3 whose tongue utters no slander,

who does no wrong to a neighbor, and casts no slur on others;

4 who despises a vile person but honors those who fear the LORD;

who keeps an oath even when it hurts, and does not change their mind;

5 who lends money to the poor without interest;

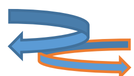
who does not accept a bribe against the innocent.

Whoever does these things will never be shaken.

(Psalm 15)

In this chapter specifically, we shall be able to form an opinion whether these religious ministers who swear an oath of service holding the Holy Books, actually serve under their guidance to mention but a few, including the scenario of the religious minister burning the same Holy Books.

Mortal gods.



"1 john 4. Beloved, do not believe every spirit, bust test the spirits to see whether they are from God, for many false prophets have gone out into the world. By this you will know the spirit of God..."

Factual situations and scriptures create a little confusion especially for some people who do not subscribe to the theory of faith i.e. believing in what you don't see. Take for instance, the Holy Scripture in *Isaiah. 43: 10* reads that, "*besides me there is no other God, there has never been and there will be."* It is confusing to find a mortal man being worshiped as of late and yet this has been actually true and we also know according to *1 John 4* that in testing the spirits to discern which ones are of God, this we shall prove by; "anyone who acknowledges that Jesus came as a human being." Yet most recently, did we see and hear of a certain Ugandan god; "Owo-busobozi Bisaka" calling himself god and gathering masses of believers. I have encountered the heading; "

Kibwetere saga and the burning of people in Kanungu.

Some members of the public argue that the unfettered granting of religious freedom is responsible for some of the hazards and misconduct existent today among religious leaders and the church at large. In 2014, parliamentarians while tabling the Kanungu massacre opined that the incident was the result of too much religious tolerance and religious freedom. They also called upon religious institutions to be investigated.

Today marks 21 years after an approximate of 1000 people lost their lives by burning in a fire ignited by *Fr. Dominic Kataribabo*, *Fr. Joseph Kibwetere, Fr. Kasapulari* and *Sr .Credonia Mwerinde as* leaders of *The Movement for the Restoration of the 10 commandments* of God Church. Though the government sanctioned the probe, the report has never been out even today. Leaders of the cult had told people that the world was coming to an end on December 31st 1999 claiming that they received this message from God and Mother Mary so they told people to sell of all their belongings and await for death. There was a dumping site built to harbor the bodies of people who were killed before the final massacre.

Those who were present at the time narrated that people were told not to have intercourse with their partners and communication would only be by sign language. No children were conceived in the commons and there was a report of woman who was beaten until she miscarried. Under **section 142** of the **penal code Act**, procuring a miscarriage is forbidden thus; *any person who with intent to procure the miscarriage of a woman whether she is or is not with child… uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen years.* This was adjudicated upon in ***Uganda v. Apunyo Hudson.***[50] The accused, a *boda-boda* cyclist impregnated a school girl below 18 years and paid money to have an abortion. Similarly, the actions of these religious leaders were in contravention with ***article 22*** of the 1995 constitution which provides that; *"no person has the right to terminate the life of an unborn child except as may be authorized by law."*

A total of 780 burnt bodies were recovered. According to IGP Kale Kayihura, *(as he was then)* the leaders are believed to have escaped but till now, no one knows their whereabouts. These

[50] Criminal session 7 of 2004 [2004] UGHC 52

religious leaders should have been charged for having committed murder contrary to **section 327(a)** of the **Penal Code Act cap 120.**

In ***Uganda v. Asobasi***[51]**,** the accused willfully and unlawfully set fire on the dwelling house, the property of a one Drichile Martin. Though hundreds of people were killed and some of the ingredients of murder are provable, it is trite law that the doctrine of minor and cognate offences requires that where a person is charged of an offence and facts are proved which reduce it to a minor cognate offence, he may be convicted of the minor cognate offence although he wasn't charged with it[52]. (S.145 MCA, S.87 TIA) take for instance, a person charged with murder maybe convicted of manslaughter, a person charged with robbery may be convicted of theft.

Given that the matter was never brought before courts of law doesn't mean that the perpetrators' action is in the good books of the law besides criminal matters have no time limitation (*omusango teguvunda)* as noted in ***Kanyamunyu Mathew v. Uganda***[53]**.**

Religious bombings by Islamists and "The Blood-Written Qur'an."

Matters of faith are one that are not easy to prove by evidential facts but through faith itself corroborated by physical facts and scriptures. As already noted, we live in a generation where people believe much the words of the Pastor but forget the word of God; where the religious ministers' words ae taken to be gospel truths and their actions "copied and pasted" by the congregation. In summary, we've fallen short of the scripture insinuating that do as I say not as I do. *Mathew 23.3 states that; "so practice and observe everything they tell you. But do not do what they do, for they do not practice what they preach."* The scandals of today's time reflect some instances where church members follow strictly the conduct and words of their professionals (Ministers) as commands upon them "sheepishly" without first of all "testing the spirits to discern if they are of God[54]"; a thing which has caused religious scandals such as the burning of bibles, the burning of people in Kanungu, the Holy rice scandal, Holy water, seed scandal etc… and most recently, the affirmation of bleaching by one prominent female pastor in Kampala claiming that she bleached in order to please her God. The unregulated religious fallacies too are signs of professional misconduct if reliance is made upon them and through such, harm or loss is sustained.

Take for instance, in one of the Inside stories, Saddam Hussein ordered for the writing of the Qur'an using his own blood and reportedly, donated 27 liters of his blood to the project[55]. Upon completion of this project, the Holy book was to be distributed to his followers and Islamic believers.

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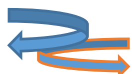
[51] [2018] UGHCCRD 50
[52] https://www.legrandebenjie.blogspot.com/2021/12/charges-and-indictments
[53] Criminal miscellaneous application 151 of 2020 [2020] UGHCCRD 144
[54] As above in; 1 John 4. – the Holy Bible
[55] https://www.businessinsider.com/nobody-knows-what-to-do-with-the-koran-written-in-saddam-husseins-blood-2012-8 accessed on 23rd December 2021



The sacred scripture of Islam, Qu'ran, also spelled Quran and Koran, was revealed to the Prophet Muhammad by the angel Gabriel in the West Arabian towns of Mecca and Medina beginning in 610 and ending with Muhammad's death in 632 CE, according to conventional Islamic belief.

Saddam Hussein ordered a copy of the Quran to be written in his own blood in 1997. He explained that he wrote the book as a thank you to God for allowing him to survive many dangers while avoiding bloodshed. A copy of the Qur'an, Islam's main religious text, written in his own blood is one of the most morbid relics of Iraqi dictator Saddam Hussein's reign. The book's composition varies widely between reports. It is said to have taken two years and more than 20 pints of Hussein's blood, which was drawn by a nurse and handed over to an Islamic calligrapher. Others claim that only a small amount of blood was used, along with ink and other chemicals.

According to some medical experts, donating such a large amount of blood in such a short period of time would have put Hussein at serious risk for anemia. In the United States, donors are typically limited to one pint every two months or so.

The Blood Qur'an was kept in Baghdad's Umm a-Ma'arik mosque ("Mother of All Battles") during Saddam Hussein's reign. The priceless artifact was hidden after Saddam Hussein's regime was deposed. The 605-page book is the subject of heated debate. Some people consider it to be a blasphemous evil symbol. Writing the Qur'an in blood is "haram," or sinful, according to Islamic law, but some argue that destroying a religious doctrine would also be blasphemy. Despite its macabre origins, those who have seen it say it is indescribably beautiful, with two-centimeter-high lettering and "dazzling" multi-colored decorative borders. In the early hours of December 30, 2006, Saddam Hussein was hanged for his crimes. This created a serious situation in law and in Islam whereby the dilemma holds that on one hand, it is illegal to write the Qur'an in blood and on the other hand, it is also illegal to destroy the Holy Book. This is one of those situations where a leader, both religious and political, places his followers in a sensitive situation of criminality and doing evil on the other hand.

Manipulation of "tongues"

Today we have seen institutions like churches teaching people how to speak in tongues as part of the church curriculum, yet this according to the scripture, shouldn't be taught since it is only inspired by the Holy Spirit. I have heard and read about churches which offer a program of teaching people how to speak in tongues. God knows for what purpose. A certain article written by ***Antredd, (2009)*** that; "*I was floored when a friend of mine told me that his niece goes to a church where it teaches its members how to speak in tongues. Even though there are many churches popping up and teaching its members how to speak in tongues, there is no biblical support for any church to teach this false doctrine*[56]*."* St. Paul tells the *Corinthians in 1 Cor. 12.30* that not all people speak in tongues, meaning that we are called differently. Not all are healers, not all interpret, not all work miracles, *etc*… you now may wonder where the doctrine that everyone interested can speak in tongues by paying money and going to learn. It probably comes from the view that right after the

[56] Accessed at https://www.city-data.com/forum/christianity/801156- on 14h December 2021

baptism in the Holy Spirit occurs, all Christians possess the same state as the early Christians on the day of Pentecost. The problem with that view is that it contradicts the word of God expressed in what St. Paul writes in *1 Cor.12.30.* Accordingly, the right view would be that the gift of tongues is not given by the Holy Spirit to every Christian who seeks it. The Holy Spirit apportions this to anyone as He wills.

I think it is a dangerous thing when people are simply taught tongues because the devil can give them the words to say. We cannot over look this issue because members of the congregation are wandering about wrongly in reliance upon the Pastors words. These situations are legal in character because they bring about reliance upon consideration being sufficed. Just like meeting a Doctor has charges, so have the pastors' services today. The evolution of paying "*seed"* or call it "*ensigo"* has discouraged some "*sheep"* from approaching their *"shepherd"* because a mandatory consideration for a miracle to happen, will certainly be demanded.

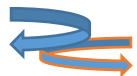
Talks and demonstrations against **Sexual harassment** have rocked the streets most recently as church members protest the sexual harassment taking place within and behind church alters. Perhaps, we could be heading for worse times like sacrificing *"other Isaac's"* on the alter for the sake of miracles. Indeed it is a human rights issue and criminal too, that for instance last year for instance, of the 19 teenage pregnancies in an area in Kabare, Burundi, 5 were linked directly to Preachers i.e. ministers of the church whereby admissions of guilt were also made. The situation is worse for Nigeria and Uganda as I will express hereinafter. The article; "Youths Expose FAKE preachers that sexually abused minors" reads that; "*it seemed a nauseating rumor; men acting as preachers and forcing young girls to have intercourse with them in the name of preparing them for their baptism."*[57] This violates international codes of practice such as in the **Convention on the Rights of the Child** and the **Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child prostitution and Child pornography. (Jan. 2002)**

Article 4 provides that *each state party shall ensure that as a minimum, the following acts and activities are fully covered under its criminal or penal law, whether such offences are committed domestically, or transnationally or an individual or organized basis.*

(a) In the context of the sale of children as defined in article 2.
(b) Offering, delivering or accepting by whatever means a child for the purpose of;
(i) Sexual exploitation of the child.
(ii) Engagement of the child in forced labor.

This book exposes the misconduct done by members of the religious fraternity which violate ethical and moral standards. Unfortunately, on a bigger scale, victims of injustice occasioned by ministers often meet a challenge of social stigma and they fear to reveal the truth since the perpetrator is a person perceived to be of high moral character and can easily defended, protected and believed by most members unlike a lay person.

[57] https://www.cordaid.org/news/youths-expose-fake-preachers-that-sexually-abused-minors accessed on 14th Dec. 2021



Take for instance, police on October 4th 2021, was investigating about a city pastor, charged with aggravated human trafficking and sexual exploitation of children in his church[58]. This was following a raid conducted on his churches in Tororo and Buwenge wherein a total of 54 victims were recovered all aged between 4 and 25 years and the bigger number of the being juveniles according to CP, Fred Enanga; Police Spokesperson (*as he was then).* To impute criminal liability upon the accused on a count of defilement, courts are tasked to prove, with the aid of experts, the occurrence of sexual intercourse, that the children are below 18 years and that the defendant is the one involved in the intercourse. These ingredients were listed in ***Basiita Hassan v. Uganda.***[59]

According to ***R. v. Recorder of Grimsby ex parte Purser***[60] the best evidence in proof of age us the birth certificate, immunization card or baptism certificate whichever is available. However, in the absence of the above, court can rely in the evidence of a close relative, of the victim who is well acquainted with her age. The court can also rely on observation and the application of common sense in determining the age of the victim for forensic purposes.

In other times, the world was left in shock after a one *Rev.Fr. Anthony Musaala,* a renowned singer and "dancing priest" wrote an open letter to the Archbishop of the time, *Cyprian Lwanga,* intimating to him about the gross sexual abuses existing in the church which are widely known yet ignored by the Vatican. He wrote that;

"The Vatican church turns a blind eye because it doesn't want to be embarrassed about this blooming church. But I think it's time we has the truth," says Fr. Anthony Musaala. He wrote to the Archbishop about priests who among others, kept secret wives or abused girls and boys, and then called for a debate on marriage for priests. He testified about himself, having been sexually abused at 16, by Catholic brothers at one of Uganda's best boarding schools. He also alleged several other cases of child sex abuse in his letter. Shortly before, South African Cardinal Wilfrid Napier of Durban said in a BBC interview that he had dealt with cases of child sex abuse, that these were handled by the church internally and not referred to the police. One may question whether substantive justice, due process and rule of law principles were adhered to in the process. Good enough, the Bishop suggested that the perpetrators weren't criminals and needed counseling.

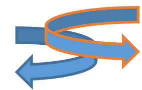
In my opinion, the major challenge goes beyond the fact that the perpetrator is a religious minister; it is that the victims are naturally ashamed of coming up to report or seek formal justice reason being that the perpetrator is of a certain exceptional status. In fact, it is suffice to say that it is so scandalous for one to report sexually immoral cases involving members of the clergy. It is almost conclusive that certain impunity is enjoyed by religious men and women not on merit but by the social attribute given to them. Such indecent offences should to have been tried

Most recently, police also arrested a pastor who according to police investigation, has been routinely abusing many of the vulnerable girls at his church. That, not only has he destroyed their innocence, but he could have exposed them to sexually transmitted infections including

[58] https://www.upf.go.ug/pastor-arrested-for-aggravated-human-trafficking-and-sexual-exploitation accessed on 16th Dec, 2021

[59] SCCA No. 35 of 1995 (unreported)

[60] (1952) 2 ALL ER 889



HIV/AIDS. At the time he was arrested, he had turned young girls under his been using 6 girls as sex slaves and impregnated one of them. The pastor has a church In *Lugala, Masanafu road* in *Rubaga Division* according to Daily Monitor.[61]

Ordinarily, this pastor should have been charged with among other offences, aggravated defilement in respect of his actions upon minors. According to ***Uganda v. Adinani Fahamu***[62] for the accused to be convicted of aggravated defilement, the prosecution must prove each of the following essential ingredients beyond reasonable doubt;[63]

- *the victim was below 14 years of age;*
- *A sexual act was performed upon the victim*
- *It is the accused who performed the sexual act.*

The Uganda penal code Act defines defilement as "unlawful … sexual intercourse with a girl under the age of 16 years" and makes the offence punishable by death per section 129(1).[64]

According to a commentary on the case of ***Uganda v. Kusemererwa***[65] by Women and Justice[66], it was argued that in sexual offences relating to children, "rape" should not be cited as an offence. The law does not allow rape charges for children because of the element of consent; unlawful sexual intercourse with children must be prosecuted as defilement. The victim in this case was 16 when the defendant had unlawful carnal knowledge of her without her consent. In Uganda, the maximum penalty for rape is death. The victim argued that he should be charged with simple defilement instead of rape because rape only applies to an adult woman who can give consent whereas the state argued that the statutes give the state discretion to choose between the charges. However, it is now settled law that in sexual offences relating to children, the person cannot be charged with rape, rather defilement.

Religious men preaching revenge.

Yiga was cast on the limelight in 2006 when he started announcing on radios that he was capable of cleaning Christians and would return their problems back to the sender in his popular church sessions dubbed Abizzaayo. It is understood that Christianity presumes forgiveness and peace, however, Yiga's approach of "Abizzaayo" painted a picture of religious leaders who are promoting spiritual revenge, notion much known to traditionalists[67]. St. Paul the Apostle says in Romans Chapter 12; "*bless those who persecute you; bless and do not curse. Do not repay anyone evil for evil. Do not take revenge, my dear friends but leave room for God's wrath, for it is written, it is mine to avenge; I will repay," says the Lord.*

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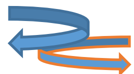
[61] https://monitor.co.ug/uganda/oped/editorial/government-to-blame-on-sexually-abusive-pastor-1724388
[62] Criminal Case 168 of 2020
[63] See also Uganda v. Kiiza Manira (criminal session) case 159 of 2017 [2019]
[64] Also section 129(3) and (4) (a) (b) _ Uganda Penal Code Act
[65] HCT -01- CR- SC 15 of 2014
[66] https://www.law.cornell.edu/women-and-justice/resource/uganda_v._kusemererwa accessed on 16th Dec. 2021
[67] https://www.monitor.co.ug/uganda/news/national/the-turbulent-life-of-pastor-yiga



Christian teaching embodies some statutory principles such as the courts having power to "avenge "or punish one for their offences but not for the afflicted to take the law in their hands. Secondly, the bible discourages abortion Just as the law does. In Islam, Muslim authorities consider abortion as an act of interfering God's role as the author of life and death. (AL Faruqui 1982) the same applies to the act of abortion which is criminalized by ***section 212, 142, 142*** of the **Penal Code Act** of Uganda. As often noted, the pastors' preaching today is so greatly believed in that sometimes people ignore the real scripture, an example of this is the "Abizzaayo" scenario.

This poses a legal issue since at one point, continuous deviation from Biblical Principles towards copying the Preachers' life style could cause contravention with statutory laws. Religion preaches morals. The law and morals are sometimes incapable of separation owing to the similarity of religious principles with legal and equitable doctrines. Take for instance the doctrine that *"equity considers done that which ought to be done."* This is in line with ethical and moral principles of justice and fairness. The same pastor is known for having told his followers to reject the rumor of covid-19 terming it as uganda politics. This means that his innocent followers would be exposed to the deadly virus and succumb to it by following the pastor's fallacy sheepishly. On a good note, quick action was taken to prevent his followers from falling culprit to this deception.[68]

The "holy rice" deception.

Another form of deception and financial exploitation by the clerics profession is manifest in the "Holy Rice" saga where a one Pastor Kakande who started up a huge farm of rice crop and owns a huge farm of rice which he started way back in 1997. In the recent years as he craves for bigger market, he starts a homily of the "holy rice" bringing blessings and selling each kilogram at US $ 14 almost. This is a great exploration of the congregation. The Christian fraternity ought to come up with a proper code of conduct as a legal regulation governing such people or else the law ought to deal with such situations specifically to save the poor and ignorant.[69]

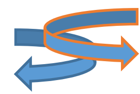
Burning of bibles.

Most recently, media was shocked upon receiving news of a certain pastor who took on the burning of certain bibles claiming their version containing the words "holy ghost" was deceptive and misleading his followers. In April this 2017, former Ddembe Presenter Aloysius Matovu Kiiza and Evangelist Semugooma Francisco (both born-again Christians) through their lawyers Wamell and Co. Advocates filed a case accusing the pastor of "insulting religion and wounding Religious feelings" when he burnt hundreds of Bibles at his church in Makerere Kikoni. Another question to answer would be whether the publishers and authors of this version of bibles would sue the pastor legally liable for false utterances against their literature works which subsequently causes economic loss.

In such a situation, it's important as lawyers or legally interested parties to bisect the legal issues within this incident by pondering on whether it is an offense for one to burn certain bible versions. **The 1995 constitution of the republic of Uganda** allow everyone the right and freedom to

[68] https://allafrica.com/stories/202003300086.html accessed on 31st Dec. 2021

[69] https://panafricanvisions.com/2017/02/uganda-pastor-sells-holy-rice-followers-u-s-14-kilogram/ accessed on December 31, 2021



practice their religion. The **Penal Code Act** states that *any person who intentionally insults another person's religion by destroying, damaging or defiling any place of worship or any object which is held sacred by any class of persons commutes a crime and could face imprisonment for up to two years in prison.* This section could mean that intentionally burning bibles which is a scared holy book might be an offence. However, legal standards of proof and the presumption of "innocent until proven guilty" would still apply. **Article 23** allows that everyone is presumed innocent until proven guilty.

This means that much as some people might be offended by an act such as burning of bibles, it is also good that we avoid situations of mob justice and let the law decide. In that particular case, the learned Nasamu J stated that the plaintiff was supposed to first consult the authors of the Bible to find out whether Bugingo's act of burning bibles was right or wrong thus the Pastor was acquitted in the matter of **Aloysius Matovu Kiiza & Francisco Semugooma v. Pr. Aloysius Bugingo (2017).**

Financial exploitation of congregations.

It has become common talk that some religious leaders openly stated before their congregation that they do not accept coins as offertory money in their church. This can be viewed as financial exploitation of the church members. It may also show that certain churches have become money minded. It has also caused certain church members to give in counterfeit money as offertory in fear of bringing coins yet they need the miracles. In retaliation, some pastors too have decided to bring in machines that detect counterfeit money.[70]

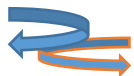
The National Policy on Religious and Faith-Based Organization was first announced in December 2018 by the Uganda State Minister for Ethics and Integrity, Fr. Simon Lokodo. It aims to enforce transparency and financial accountability among religious-based institutions. In October, Lokodo asked churches to help finalize the policy to prepare the country's cabinet to discuss and pass or reject it as law.

Currently, churches are not required to declare revenues to the government even when there are concerns about some of the sources and misuse of funds. It's common to find a pastor owning a fleet of luxurious cars and apartments in the plush city suburbs of the capital Kampala when their flock is drowning in abject poverty.

"The policy will stop the exploitation of the flock by some unscrupulous religious leaders, who have taken advantage of the gaps in the current law to manipulate their flock and extort from them,"

Lokodo said. Lokodo also observed that manipulating church congregations has become a "norm." For example, people who go to church for blessings to find a job or to be healed

[70] https://ekyooto.co.uk/2019/07/29/pastor-bugingo-complains-of-worshipers-giving-in-fake-money-as-offertory/ accesed on 31st Dec. 2021



are first asked to pay money to the pastors. The policy requires that the pastors present an annual financial report for the revenues collected from their congregations and external funders.

Many pastors rejected this policy alleging that it prohibits their freedom under **article 29 (c) of the constitution.** **Article 29(c)** of Uganda's constitution guarantees freedom to practice any religion, which includes freedom to participate in the practices of any particular religious body or organization. *Article 7* of the Constitution says that the country shall not have a state religion. The definition of what makes a religion is not clear. Ugandan Pastors also rejected the Policy Requiring Official Training To Start A Church which in essence would have enabled us to sieve out unprofessionalism from the religious sector.

Kissing the pastor's feet for blessings.

This is yet another demeaning practice done by certain religious leaders. The Bible preaches about the Master washing his servants' feet in **John 13:1-17** and not the reverse. It emphasizes that those are first will be last. As the pastor claims he has been to heaven walking on its streets, so church members kiss his feet for blessings. Men and women of great dignity being photographed kissing the pastor's feet is in my view, degrading of their dignity.[71]

Sodomy among religious heads.

Most recently too[72], a group of male youths went on streets demonstrating because their pastor has sodomized them and all efforts to make him legally liable had failed. They held placards written on; "*You spoilt my behind, you killed Ashraf but not us*," as these Young men protest over Pastor Kayanja's acts of sodomy against them.[73]

These boys were not just members of his church but were among those he serves with on the alter. Acts of sodomy attract criminal punishment according to the **Penal Code Act.** It provides that; ***section 145*** of the **Penal Code Act 1950** criminalizes "carnal knowledge… against the order of nature", and is punishable with life imprisonment. **Section 146** of the same Act criminalizes attempts to commit any of the offences prohibited under *Section 145*, punishable with seven years imprisonment. ***Section 148*** prohibits acts of "gross indecency", punishable with seven years imprisonment. The provision is gender-neutral, applicable to acts between men and between women. Ordinarily, this Pastor should have been investigated without delay and immediately probed for committing these acts if the allegations are proved. The laws relating to LGBT rights faces a lot of challenges in Uganda as it is usually challenged by activists. It is commonly suspected that LGBT activities in Uganda may have big sponsors who often sabotage the process of litigating against it. This could have also hindered the process of charging perpetrators of the same practice some of whom are professionals. The question of how to sue successfully such a professional for their sexual malpractice remains difficult and unanswered and various examples will support this.

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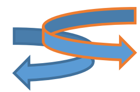
[71] https://www.thenewsguru.com/news/photos-church-members-kiss-pastors-feet-blessings/ accessed on 31st Dec. 2021

[72] SEPTEMBER 28, 2021

[73] https://uelresins.com/ugandanews/archives/16459 Accessed on December 31st 2021



The Ugandan Constitutional Court was on 8 July due to hear the matter of ***Jjuuko Adrian v. Attorney General,*** which has been awaiting trial for seven years, but failed to do so. The case concerns a challenge to provisions in Uganda's Equal Opportunities Commission Act of 2007 preventing the Equal Opportunities Commission from investigating cases of LGBT rights abuses.

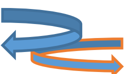
In May 2021, the Ugandan Parliament passed the Sexual Offences Bill, further criminalising same-sex sexual activity and sex work and consolidating a range of other sexual offences. Ostensibly to tackle sexual violence, the Bill received criticism from Ugandan LGBT groups including Sexual Minorities Uganda (SMUG) who stated that the new law would be another tool used to target and arrest LGBT people in the country, as well as being condemned by UN mechanisms and international civil society. In August, President Museveni declined to give assent to the Bill, returning it to Parliament on the basis that many of its provisions duplicate offences already included in the Penal Code, though the ultimate fate of the Bill is not yet clear.

Another challenge faced by Uganda's legislative system is that our former colonial master Britain has legalized same sex marriages of which there is reason to believe that they have indirect financial influence upon Uganda. England is dominantly and Anglican based country and gayism support are most susceptible to claim influence in Uganda through such religious channels. A highlighter to this would be in statements made by religious leaders which show support or lenience towards LGBT rights. Why should we want to kill homosexuals for doing something in private that affects no one else? Our job is to love them, to bring them close and show them God's love." Said, *Reverend Fred Komunda,* St. Peters Church, church of Uganda.

Unprofessional misleading conduct and law breaking among religious.

On several instances social media has been washed with exchange of embarrassing statements between members of the clergy and other times, church heads insulting members of the congregation. A case in point is the statement made by a famous city pastor Aloysius Bugingo insulting a lawyer Male Mabirizi as he called him a "pig." Speaking on both a radio station station and within his church, the Man of God bragged that his critiques are all "pigs;" that God cannot side with a pig and yet leave a one Bugingo (referring to himself) who speaks with the sick and blind. The statements came following a suite against Pastor Bugingo where he is being charged for allegedly celebrating an illegal marriage with his new wife shortly after having divorced with his official wife as against Christian norms. The impugned pastor divorced his wife and took on one of his employees, carried on a traditional introduction and upon being charged contrary to the Marriage Act, the pastor denied having been introduced. The pastor was introduced in a traditional marriage practice *"kwanjula"* while still having an existing divorce charge against him, pending for hearing.

The **Marriage Act** which governs Bugingo and Teddy's marriage is very clear on this issue that; any person who is still in an existing civil marriage (church marriage is also known as civil marriage) is incapable of contacting a valid marriage under any customary law. Furthermore, **section 11** of the **customary Marriage Registration Act** emphasizes the provisions of the Marriage Act that; a customary marriage shall be void if one of the parties has previously contracted a monogamous marriage, which is still subsisting. Whereas customary marriages are



potentially polygamous, all Civil marriages are all monogamous. A year after divorce, the man of God came up to state that he doesn't believe in divorce and the Christian faith forbids it. Isn't this confusing or misleading to the inexperienced followers looking up to their leader for direction? A one Teddy Naluswa has taken action against the impugned pastor for violating clear provisions of the law and the matter is now set for hearing. this is illustrative of how and when you can sue your professional for misconduct.

In conclusion therefore, every profession ought to have a set of rules governing the conduct of professionals thereunder. Short of this, the "believers" world is susceptible to being misled, exploited and abused in many aspects as visible above. It would have been proper that although efforts to have all religious men and women taken for a compulsory training program and for matters of strict factual knowledge about doctrines of theology; have been rendered futile by the professional members themselves, another try should be done to encourage the same as this could probably form the best solution per now.

Suing a clergy member.

The US has succeeded in installing a way of liability against religious institutions, breaking the undue impunity of members of the clergy and their estate. Religious organizations organize themselves according to religious principle, vesting responsibilities in certain entities. It is common today that suing a local church over a doctrinal matter would be improper even if constitutional; using a national church because someone fell through the roof of a parish church is likewise not proper even if constitutional.

Nevertheless, the principle that where there is a right, there is a remedy will always stand in favor of an aggrieved person be it even under vicarious liability. In an era like to-date where the world believes more in the words of the pastor that they forget the word of God, It is imperative to put a check on the effect of reverends, sheikhs, and all ministers of Christ and especially how such affects their followers. The situation is made more difficult by the unequal relationship between elites and the inexperienced. Similarly, I think that for religious issues, it should not be about who is educated and who is ignorant but the fact that someone vests a lot of trust in another, places them in a fiduciary relationship, with a duty of care.

I risk being lynched by mob when I state certain injustices and fraud veiled in glittering testimonies by believers sponsored and staged by some rich pastors around the city for the purpose of winning more church numbers. It has become common today that some pastors ask for *"ensigo"* or call it *"seed"* in exchange for miracles. This seed is often extortionate for one to obtain and yet there is no visible assurance of gain; in legal terms, consideration is given for a promise in the future without surety of fulfilment. There is a lot of uncertainty in such contracts, a thing which puts the contracting parties at an unequal bargaining power. It vitiates the contractual element of consideration and meeting of minds.

A contract according to *section 10* of the contracts Act is defined as an agreement made with the free consent of parties with capacity to contract for a lawful consideration and with a lawful object. Similary so was it defined in ***Ssempa v. Kambagambire***[74]**.** In this domain, am talking about situations of faith which entail a promise made and reliance is made thereupon through action or forbearance. Faith has been defined by the Holy Scripture in *Hebrews 11* as believing in what you don't see. Gene if such agreements should be actionable in courts of law and even if the panel of judges was composed of believers, a consideration of a vehicle placed by a church member for a pastor's prophecy which is unseen at the time of the agreement, places an impossible burden of proof and belief given the nature of faith. Some pastors sexually exploit female church members with a promise of bringing about spiritual cleansing. There is need for the good lawyer to explain the rights of this church member. Recently, I learnt of a confession by a mother who left home with her vehicle she uses to take children to school, but only to come back on a *boda-boda* after the pastor had convinced her congregation to leave at the church, everything they came with and God would ward them a thousand times more. Yes, this is a true story. So in this particular chapter, we're talking about how to advise such a woman concerning her rights.

We have seen instances of church ministers acting unethically against their clients where for instance a Kenyan male pastor touches a woman's private parts and requires the barren woman to touch the pastor's as well with faith that this is a way through which the latter will conceive a baby. You wonder where such leaves one's dignity! In Africa there is a widespread spiritual revival pioneered by Pentecostal pastors who claim to deliver prophecies, miracles, and healings. In many places, multiple churches can be seen within a few hundred yards of each other, while in other places, different floors of multistory buildings are occupied by different church denominations. There is competition among the pastors to present themselves as spiritually powerful and financially favored by God. Some of the pastors, calling themselves "prophets," engage in immoral and fraudulent activities. Women are the predominant followers of these male religious leaders, and sexual exploitation of vulnerable women by these religious leaders is common[75].

I have encountered an article entitled "Sexual exploitation of female church members by "prophets" in Nigeria." bearing a confession thus; *"he told me that my waist and private parts have been ravaged demons."*

I have read about a church in Kenya called **Breast and honey harvest fellowship international**[76] where the pastor who came from Nigeria, does healing by sucking the breasts of female church members so as to get out the spirit of rejection and all the church members have to come without their bras ready to be sucked and essentially the church is composed of mostly females. The pastor claims that the spirit of rejection rests in the breasts and the healing has to be done by sucking the

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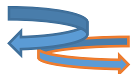
[74] Civil Suite 408 of 2014 (2017) UG Commc. 133

[75] Chima Agazue The University Centre, Blackpool and the Fylde College, at: https://digitalcommons.uri.edu/dignity

[76]https://ng.opera.news/ng/en/religion/02fc6d5c4f3b444a918283705511c695 accessed on 31st December 2021



breasts. It is absurd that this pastor has practiced such indecency on thousands of women. Once more, you may wonder where this leaves our ethics! This so called "man of God" makes reference to the same Holy Book which other true pastors refer to, but with a different construction to bring about a different result.

Perhaps it saves a great deal when all religious ministers undergo a specific training/study of Theology and Philosophy before they can start to minister. I have also come to realize that such habits are more common among the Pentecostal Churches unlike the Catholic Church where specifically, priests must study their profession for more than 8 years in addition to most times, attending classes from the minor and major seminary for other 9 years (for the sake of learning ethics) hence making it about 17 years of training.

As a first remedy, separate institutions specialized in training religious ministers should be built whereby Ethical intelligence and integrity should be taught. This will consolidate morals among the clergy and also protect the dignity of church members against abuse by their pastors. It will not only shape morals of the clergy but also of the nation at large since clergy men and women are also parents who will raise morally upright children and nations. For some reasons, the clergy have posed in respect and some implied impunity which today needs to be broken in the interest of justice. No wonder, some jurisdictions and some activists, authors, etc… have come about to emphasis the legal position for suing a church minister or church estates.

The doctrines of Tort need to be applied against the "women and men of God" so as to prevent injustice from going unpunished. Negligence and misconduct ought to be judged against ministers and church.

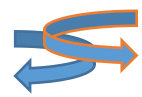
It has been noted on countless times when courts have said that religious disputed are not within the jurisdiction of civil suits. This sweeping statement gets limited to read that a purely ecclesiastical or doctrinal issue is outside the scope of civil jurisdiction, thereby enabling them to assume decision-making function over factions whose property squabbles are inextricably interwoven with doctrinal undertones.[77] Or to put it the other way, *Justice Musa Ssekaana* in ***Rev. Charles Oode Okunya Vs. The Registered Trustees Of The Church Of Uganda***[78] stated that a judge may say that religious dispute which involve property or civil dispute are within the scope of court.

The practicality of Ecclesiastical courts

Do we need separate courts for the religious ministers?

In my well-considered opinion, I think this is a right position to defend; that matters against the religious should be handled in separate courts so as to maintain good social attitudes towards these church ministers. The rationale for this is that religious minsters are by common practice, looked

[77] Obiter in David Nsiyona v. Scandi Trading LTD [2021] UGCommC 32
[78] CIVIL SUIT NO. 305 OF 2020



unto as an example of good Christian living, perfect morals *etc…* and it is true still that a big portion people today trace their inspiration upon and are mentored by the lifestyle of their Sheikh, pastor, preacher, priest, among others and that some people have modeled & adjusted their lifestyle simply by following closely the spirituality of others. Therefore on such basis and recognizing the many dark scandals in the church today which have led many to cast doubt on their clergymen, it is imperative to consider having a separate and private process for trying such clergymen.

In the case of ***United States v. Ballard***[79] court noted that;

> *"judicial intervention into religious questions is similar to the doctrine of a political question, wherein it can be understood that just like it is expected that political branches are more opposite to decide the political question, religious bodies are suitable to decide questions about religion."*

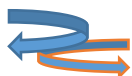
This can also be perceived as a fear by the state not to intervene into affairs of religion and also poses a critical question on state versus church superiority i.e. who is superior to another. It should be remembered that Uganda cannot be detached from religious affiliations. From the time of Kabaka Mutesa I when he was converted to Islam,

The court is basically ignorant of the historical beliefs and the reasoning behind it; hence they apply the judicial mind to check the veracity of faiths and beliefs because of which their interpretation is different from the beliefs of devotees. The court has to understand that they are ill-equipped to deal with religious beliefs and practices because of remoteness and lack of familiarity hence should only interfere when any practices seriously damage the constitutional fabric. This makes it the main reason for prohibiting courts from litigating religion because they lack the ability to address religious questions. There is 'limited jurisprudential competence' to decide such religious matters.

Therefore, courts generally have extracted the prohibition against litigating religion from the 'church autonomy doctrine' which requires judicial deference to religious institutions *"whenever the questions of discipline, or of faith, or ecclesiastical rule, custom, or law have been decided by... church judicatories."*

The distinction between church and state is still a question of debate up to today. the argument that is Uganda a secular or religious state still remains unconcluded. Constitutionally, we can argue that Uganda is secular state by the fact that we haven't yet zeroed down on a particular religion. But on another case, Uganda was colonized by Britain which is traditionally Anglican state and most of Uganda's presidents since independence have been majorly Anglican except ij the reign of H.E. Iddi Amin under which to a larger extent churches were subjugated. It was only in the time of H.E. Iddi Amin wherein Uganda was "almost" Islamized. Uganda has had a fight in terms of religious belonging. Going back a little, the first Arab traders entering Uganda Islamized the

[79] 322 U.S 78 (1944)



settlers including a one Kabaka Muteesa but with the coming of English Missionaries, a battles of belonging started first within natives as missionaries sought to convert the previously Islamized Ugandans. No wander, a few years later, this left some Ugandans dying within the religious battle as missionaries in Namugongo. After independence, with Kabaka Muteesa, H.E Obote; not forgetting H.E. Y.K. Museveni among others, all being Anglicans, then Amin's regime comes in, an Islamic. The constant battles in uganda about which religion is uganda is not a thing of today. The killing of Bishop Hannington is similary attributed to the same *Christo-Isamic* battles as believed by some historians.

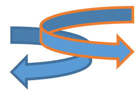
In the drafting of the 1995 constitution, the framers are mindful of this religious battles and no wander there is no particular religious designation awarded to Uganda but according to **article 29,** every person enjoys the right of freedom to practice their religion but history aside, the consideration of whether Uganda can adopt Ecclesiastical courts generates more difficulty in Uganda than in England where the country is predominantly affiliated to a particular religion.

Church courts had jurisdiction over all disputes concerning discipline or administration of the church, property claimed by the clergy or ecclesiastical corporate bodies, tithes and benefices, questions touching on oaths and vows, and heresy. A consistory court is a type of ecclesiastical court, especially within the Church of England where they were originally established pursuant to a charter of King William the Conqueror, and still exist today, although since about the middle of the 19th century consistory courts have lost much of their subject-matter. ecclesiastical court, tribunal **set up by religious authorities to deal with disputes among clerics or with spiritual matters involving** either clerics or laymen. The courts also claimed jurisdiction over clergy accused of most types of crimes. In England, Deployment of the full judicial power of the state in the prosecution of a crime that was primarily spiritual nature. It was a spiritual crime, crime of apostasy and heresy, and so merited punishment by ecclesiastical authorities.

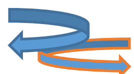
Ecclesiastical Law is the body of law derived from canon and civil law and administered by the ecclesiastical courts. Ecclesiastical law governs the doctrine of a specific church, usually, Anglican canon law.

These courts often tried cases such as Fornication, bigamy, adultery, bastardy, homosexuality, prostitution and incest were all within the province of the ecclesiastical courts. For many, being tried in a church court was preferable to being tried in any of the other courts, especially for murder, since the church courts could not order capital punishment.[80] Indeed these are nature of cases that would otherwise appear embarrassing to a religious minister in the face of the public and so require special handling in specialized courts. As of today, ecclesiastical courts are not functional as they used to be and this poses a serious questions on whether they can last in Uganda today. I opine that much as they are most important given the sate of affairs as I explained before, their actual operation is much affected by the multi-religious nature and the wide range of religious freedom in Uganda. Put simply, the lack of a uniform religion and culture prohibits the application of certain

[80] https://www.worldcat.org/title/practice-of-the-spiritual-or-ecclesiastical-courts-to-which-is-added-a-brief-discourse-of-the-structure-and-manner-of-forming-the-libel-or-declaration-the-third-edition-corrected-with-large-additions-by-hc/oclc/642435911 accessed on 31st December 2021



reforms in a view to solve professional misconduct by religious professionals secretly, sacredly and justifiably.



CHAPTER FIVE

MEDICAL LAW

5.0 MEDICAL LAW

BACKGROUND:

Medical law is the branch of law that covers the rights of medical practitioners and their patients. It is a certainty that at some point in their lives everyone will be forced to rely upon the medical profession. Even if the need to use doctors, dentists and hospitals is avoided throughout the majority of life, the activities of birth and death will inevitably involve recourse to medical treatment.[81] As the average life expectancy increases, people will have to endure the pains of old age for longer and will once more be faced with having to rely upon the medical profession.[82] The almost certain involvement of the medical profession in achieving good health[83] makes the laws governing the availability of treatment vitally important.

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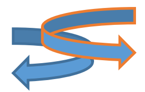
[81] Adam Peter Bunting- LLM (University of Birmingham)- Guiding Principles In Medical Law: The Ability To Treat- pg. 2

[82] S.A.M. McLean, *A Patient's Right to Know* (Aldershot: Dartmouth, 1989), p.3

[83] It has been argued that for many people the achieving of good health is one of the most important concerns in life, see WHO, *Promotion of the Rights of Patients in Europe* (London: Kluwer Law International, 1995)



The discipline of medical law[84] is a relatively new one necessitated by the advances in medical technology that have occurred in recent decades.[85] In essence the issues which arise in relation to medical treatment have not changed over those decades,[86] yet the scenarios in which these issues are encountered have altered considerably. The problem is that, whilst technology and science have advanced at a startling rate, the law has lagged behind and this creates a level of uncertainty which is far from desirable.[87] As cases are brought, the courts are constantly faced with new, and previously unconsidered, problems. As the involvement of Parliament in this area of law is minimal, and is likely to remain so,[88] it is left to the courts to find coherent solutions to these problems. This discussion is, at least partly, concerned with the manner in which the courts deal with these new problems as they arise and are brought to their attention.

Many of the issues that arise in medical law debates are based on morality. Mason, McCall Smith and Laurie state that these moral debates touch upon people's most intimate interests, namely sex and death.[89] The problem is that there is no common morality and that the search for such is like the search for the end of a rainbow.[90] It is not unusual to find that strong moral convictions lie at

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[84] To a certain extent it is misleading to talk about medical law as a legal discipline. Whilst it is now an accepted, and widespread, discipline of study it has certain characteristics which set it apart from other legal disciplines. Medical law is, in reality, an amalgamation of multiple areas of law. It borrows from both the public and civil law spheres, and elements of tort law, criminal law, public law and family law are evident.

[85] K. Paterson, 'Introduction' in K. Paterson (ed) *Law & Medicine* (Bundoora, Australia: La Trobe University Press, 1994), pp.1-2

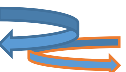
[86] J.K. Mason & R.A. McCall Smith, *Law and Medical Ethics* (London: Butterworths, 5th, 1999), p.vii

[87] J.D.J. Harvard, 'Legal Regulation of Medical Practice – Decisions of Life and Death: A Discussion Paper' (1982) J Roy Soc Med 351, p.354

[88] A. Kennedy & I. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000), p.6. There are a number of areas where Parliament has intervened. Amongst these are abortion, assisted suicide, assisted conception and the treatment of the mentally incompetent. In general though Parliament refuses to intervene, possibly due to the way such issues cross the boundaries of party politics and involve complex issues of public morality.

[89] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002), p.3

[90] J.K. Mason & R.A. McCall Smith, *Law and Medical Ethics*, p.vii



the heart of the arguments encountered in medical law and that it is unlikely that those holding such convictions will be willing to compromise.[91] These moral debates raise questions as to the definition of a person, the value of human life and the role of the law in determining the future biology of the species.[92] The law, and specifically the courts, are faced with the task of having to answer these questions and provide guidance in a world of increasing moral uncertainty. It is, however, not for the courts to concern themselves with issues purely of morality. Court decisions must be based upon law; even if moral issues are concerned they must be approached through the application of legal principles. It is highly probable that decisions made from a legal viewpoint will vastly differ from those of a moral basis.[93] It may be that the law adopts a more flexible approach to the problems in question, alternatively the law may take a more restrictive position. The law will define when it is acceptable to provide treatment and when it is not, yet there will always be an element of individual morality and choice to be exercised by the patient. An example of this is the law of abortion: whilst statute sets down what will be permitted, the individual can still decide whether or not they will ever approve of abortion. In essence the medical law places limits upon the freedom of doctors to treat their patients and recognizes the freedom of a patient to receive treatment.

The right to health in Uganda.

Uganda has had a turbulent constitutional history deeply rooted in militarized politics. In the precolonial era, the country was organized and governed along tribal kingdoms headed by cultural leaders such as the Kabaka of Buganda and Omukama of Toro and Chiefs in the north and east. In 1894, Uganda became a British Protectorate and the kingdoms signed power agreements with the British (Examples include the 1900 Buganda Agreement and Toro Agreement; the Ankole Agreement, 1903; the Bunyoro Agreement, 1933; The British legislated by way of Orders in

[91] B. Markesinis, S. Deakin & A. Johnston, *Markesinis & Deakin's Tort Law*, pp.267-268
[92] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.3
[93] B. Markesinis, S. Deakin & A. Johnston, *Markesinis & Deakin's Tort Law*, p.268

Council, 1902 and 1920). In 1902, the British passed the Uganda Order in Council which set up a centralised system of governance, which included a legislature, judiciary and executive to govern the whole country (Mukholi, 1995)

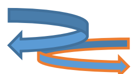
In 1962, Uganda became independent with a new Constitution that entrenched federalism. In 1966, the Prime Minister Milton Obote abrogated the Independence Constitution, declared himself President under an Interim Pigeon Hole Constitution, and mandated Parliament to draft a new constitution. In 1967, the Republic Constitution was introduced, abolishing kingdoms by restoring centralized governance (Constitutionnet, undated). In 1971, General Idi Amin seized power and ruled by constitutional decrees until 1979 when he was ousted by a coup d'état. In 1985, Milton Obote was re-elected president, but was expelled in 1986 by the National Resistance Movement which enacted Statute 5 of 1988 and embarked on a constitutional reform by an elected Constituent Assembly (Constitutionnet, undated). All of these constitutions did not include the right to health.

In 1995, the current constitution was promulgated. It made unseen efforts to recognize human rights and freedoms in Uganda. However, like its predecessors, it ignored several social economic rights such as the right to health, and tucked it in the national objectives and directive principles of state policy which guide policy development and implementation. However, it did not define the standards of enjoying the rights which are justiciable (Uganda Constitutional Court, 2012). Substantive provisions, such as Chapter Four, introduced a bill of inherent rights not granted by the State (Republic of Uganda, 1995a). They specifically guarantee the right to life, to a clean and healthy environment as well as freedom from discrimination and torture, but not the right to health. In 2005, the Constitution Amendment Act was passed and introduced several changes, including Article 8A, on national interest, which bolstered the justiciability of the national objectives and directive principles, and Article 32(2), which reinforced affirmative action for women.

The public health Care in Uganda and Kenya Compared.

In Kenya:

The Public Health Act of Kenya requires: every person suffering from venereal diseases is to seek medical treatment from medical practitioner this is provided for under ***Section 43 of the Kenyan Public health Act.*** Furthermore, parent or guardian are required to seek treatment for child believed to be suffering from venereal disease ***under Section 46 of the Act***. The Act also makes it an offence to fail to have the child treated under ***Section 46 (2)*** and persons suffering from communicable venereal diseases should not work in employment entailing care of children or handling food intended for consumption under ***Section 47***.



All medical officers with knowledge of a person suffering from a communicable venereal disease must give such person notice to attend medical treatment ***Section 48***. It is an offence for anyone with venereal disease to willfully or negligently infect another (***Section 49).*** Examination of female patients should be done by female medical practitioner this is provided for ***under Section 52***. Advertising or sale of medicines, appliances or articles to alleviate or cure venereal disease, disease affecting generative organs or sexual impotence is prohibited under the ***public health Act of Kenya and it is seen under Section 55.***

In Uganda;

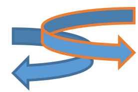
Under Public Health Act, it is an offence for anyone: who while suffering from any venereal disease in a communicable form, accepts or continues in employment either as an employee or on their own account in or about any factory, shop, hotel, restaurant, house, or any place in any capacity entailing the care of children, or the hand ling of food intended for consumption, or food utensils for use by any other person this is seen under ***Section 50(1)***.

Furthermore, the acts provides that, to employ or continue to employ any person suffering from any venereal disease in a communicable form and it is well stated ***Section 50(2))*** this is also seen in the ***Kenyan Public Health Act under Section 47.***

The Ugandan ***Public Health Act,*** gives an opportunity to any person, to publish, exhibit or circulate any advertisement or statement intended to promote sale of any medicine appliance or article to alleviate or cure any venereal disease or disease affecting the generative organs or functions, or sexual impotence, or any complaint or infirmity arising from or relating to sexual intercourse this is seen and provided for ***under Section 51*** of the Public Health Act of Uganda this also was provided for under the Kenyan public health Act as seen above.

The act provides also that no person should for reward either directly or indirectly, unless he or she is a duly registered or licensed medical practitioner, treat any person for venereal disease or suspected venereal disease or prescribe any remedy for venereal disease, or give any advice in connection with the treatment of it, whether the advice is given to the person to be treated or to any other person as provided under ***Section 52***.

Furthermore, other laws that are provided for in the field of addressing public health in relation to sexual and reproduction health which include;



The Children Act of 2001of Kenya provides that children should be protected from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity, and exposure to obscene materials this is providing for ***under Section 15.***

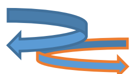
The Employment Act of Kenya 2006 prohibits sexual harassment in employment and this is provided for ***under Section 6***.

The ***Sexual Offences Act 3 of 2006*** **also** makes provision for sexual offences, their definition, prevention and the protection of all persons from harm from unlawful sexual acts in its Preamble. It is also an offence for any person to rape under ***Section 3 of the Sexual offences Act of Kenya*** and to defile a child under ***Section 8 of the Act***; or sexually harassed ***under Section 23***; and for any person with actual knowledge that s/he infected with HIV or any other life threatening sexually transmitted disease intentionally, knowingly and willfully infects another person unde***r Section 26 of the same act***.

In Uganda, the other Ugandan laws include;

The Penal Code (Amendment) Act, 2007 makes it an offence to defile a girl below the age of 18 years under ***section 129*** and requires that offences of child sex be handled by the Children Act under ***Section 129(a))***. It is an offence for anyone to have unlawful carnal knowledge of a woman or girl, without her consent, or with her consent, if consent is obtained by force, by means of threats or intimidation of any kind or by fear of bodily harm, or by means of false representations as to the nature of the act, or in the case of a married woman, by impersonating her husband unde***r Section 123 of the Act***. The act also makes it an offence to: attempt to commit rape under ***Section 12*** ; and indecently assault any woman or girl under this act is an offence under the Uganda laws this is provided for under ***Section128*** of the penal code Act ; or commit aggravated defilement where: a person against whom the offence in committed is below the age of 14 years; the offender is infected with HIV; the offender is a parent or guardian; the victim of the offence is a person with disability; and the offender is a serial offender.

The Act makes it an offence for any person who, knowing a woman or girl to be an idiot or imbecile, has or attempts to have unlawful carnal knowledge of her under circumstances not amounting to rape under **Section 130.** It is also an offence to, by threat or intimidation, procure or



attempt to procure any woman or girl to have any unlawful carnal connection under **Section 132** of the penal code Act.

It is also an offence for an owner, occupier of premises, or who acts or assists in managing or control of premises, to induce or knowingly suffer any girl under the age of 18 years to resort to or be upon such premises for the purpose of being unlawfully and carnally known by any man, whether such carnal knowledge is intended to be with any particular man or generally under ***Section 133***.

No person may: unlawfully detain another person for the purpose of sexual intercourse under **Section 134 of the penal code Act**; knowingly live wholly or in part on the earnings of prostitution (Section 136); practice or engage in prostitution unde**r Section 139**; conspire to induce any woman or girl, by means of any false pretence or other fraudulent means, to permit any man to have unlawful carnal knowledge of her under **Section 140 of the Act.**

No person may with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administer to her or cause her to take any poison or other noxious thing, or use any force of any kind, or use any other means under **Section 141** for a woman to procure a miscarriage unde**r Section 142**.

The Act creates unnatural offences for persons who: have or attempt to have carnal knowledge of any person against the order of nature, of an animal, or permits a male person to have carnal knowledge of him or her against the order of nature under **Sections 145, 146)**; unlawfully and indecently assault a boy under the age of 18 under **Section 147**; willfully and by fraud cause any woman not lawfully married to him to believe that she is lawfully married to him and to cohabit or have sexual intercourse with him in that belief under **Section 152**.

The 1995 Constitution.

The Constitution of the Republic of Uganda is the supreme law of the land and any law, culture or custom contrary to it is void to the extent of its inconsistency as cited in **Article 2 of the Constitution (Republic of Uganda, 1995a)**. The Constitution takes precedence over all laws and all health laws must thus adhere to its provisions or else it may be nullified. For the first time in Uganda's history, the **1995 Constitution** ushered in a bill of rights which guarantees Ugandans their inherent entitlements. However, it does not expressly stipulate the right to health. Instead, the constitution has a number of health-related provisions, which are discussed in the following section. Since **2005, Article 8A** requires the state to be guided by national objectives and directives

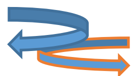
of state policy in applying or interpreting the constitution. Previously, the Ugandan courts held that national objectives were not justiciable, but scholars argue that Article 8A now renders them legally binding and enforceable. (Uganda Constitutional Court, 1999; Mbaziira, 2008).

In order to assess the success of the legislative and institutional frameworks that ensure right conduct and access to medical health, it is crucial to ascertain the **justiciability of the right to health in Uganda** which is the starting point in analyzing any health issue.

The 1995 Constitution does not expressly provide for the right to health, however, the ***National Objectives and Directive Principles of State Policy (NODPSP)***[94] acknowledge the right, although it is still uncertain whether the principles are justiciable. *Egonda Ntende J* in ***Tinyefuza v Attorney General,***[95] held that NODPSP are important aids in interpreting the Constitution, however, he did not expressly state whether they are binding. Discordant views were expressed in ***Zachary Olum & Another v Attorney General,*** where the court agreed that NODPSP are part of the Constitution, however, the learned justices were quick to add that they are not justiciable. It is therefore uncertain whether the NODPSP are justiciable. However, with the introduction of ***Article 8A (1)*** in the 2005 constitutional amendment which provides that Uganda shall be governed based on principles of national interest, it can be argued that the NODPSP are now justiciable.[96] However, some commentators such as Twinomugisha,[97] have argued that this provision is not absolute because clause 2 requires Parliament to 'make laws for purposes of giving full effect to clause (1) of this Article.'[98] Unfortunately, Parliament has not yet invoked this clause.

Although there is not specific law that provides for the right to health, this does not mean that there is no remedy in law for an aggrieved party and for purposes of this particular book, a patient who has suffered the misconduct of a professional. In such cases, courts have gone ahead to rely on civil and political rights to advance the broader right to health in numerous cases, an example of such a case is ***CEHURD and 2 Ors v The Executive Directive Mulago Referral Hospital and the Attorney***,[99] where *Justice Lydia Mugambe* held that denying the parents of the child the

[94] Objective XX (on medical services)
[95] Constitutional Petition 1/1999.
[96] C Mbazira 'Public interest litigation and judicial activism in Uganda: Improving the enforcement of economic, social and cultural rights' HURIPEC Working Paper (2008)
[97] Ben Kiromba Twinomugisha, 'Fundamentals of Health Law in Uganda,' at p.29.
[98] Art 8A(2)
[99] (CIVIL SUIT NO. 212 of 2013) [2017] UGHCCD 10



opportunity to bury their baby, was a violation of their right to health in contravention of objectives XX and XIV (b) of the Constitution, in addition to Article 12 and Article 16 of the ISECR and the African Charter respectively which guarantee the right to health. This judgement is important because it demonstrates judicial activism where judges have relied on civil and political rights which are well defined in the Constitution to protect the right to health. Specifically, the court observed that the hospital's actions amounted to psychological torture which violated Articles 24 and 44 of the Constitution.

David Mugerwa v. Attorney General and Ors**,** the Court explicitly held that the right of the deceased mother to basic medical care was violated by the district hospital due to its failure to provide emergency obstetric care (Uganda High Court, 2012). This requirement for appropriate maternal health care delivery is based on several provisions: **Objective XIV on** social and economic objectives, **Objective XV** which recognizes the role of women in society, **Objective XX** on the state's duty to ensure the provision of basic medical services to the population, **Objective XXI** which provides for clean and safe water at all levels and **Objective XXII** which provides for food security and proper nutrition.

It is arguable whether the **National Objectives and Directive Principles of State Policy** (**NODPSP**) in the Constitution are justiciable since they do not appear in the main body of the Constitution, especially the Bill of Rights. The Constitution simply provides that the NODPSP shall guide all organs and agencies of the State, all citizens, organizations and other bodies and persons in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions for the establishment of a just, free and democratic society.[100] Thus in ***Zachary Olum & Anor v. Attorney General***[101] the court observed that although the National Objective and Directives Principles of State Policy form an important part of the Constitution and are crucial canons in the interpretation of the Constitution, they are not justifiable.

Article 8A[102] requires the state to be guided by **National Objectives and Directives of State Policy** in applying or interpreting the Constitution. Previously, the Ugandan courts held that national objectives were not justifiable, but scholars argue that **Article 8A** now renders them legally binding and enforceable.[103]Accordingly, judicial views have evolved to recognize that government has a negative obligation to respect the rights and embrace cases to determine whether state affirmative duties are fulfilled to allow for the realization of rights.

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[100] NODPSP
[101] Constitutional Petition 6/1999
[102] 1995 Constitution of the Republic of Uganda
[103] Uganda Constitutional Court, 1999; Mbazira, 2008

For instance in the landmark case of ***David Mugerwa v. A.G & Others*,**[104] the Court explicitly held that the right of the deceased mother to basic medical care was violated by the district hospital due to its failure to provide emergency obstetric care (Uganda High Court, 2012). This requirement for appropriate maternal health care delivery is based on several provisions to include among others; **Objective XIV on Social and Economic Objectives, Objective XV** which recognizes the role of women in society.

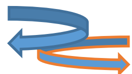
Statutory Legislations.

Uganda has a collection of laws which complement the constitution or fill in some of its gaps. **Article 79 of the Ugandan Constitution** mandates Parliament to make laws for the peace, order, development and good governance of Uganda. This provision establishes Parliament as the primary legislator. For each act proposed by Parliament to have the force of law, it must be approved by the President and must conform to the Constitution. A series of acts are dedicated to the protection, fulfilment and respect of the right to health. For instance, **the Food and Drugs Act, Cap 278** focuses on preventing food and drug alterations that are unsafe for human consumption and the **Water Act, Cap 152** governs the use, protection and management of water resources. Another category of acts focuses on the state implementation of Parliament's constitutional duties by establishing public agencies responsible for providing health services. Some examples include the **National Medical Stores Act, Cap 207** which established the country's hub for efficient and economical procurement of quality medical supplies for public health services. There is also the **National Drug Policy and Authority Act, Cap 206,** which set up an authority to ensure the availability of efficacious and cost effective drugs, and the National Environment Act, Cap 153, which oversees the management of a clean and healthy environment in line with Article 39 of the Constitution.

Health workers have laws that govern them in their different categories. **The Uganda Medical and Dental Practitioners Council (UMDPC)** regulates the conduct of all medical and dental practitioners in Uganda guided by the **Medical and Dental Practitioners Act, Cap 272**. The Council has a code of ethics which spells out the obligations that health workers have in the protection of human rights. The **Uganda Nurses and Midwives Council (UNMC**) similarly is regulated by the Nurses and Midwives Act, Cap 274 which requires nurses and midwives to protect human rights. The professionals have ethical codes set out standards through which human rights can be protected. The Code of Ethics for medical and dental practitioners for example under Rule 4 requires medical and dental practitioners to respect and protect human rights but phrases their respective obligations as ethical responsibilities (Republic of Uganda, 1996; 1998).

Health workers in the public sector are collectively regulated by the **Health Service Commission which was created under the Health Service Commission Act of 2001 (Republic of Uganda**,

[104] Constitutional Petition No. 6 of 2005



2001). The act recognizes the duty of health workers in relation to rights of patients by phrasing them as responsibilities. The Act recognizes the duty of health workers to act in the best interest of patients at all times, to ensure informed consent, respect the privacy and confidentiality of a patient, avoid conduct detrimental to the community and abide by all laws and regulations governing their professions.

The *Public Health Act of 1935* (amended in 2000) is very old and is not anchored on human rights principles. It focuses primarily on the control of sexually transmitted infections and the nature of sexual offenses against vulnerable groups (Republic of Uganda, 1935). The sexual offences bill has been in place for the last two years but has faced resistance by many law makers

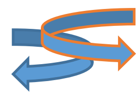
The HIV and AIDS Prevention and Control Act of 2014 is reported to have commendable provisions and presents an opportunity for intensifying response to a global health security crisis (Republic of Uganda, 2014). The act advances pre-test and post HIV counselling; voluntary HIV testing; state responsibility in HIV control; Legislation against discrimination in access to employment and other social opportunities on the grounds of HIV status, and creation of the AIDS Trust Fund. After the law was passed, a number of civil society organizations arose to contest certain clauses of the law, including mandatory testing of pregnant women and their partners, and disclosure of HIV status of a client by health workers to people who according to the health worker are at risk of being infected by this client.

This contest led to a **constitutional petition No. 24/ 2016** challenging discriminatory HIV Criminalization Legislation (**UGANET, 2016**).

The international laws expressly guarantee the right to health. They elaborate its prerequisites, components and the standard to which it should be enjoyed. They further impose obligations on various stakeholders such as the state, individuals, civil society and international community to promote and implement the right. Furthermore, they buttress the right to health by providing for other supportive rights and freedoms such as life, equality, dignity and access to information, thereby creating an increasingly enabling environment for implementation.

Regionally, the text of **the East African laws** does not categorically mention the right to health. However, their various provisions commit the state to ensuring more efficient delivery and management of health services using different legal, institution, policy and administrative mechanisms. In reality, this is gradually translating itself into policy implementation, but there is a great need to intensify the benchmarking of laws and best practices towards harmonizing the right to health in the region.

For example, a clear gap is that Kenya's constitution mentions the right to health, whereas Uganda's is still silent in this respect, yet both states actively participate in the EAC health programs. Locally, the current Constitution of Uganda is criticized for its silence on the right to health. However, it has provisions which affirm the existence and enforceability of the right despite the imprecision of the text. In addition, Uganda is a signatory to multiple international and regional



laws which expressly stipulate the right, among other health related rights, and demarcates clear obligations of the state parties. Thus Uganda has a sufficient legislative regime within a diversified human rights framework to recognize and implement the right to health, to the standard set as well as to hold the state accountable for its duties.

Fortunately each convention clearly stipulates the mechanisms of implementation by the state and accountability through filing periodic reports. The opportunity here is for individual citizens, and the international community to consistently monitor the government's compliance with the implementation and reporting frameworks so that the law translates into actual health. Further, based on the regional frameworks, there are institutions charged with interpreting and enforcing the right to health.

The task remains for citizens as rights holders to make use of the commissions and committees to ensure that they compel government to deliver on its expectations. The institutions have demonstrated openness to engage and take decisive positions on the right to health and their decisions are binding. The likely challenge here remains the cost of litigating in the regional and international forums, as well as Uganda evasively asserting that it is a sovereign state not bound by international orders.

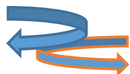
Nationally, there is a limitation that the constitution is not explicit in guaranteeing the right to health. However, it extensively provides for health related rights which are justiciable and are direct basis for implementing the right to health. Moreover, the constitution recognized that some rights may not be manifest in the text but they are still existent and enforceable. The constitution also establishes obligations for both the state and the citizens, individually and collectively.

First, it categorically obliges government as a whole to promote, protect and uphold the rights. Secondly, it details the duties of each arm of government in rights enforcement. Thirdly, it also tasks the citizens individually and under civil society organizations to observe human rights and report violations when threatened or actually violated. Further, the Constitution establishes enforcement avenues through institutions such as the Courts, the Uganda Human Rights Commission, policies, programs and legislative powers of parliament.

However, since the Constitution is the supreme law, it does not detail the implementation mechanisms or how to hold the duty bearers and rights holders accountable. However, very few cases have been reported at the international and regional level from Uganda in respect of the right to health, and more so maternal health care.

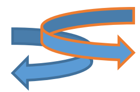
Conclusion.

In summary, Uganda has sufficient laws to recognize and implement the constitutional right to health, although gaps remain. It thus appears that Ugandans need to be more pragmatic to harness the international and regional laws and institutions to promote and enforce the right to health at home. In addition, more vigilance is needed to hold government and other stakeholders



accountable in reporting and delivering quality health care services in Uganda. There is a need to further tap international cooperation to better aid the realization of the right to health in Uganda. These measures for implementation are further explored in the next section.

The laws across the countries focus primarily on the control of sexually transmitted infections (through relatively old legal provisions on notification, treatment and control) and on the nature of sexual offences against vulnerable groups (through more recent laws linked to HIV). While these laws provide some level of public health intervention, vulnerable groups such women and children do not know or exercise their rights, fear to report sexual abuse cases, face taboos and norms about sexuality and reproduction that undermine their reproductive health, with child marriage, female genital mutilation and early sexual initiation still being practiced notwithstanding their prohibition under the law. There are still weak mechanisms for investigating and prosecution of sexual abuse cases, particularly through ‘victim friendly legal and court processes’.



CONSENT TO TREATMENT

5.1 CONSENT TO TREATMENT

Consenting to treatment does not arise as a mere privilege allowed by the medical practitioner but it is a right recognized under common law. I will first of all discuss the nature of rights and proceed to the exercise of this right of consent

RIGHTS:

Heavily linked to the moral debates central to many of the issues relevant to the availability of treatment are rights based arguments. The link between morality and rights is shown by Feldman when he states that a commitment to any right must be based upon a belief about the range of aspirations which it is proper or desirable for people to pursue.[105] In modern society the patient is more aware than ever before of the rights that they have and they are thus more likely to invoke rights based arguments.[106] Whilst the courts do not always give judgments in terms of rights, essentially it is rights that are being dealt with.[107] An example of this is *Re T (A Minor) (Wardship: Medical Treatment)*.[108] Whilst the judgment was phrased in terms of the child's interests and the practicalities of post-operative care, it could just as easily be seen as looking at the child's right to treatment when conflicting with the parent's right to determine what treatment the child should receive. Hence the importance of rights to this discussion cannot be denied and any attempt to look at medical law without looking at the rights involved would be fundamentally flawed. For one to obtain a remedy in law, they must first of all possess a right as the Latin maxim goes that; "*Ubi jus ibi remedium.*" A right is a legal entitlement, a benefit/ privilege recognized by law. It is an entitlement to something, whether to concepts like justice and due process or to ownership of property or some interest in property, real or personal[109]. For example, a person has a right to institute and withdraw a case and a right to legal representation which includes a state afforded

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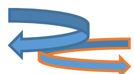
[105] D. Feldman, *Civil Liberties and Human Rights in England and Wales* (Oxford: Oxford University Press, 2nd, 2002), p.6

[106] S.A.M. McLean, *A Patient's Right to Know*, p.4

[107] ibid, p.84

[108] [1997] 1 All ER 906

[109] https://dictionary.law.com accessed on 24th Dec, 2021



lawyer in criminal capital offences as visible in ***Kwoyelo v. Uganda Communication***[110] where a party was availed with a legal representation at state expense but he declined the offer/right.

Whilst a person need not be autonomous in order to have rights worthy of protection by the law[111] it is certainly true to say, at least in relation to medical law, that the rights we have are intended to protect the dignity and autonomy of ;human beings. Yet autonomy and dignity are not clearly defined terms and can contradict each other.[112] Whilst dignity can exist on a number of levels,[113] different authors use autonomy to refer to different things.[114] The same is true of the notion of rights itself which Feldman divides into five categories: Liberty, Liberties, Civil Liberties, Fundamental Liberties and Human Rights.[115] This classification set is only one of many suggested ways of grouping the interests covered in relation to rights.

Halpin states:

"*One can find 'right' being used to signify some position of benefit or advantage that has been determined as applying to a particular individual, but one can also find it employed to signify a claim to such a position that has yet to be determined, and even to signify a claim for such a position that has failed to be established.*"[116]

Patients need to be made aware that they have a right to consent to any sensitive treatment before it can be effected upon them. This requirement is broadly discussed in this book.

THE REQUIREMENT OF CONSENT

The fundamental position in English law is that treatment of a competent adult will be unlawful unless the patient consents to it.[117] The need for consent is the legal expression of the principles of self-determination and autonomy.[118] Due to the centrality of consent to the ability to provide

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[110] 431/12 [2018] ACHPR 129

[111] M. Minow, *Interpreting Rights* (1987) 96 Yale Law Journal 1860, p.1885

[112] This would be the case where a dignified death relied upon the use of pain control methods which the patient was opposed to. In such instances autonomy will probably be seen, by society at least, as more important than dignity.

[113] D. Feldman, *Civil Liberties and Human Rights in England and Wales*, p.125. The suggested levels are; the dignity of the species as a whole, the dignity of groups within the species, and the dignity of individuals.

[114] G. Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), p.5. Whilst some authors see it as the ability to decide for-oneself without any constraints, others, including Dworkin, accept that this is unrealistic and argue that what is needed is freedom to rule oneself according to moral and social rules.

[115] D. Feldman, *Civil Liberties and Human Rights in England and Wales*, pp.3-5

[116] A. Halpin, *Rights & Law Analysis & Theory* (Oxford: Hart Publishing, 1997), p.3

[117] Re T (Adult: Refusal of Treatment) [1992] 4 All ER 649

[118] D. Feldman, 'Human Dignity and Legal Values – Part II' (2000) 116 LQR 61, p.67

treatment, and its impact upon all areas of the law to be considered, it is important to be able to understand it from the outset. Without such understanding it would not be possible to fully comprehend the approach taken by the courts when confronted with new scenarios and problems.[119] It is also important due to the way consent is essential to the protection of the patient's rights.

Any treatment imposed without the consent of the patient will constitute the tort of battery.[120] It is exceedingly rare that, in the case of a competent adult patient, treatment will be allowed to proceed without their consent. One scenario where treatment without consent will be possible is that of a patient with a highly contagious and dangerous disease who refuses to be quarantined or treated.[121] In such a situation treatment would be allowed to proceed for the benefit of both the patient and society in general. More typically such paternalistic arguments are rightly rejected by the courts and the autonomy of the patient remains paramount.

Consent on its own may not be enough in certain circumstances but what may suffice would be **informed consent.** Informed consent is a principle that a patient should have sufficient information before making their own free decisions about their medical treatment. this requires a medical officer to educate the patient about the risks, benefits and alternatives of a given procedure of intervention. Informed consent is not only and ethical but also a legal obligation of medical practitioners in Uganda as simultaneously governed by the Patients' charter. To satisfy informed consent specifically, an assessment of the Patient's understanding, rendering an actual recommendation and documentation of the process needs to be done.

Consenting capacity.

Consent must be obtained without duress or undue influence. According to **article 10(b) of the Patient's Charter**, consent in a medical emergency, consent shall be given as soon as afterwards. For adults they are presumed to have capacity to consent or refuse a treatment. In **Re T**[122] Capacity was defined as competency to make a decision with respect to medical health.

For Children in Uganda, consent can be made by the parent or next friend. The constitution gives a right to children to be cared for in their best interests by their parents or those entitled to bring them up. **Section 5(1) of the Childrens Act** gives children a right to medical attention. According

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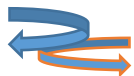
[119] M. Davis, *Textbook on Medical Law*, (London: Butterworths, 2nd, 1998), p.126

[120] It has been suggested that informed consent is a prerequisite for the adequate respect of the legal requirement of consent, see S.A.M. McLean & G. Maher, *Medicine, Morals & The Law* (Aldershot: Gower, 1983), p.80. The suggestion is that, in order for consent to be real, the patient must be given information so that the decision can be made on a more adequate basis. Whilst English law has accepted that there is a duty of disclosure, it has rejected the notion that it is essential to the validity of consent. This is clearly shown by the way that treatment without consent will give rise to an action for trespass whereas failure to give information will give rise to an action for negligence and the patient will have to show that, had the information been given, they would not have consented.

[121] Public Health (Control of Diseases) Act 1984

[122] Re T (1992) 4 ALL ER 649



to **section 7 of the Children's Act,** the children are entitled to protection from social or customary practices that are harmful to their health.

In relation to English law, the law gives a separate treatment to children under 16 years as different from adults. whilst it is not assumed that they are competent, they may be seen as such. This is known as *Gillick* competence and was first established in ***Gillick v. West Norfolk and Wisbech Area Health Authority*.**[123] In order to be competent, the child must not only understand the nature of the treatment proposed but also the consequences and side-effects and any possible consequences of refusal.[124] If the child possesses sufficient competency to understand these issues then they can consent to treatment. For the *Gillick* competent child, however, there is no ability to refuse to give consent to treatment.[125] The Court of Appeal has referred to consent as a flak jacket designed to protect the doctor from litigation; whilst the child may provide such protection, the parent or court may do the same and the child cannot prevent it.[126]

Important to note is that a child is defined by the Convention on the Rights of the Child as every human being below the age of 18 years.[127] **Article 34 of the Constitution** provides that a child shall not be deprived of medical treatment or education or any other right due to the cultural beliefs. Thus parents are not supposed to deny consent basing on religious, or cultural or moral beliefs. This was also upheld in the case of **Re R (a minor) (blood transfusion)**[128] where a nine year girl that was suffering from B-cell leukemia and needed a blood transfusion but the parents were staunch Jehovah witness followers and refused to consent. Court guided by the principle of child's welfare and best child interest overrode the parent's wishes and directed that the transfusion takes place.

Treatment without consent is punishable. In ***Njareketa V The Director Of Medical Services and Another***[129], the appellant had a malignant growth in his leg. The surgeon found it necessary to amputate his leg. The patient consented, subsequently retracted and later expressly refused. However the surgeon insisted on the operation hence the suit. Court awarded nominal damages because the aim of the operation was to the patient's benefit.

In ***Medical and Dental Practitioners Disciplinary Tribunal v. Okwonkwo***[130] the adult was treated despite his refusal to consent. Court held that treatment without consent can give rise to an action in trespass.

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[123] [1986] AC 112

[124] *Re R (A Minor)(Wardship: Medical Treatment)* [1991] 4 All ER 177

[125] ibid

[126] *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097

[127] Article 1 of the Convention on the Rights of the Child.

[128] Re R (a minor) (blood transfusion) 1993.

[129] Njareketa V The Director Of Medical Services and Another {1950} 17 EACA 60

[130] Medical and Dental Practitioners Disciplinary Tribunal v. Okwonkwo (2002)AHRLR 159

Information to be material.

The information given to the patient for the purposes of the latter consenting upon them should be such that is relevant and understandable to the patient, the kind that discloses the risk likely to result from the treatment and not any other useless one. Take for instance, for a patient about to undergo a critical operation due to appendicitis, it is immaterial for the doctor to inform them only about the doctor's skill and expertise in handling similar cases, rather he/she should tell them about the process and the implications of harm likely to occur from the operation. In the *Freda Kasaira case,* it was found that there was no indication anywhere on the form as to any information given to the patient relating to the nature and range of the more or any significant risks involved in the suggested surgical procedure for which her consent was being sought. The information on this form does not meet the requirement of proof that the deceased gave her informed consent to the surgical procedure.

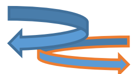
It should be remembered that consent *per se* is different from "informed consent." Whereas consent is his like saying "yes" to something, informed consent means more than the word yes. A clear explanation of this was given in the *Kasaira case* thus;

If a patient is to undergo a surgical procedure it is necessary for such patient to receive information from the medical team about the benefits and the risks of the procedure prior to the procedure being carried out. After having heard the possible risks and benefits, if the patient deems that they wish to go ahead with the surgical procedure they must sign a consent form, outlining the nature and range of the more or all significant risks involved in the suggested surgical procedure of which they have been fully advised, whereby their signature would then signify that they have understood and accepted the potential risks "inherent" in the procedure. This is what informed consent requires. Failure to fully brief a patient about the possible ill effects of the procedure prior to the surgery and thereby depriving the patient of the ability to give his or her full informed consent, could of its own be a basis for a claim of medical negligence.

In **NB V Slovakia[131],** the woman was sterilized without giving the medical practitioners informed consent and this affected her reproductive system. It was held that sterilization amounted to violation of woman's reproductive system and that the state had failed in its duty of ensuring legislations recognizing consent.

A patient's consent should not wrongfully excuse the doctor from liability where negligence is provable i.e. because the patient has consented, should not allow the doctor to act negligently. The standard set in ***Maynard v. West Midlands Regional Health Authority[132]****,* requires that even though the patient's informed consent dictates that the patient is aware that certain complications can occur, it does not mean that this covers negligent techniques or mistakes that occur during the surgery, that are not inherent in the procedure itself. The conduct of medical professionals must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of

[131] NB V Slovakia (application 29518 of 2010)
[132] [1985] 1 WLR 685, [1985] 1 All ER 635)



the alleged act of negligence. The conduct of the procedure must reflect the current state of knowledge as to the risks involved in the use of that procedure. However, the standard to be observed by medical practitioners is not to be determined solely or even primarily by medical practice. Rather, it is for the courts to judge what standard should be expected from the medical profession.

The factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill.

In awarding a remedy by way of damages in cases where dependents are involved, the court is guided by the principle applied in ***Jane Gaffa v. Francis X.S. Hatega***[133]***,*** that in apportioning the damages, court should award the younger children relatively larger portions in recognition of the fact that their dependency, upon the deceased, would have lasted longer than that of older children.

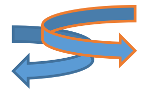
Giving Treatment Without Consent:

The obligation to provide health care extends beyond merely administering treatment but to also providing adequate and accurate information about the treatment of a patient.

Common law imposes a duty on a medical practitioner to warn a patient of material risks inherent in the proposed surgical procedure; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This standard does not deal with the foreseeability of the risk in question, save to the extent that the risk must be "inherent" in the procedure. In this respect the general law of negligence still applies. Once there is a risk which is generally known to the profession, there is a duty to warn.

In the case of ***CEHURD & 2 Others v Attorney General and Executive Director of Mulago Hospital***[134] a mother gave birth to twins but was given only one baby after delivery with allegations that the second baby was dead. After rejecting the allegations, she was given the dead body of another baby which DNA tests found were not compatible with her for parentage. The High Court held that failure of Mulago Hospital to inform a mother about the whereabouts of her new-born baby was cruel, degrading and inhuman as it violated her right to access her child's information. The court also directed the Hospital to strengthen measures for protection of new-born babies and also account for the whereabouts of the second baby who was missing. Lady Justice Mugambe granted structural interdicts against the hospital, inter alia, to report back to the plaintiff on steps taken to reduce baby theft at the hospital. This was only the second time in the jurisprudence of

[133] H. C. Civil Suit No. 1150 of 1975
[134] (HCCS No.212 of 2013)



Uganda that structural interdicts were granted and the first in the area of the right to health. The decision is celebrated globally and culminated in awarding of the Lady Justice with the Women's Link **International**

Article 10 of the Patients Charter[135] gives a right to patients to be adequately and accurately informed about the nature of one's illness, diagnostic procedures and proposed treatment so that the patient makes consent to the treatment. This was recognized in the case of **Sidaway V Bethlem RHG.**[136]

The information is always given to the patient at the earliest stages before the real treatment. However, the clinician can hold such information if it is believed that release of such information will cause harm to the patient.

According to ***Article 10(b) of the Patients Charter***, consent might be oral, verbal or in writing or implied from conduct.

Consent provides a legal justification of care to avoid allegations of committing a tort of trespass on a person's body which might be battery or assault. Consent also provides clinical function by promoting a patient's trust and co-operation. In ***Freda Kasaira & Ors v. The Registered Trustees of Nebbi Catholic Diocese***[137] It was stated that *The purpose of a consent form means the doctor has explained the procedure, how it will be done, possible complications, and the patient has understood. Only adults sign such a form. It is routine as a matter of procedure*. This was a case concerning a patient, benefactor of the plaintiffs who was diagnosed with appendicitis and an operation was done wrongly leading to the death of the deceased.

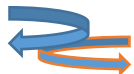
Most medical procedures, treatments or tests involve some risk. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo such. It is the medical professionals' responsibility to give the patient information about a particular treatment or procedure so that the patient can decide whether to undergo the treatment, procedure, or test. Risks that are statistically likely enough to make disclosure worthwhile should be disclosed. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. One of the factors relevant to, but not decisive of, the question of what a reasonable medical practitioner ought to have foreseen is the state of medical knowledge at the time when the duty should have been performed. In the ***Kasaira Case***, it was also held that *a reasonable medical practitioner cannot be expected to have foreseen an event wholly un-comprehended by medical knowledge at the time. The law demands no more than what was reasonable in all the circumstances of the case.*

Court administered a similar test upon the defendant's doctors as that in *Donoghue v. Stevenson* stating that; '*it is not enough to show that another expert would have given a different answer . .*

[135] Patients Charter 2009

[136] Sidaway V Bethlem RHG (1985) 1 ALLER 643

[137] HCCS No. 0020 of 2016



the issue is... whether [the defendant] has acted in accordance with practices which are regarded as acceptable by a respectable body of opinion in his profession' and 'How do you test whether this act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man in the street. He is the ordinary man... But where you get a situation which involves some special skill or competence, then the test of whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.

Thence it is notable that different standards apply to different individuals, professions, etc,,, and even within a profession, the standard will vary according to expertise and one's experience. This is not only legal but also Biblical that *those to whom a lot is given, a lot will be expected of them.*

It is a fundamental requirement that a patient be availed all the necessary information before treatment is effected and that such information is always given to the patient at the earliest stages before the real treatment. It appears that the most impelling instance where such a requirement may be ousted is if it is believed by the medic that release of such information will be of harm to the patient.

This is nature of such consent according to ***Article 10(b) of the Patients Charter***, is that such consent might be oral, verbal or in writing or implied from conduct.

Otherwise, there are certain situations in which the patient will not be able to give a valid consent to treatment. It should be noted that this does not cover the scenario where the patient refuses to give consent, rather it covers the patient who is incapable of either giving or withholding consent to treatment. These situations can be summarized as the unconscious patient, the non *Gillick* competent child under 16, and the mentally incompetent patient over 16. Whilst there will be a detailed analysis of the law relating to the ability to treat without consent in these situations at a later point in the discussion, it is useful to give a brief outline of the issues to be considered at the outset as consent, and the ability to proceed without it, forms a background for all the issues relating to the provision of treatment.

Mason, McCall Smith and Laurie talk about how one approach that could be adopted in these situations would be to say that the patient would have consented had he been able to do so.[138] It could be argued that this provides a high level of respect for the patient's autonomy. This though, can only be true if it involves looking for evidence as to what the patient would have wanted. A blanket approach, which always presumes consent, is an unjustifiable violation of the patient's rights. Mason, McCall Smith and Laurie seem to miss this important distinction. Another issue is that it creates a complex legal problem if the patient, at some later time when he is competent, expresses that he would not have consented to the procedure. The law, however, does not accept this approach and prefers to find other, less artificial, ways of proceeding with treatment if the patient cannot voice consent.

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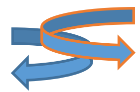
[138] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.311



Proxy consent.

A proxy is a substitution of one with another such that the latter performs a role of the former and for his benefit therefore. In relation to children, the first option is that the parent or guardian may give consent on behalf of the patient. It is accepted law that proxy consent will be sufficient to authorise treatment of a child. Even if the child is *Gillick* competent proxy consent will be enough to allow treatment to proceed as the child has no ability to withhold consent.[139] If proxy consent is withheld then the courts can intervene and authorize treatment. This is done on the basis of the best interests of the patient and, whilst the wishes of the parent may be important, they will not be decisive. For the adult patient proxy consent is not an option as there is no party who has the right to offer consent on behalf of another adult.[140] In relation to the normally competent patient who is in an unconscious state the doctrine of necessity[141] will apply. For the mentally incompetent patient we once more turn to the doctrine of best interests.[142] The effect of these doctrines will be looked at later as will the relationship and distinction between the two concepts.

THE 'NORMAL' PATIENT:

It is possible to identify a theoretically 'normal' patient. This is the patient for whom consent to treatment is really the only issue in question. If consent is given then treatment may proceed without any problems. In the event that consent is not given, there will be no way in which doctors will be legally allowed to carry out the proposed treatment. In relation to the 'normal' patient the courts will rarely become involved as the issues are clear. Rather the courts, and this thesis, are concerned with the ability to treat 'non-normal' patients.

It might be assumed that the 'normal' patient is possibly the one most frequently encountered, yet, as has already been stated, this is not true when it comes to court cases. Whilst the 'normal' patient may be the most numerous in practice, it is unlikely that the treatment of such a patient will give rise to any controversial arguments which may need to be decided by way of a court hearing. The

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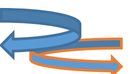
[139] *Re R (A Minor)(Wardship: Medical Treatment)* [1991] 4 All ER 177

[140] The old parens patriae jurisdiction permitted the court to consent on behalf of an adult patient but this was abolished under the Mental Health Act 1959. Hornett makes it clear that a power of attorney could not be used to authorise proxy healthcare decisions, see S. Hornett, 'Advance Directives: A Legal and Ethical Analysis' in J. Keown (ed), *Euthanasia Examined* (Cambridge: Cambridge University Press, 1998), p.303

[141] The doctrine of necessity permits non-consensual treatment, normally of the unconscious patient, which does not exceed the requirements of the patient's situation, see J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.312.

[142] This doctrine generally deals with patients who do not possess the competence necessary to be able to give effective consent. Lord Goff has stated that: "Where the state of affairs is permanent or semi-permanent, as may be so in the case of a mentally disordered person, there is no point in waiting to obtain the patient's consent. The need to care for him is obvious; and the doctor must then act in the best interests of his patient, just as if he had received his patient's consent so to do", see *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 567.



scarcity of the 'normal' patient in cases is partly due to the restrictive definition of a 'normal' patient. Firstly, the 'normal' patient must be a conscious adult who is free of both mental incompetence and any undue influence exerted by other people. Further to that the 'normal' patient will not be pregnant, nor subject to irrational fears or objectionable beliefs. Finally, and perhaps most importantly, the 'normal' patient will invariably favour life over death. A large proportion of patients will find themselves lacking in one or more of these characteristics when they are at their most vulnerable.

Hence it can be seen that whilst we talk of the 'normal' patient we are actually referring to the abnormal; the unusual. The 'normal' patient will be a rarity when it comes to important case law. It should not, however, be assumed that simply because the 'normal' patient is numerically insignificant that it is also theoretically insignificant. The concept of the 'normal' patient provides a useful 'control' against which to analyze the way the law approaches other, 'non-normal', patients. Hence the 'normal' patient remains of legitimate theoretical importance.

TREATMENT OF CHILDREN AND ADOLESCENTS

The way in which the law approaches the medical treatment of children is of importance for a number of reasons. Firstly it must be accepted that children are generally more vulnerable than adults. Due to this vulnerability the law is required to protect children from harm that may be inflicted upon them by others. Furthermore, there is the general social concern for the well being of children. This is epitomised by the strong public outrage that is exhibited towards child murderers and paedophiles.[143] In a very real way children represent the future and society seeks to protect them from risks that it would allow adults to endure.

Generally, medical treatment can be provided if it is thought to be <u>in the child's best interests</u> so long as the parents, the court, or the child, if competent, consents.[2] Whilst the need for a belief that the child's interests demand treatment indicates that the guiding principle of best interests applies, the fact that consent is also required indicates the principle of self-determination. It should be

[143] A more recent example of such concern can be found in the disgust that has met the Beslan school siege, see W. Rees-Morgan, 'Beslan is Russia's 9/11: It Will Change The World', *The Times*, 6th September 2004 [2] J. Herring, *Family Law* (London: Longman, 2001), p.359

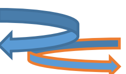
noted though that the consent does not always come from the child. The discussion that follows will assess how these, and the remaining, guiding principles are applied in the cases and whether or not they really are the main force in this area of the law.

There are two main areas which need to be considered. Firstly the possibility that the child will be viewed as competent to provide consent must be looked at. This is generally referred to as adolescent autonomy and it will be necessary to ascertain when a child will be seen as competent, and the extent of the power that this competency provides. The second area to be looked at covers those children who are not seen as competent to provide consent for their own treatment. Whilst this will cover the majority of child patients it is useful to look at this issue after discussing adolescent autonomy, as any child who claims to have competency but fails to prove his claim will then be treated in the same manner as the incompetent child.

Autonomy Of Children:

A person might be forgiven for thinking that until a child reaches the age of majority they have no ability to provide consent to medical treatment. This belief, however understandable in its existence, is erroneous. The law recognizes that some patients under the age of 18 may have the ability to provide consent to medical treatment. This ability is tiered according to the age of the patient. For the 16-18 year old the Family Law Reform Act 1969, s.8, provides automatic ability to provide consent to treatment. It has been stated that this puts the 16-18 year old minor in the same position as the adult patient.[144] To some extent this is correct, as the competence required to consent to medical treatment is presumed for these minors, just as it is for adult patients. However,

[144] I. Kennedy & A. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000), p.645 [4]
[1986] AC 112



as will be discussed shortly, the extent of the power possessed by these patients is less than that of adults.

For the child who is under 16 years of age the ability to provide consent to medical treatment is a more complex issue. The seminal case, ***Gillick v. West Norfolk and Wisbech Area Health Authority*[4]**, involved a mother who was challenging a Department of Health memorandum that permitted doctors to provide contraceptive advice to minors under the age of 16 without parental consultation. If this challenge had been accepted the result would have been that no child under the age of 16 could ever authorise any form of medical treatment however minor.[145] Lord Fraser stated that this suggestion "seems to me so surprising that I cannot accept it in the absence of clear provisions to that effect".[146] Lord Fraser then went on to say that there was no good reason to hold that a child with sufficient understanding should not be capable of expressing a valid and effective consent to medical treatment.[147] In making this decision Lord Fraser placed emphasis upon the fact that it would be unrealistic of the courts to ignore the fact that parental control is generally relaxed as the child increases in age and understanding.[148]

Lord Fraser's judgment seems to place the welfare of the child at the forefront. It was stated that the best judges of the child's welfare will generally be the parents but that this need not always be true.[149] It was also stated that the only practicable approach is to trust doctors to act in accordance with what they think is in the best interests of the patient.[150] Whilst this could represent an

[145] Taken to its most extreme, but undeniable, conclusion this would mean that a child who grazes his knee at school could not have a plaster applied without parental approval.

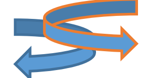
[146] [1986] AC 112, at 169

[147] ibid

[148] ibid, at 171

[149] ibid, at 173

[150] ibid, at 174



application of the guiding principle of protecting doctors this is tempered by the fact that Lord Fraser expressly stated that doctors could not totally disregard the wishes of other parties.[151] This seems to suggest that the main guiding principle to be applied in relation to adolescent autonomy is that of best interests.

It must be asked whether the concepts of 'welfare' and 'best interests' are synonymous or two distinct ideas. When considering the 'welfare' of the child the courts are required to consider the ascertainable wishes of the child.[152] In contrast to this, when the courts refer to 'best interests' they have little, if any, difficulty in disregarding the wishes of the child. Yet the requirement that the child's wishes be considered when looking at welfare only applies in certain circumstances[153] and is qualified so that the child's wishes must be considered in light of both age and level of understanding possessed.[14] Due to this it is submitted that the practical distinction between 'best interests' and 'welfare' is minimal.[154] Hence, a true focus upon either 'welfare' or 'best interests'[155] demonstrates an application of the guiding principle of best interests, a principle which

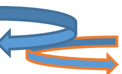
[151] ibid

[152] Children Act 1989, s.1(3)(a)

[153] ibid, s.1(4) which states: "The circumstances are that – (a) the court is considering whether to make, vary or discharge a section 8 order and the making, variation or discharge of the order is opposed by any party to the proceedings; or (b) the court is considering whether to make, vary or discharge an order under Part IV" The orders in question are residence, contact, prohibited steps and specific issue orders under s.8 and care and supervision orders under Part IV. [14] ibid, s.1(3)

[154] As will be seen shortly the test for competency is also based upon age and understanding so the effect of the qualification, if it is the guiding principle of best interests that applies here, would be to make the two concepts virtually identical in their practical effect.

[155] The real distinction is one of usage; whilst the courts refer to welfare when talking about children they use the term best interests in relation to adults. This may be due to a desire to differentiate between adults and children, at least on a semantic level.



assesses the ascertainable interests of the patient in order to decide whether or not treatment should be available in order to further those interests.

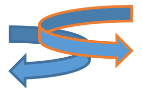
Lord Scarman took a different approach to that of Lord Fraser and seems to place more importance upon the guiding principle of self-determination. One of the arguments put forward was that the memorandum adversely affected the rights of parents. In dispensing with this proposition Lord Scarman stated that:

"*As a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.*"[156]

This seems to suggest that once the child possesses sufficient understanding, and therefore has the competency to consent to treatment, the parent's right to consent to treatment ends. The result of this would be that the child's right to determine what should happen to him is absolute once he has the requisite understanding. In essence the child would be in the same position as the competent adult, or 'normal' patient referred to in Chapter 1, and treatment would only be lawful if the child's consent were obtained. Whether or not this is true will be discussed shortly, for now it is sufficient to recognise that Lord Scarman's judgment strongly supports the guiding principle of self-determination which safeguards the autonomy of the patient through the requirement of consent.

From what has already been said it should be clear that understanding is the key factor in determining whether or not a child will be seen as competent. The question that must be asked is what must the child understand in order to possess sufficient competency? Kennedy and Grubb

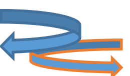
[156] [1986] AC 112, at 188-189



argue that the cases have required a very high level of understanding.[157] It is certainly true to say that the majority of cases have involved children who were eventually held to be incompetent. The first indicators, as would be expected, come from the *Gillick* case itself. Both Lord Fraser[158] and Lord Scarman[159] referred to the need to understand what is being proposed by the doctor. Lord Scarman went beyond this though and stated that mere understanding of the nature of treatment is insufficient, there must also be an understanding of the moral and family questions that may arise.[160] Whilst it has been argued that this should be limited to the immediate treatment discussed in *Gillick*, that of contraception,[161] this seems to ignore the fact that such questions could be raised by many other medical treatments.

Since *Gillick* a number of cases have attempted to clarify what is required in order for a minor to be competent. The first point to note is that the courts, in *Re R (A Minor)(Wardship: Medical Treatment)*,[162] have rejected the idea that the child can fluctuate between competency and incompetency; it is an all or nothing test.[163] Whilst this shows that competency must be a permanent state it does little to explain what understanding is required. In addressing this issue, Lord Donaldson accepted Lord Scarman's rejection of simply understanding the nature of treatment and stated that what the law actually required was:

[157] I. Kennedy & A. Grubb, *Medical Law*, p.647
[158] [1986] AC 112, at 169
[159] ibid, at 188
[160] ibid, at 189
[161] I. Kennedy & A. Grubb, *Medical Law*, p.647
[162] [1991] 4 All ER 177
[163] ibid, at 187

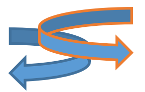


"A full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects and, equally important, the anticipated consequences of a failure to treat."[164]

In ***Re S (A Minor)(Consent to Medical Treatment)***[165] the court went even further and stated that understanding that the result of refusing treatment would be certain death was insufficient. Instead it was held that the child had to comprehend the manner of the death and the pain that would be involved.[166] The same approach was adopted in *Re E (A Minor)(Wardship: Medical Treatment)*[167] where a child was held to be incompetent due to the fact that he did not comprehend the manner and process of his death, nor the extent of suffering that would have to be endured by both him and his family.[168]

The child's experience of life will also be a major consideration as this will affect the ability to assess the importance of information he receives and understand what will happen to him. Both Stephen Brown J[169] and Johnson J[170] have held that a child had led too 'sheltered' a life to allow an informed decision to be reached. In both instances the child was a member of a devout Jehovah's Witness family and the courts held that being raised in this culture resulted in an overly protective upbringing. Stephen Brown J stated that bringing a child up in this way was not to be criticised, instead he approved of the fact that the child had been subjected to sensible disciplines.[171] It appears that the court was congratulating the parents on the way they had raised

[164] ibid
[165] [1994] 2 FLR 1065
[166] ibid, at 1076
[167] [1993] 1 FLR 386
[168] ibid, at 391
[169] *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810
[170] *Re S (A Minor)(Consent to Medical Treatment)* [1994] 2 FLR 1065
[171] [1998] 2 FLR 810, at 813



their child but then holding that it meant she could not be competent. In effect the courts are saying that the possession of worthwhile character traits may result in lack of competence. Similarly, a child who hoped for a miracle that would save her life was incompetent because she did not accept that death was an inevitable consequence.[172] Surely hope is a good thing for a child who is facing death to have? Surely the knowledge that a miracle would be required to save her life indicates that she knew the normal course of events would result in her death?

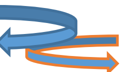
It should be noted that all of the cases discussed above have involved children who are attempting to withhold consent to treatment. Setting aside the question of whether or not a competent child can withhold consent, there are a number of points raised by this. From the absence of cases involving children wishing to consent it can be ascertained that there are usually no competency problems encountered when the child supports the proposed treatment. Yet when the child does not consent the courts will continually find ways to reject the claim he is competent. Whilst Herring summarises the comprehension requirements as the need to understand the nature of condition and treatment, the moral and family issues raised, life experience, constant mental state and the ability to weigh information appropriately[173] the courts have gone even further. It is incredibly hard for a child to show the required understanding and it appears that this will only be the case when he is acquiescing to treatment.

Whilst it is possible to argue that the above cases represent an attempt to apply the guiding principle of doctor protection through abdicating the decision of what should happen to the doctor,[174] this is

[172] [1994] 2 FLR 1065, at 1073-1074

[173] J. Herring, *Family Law*, pp.360-361

[174] G. Douglas, 'The Retreat from Gillick' (1992) 55 MLR 569, p.576



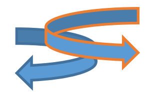
dispelled by ***Re W (A Minor)(Medical Treatment)*.**[175] In that case there were two possible courses of action supported by medical opinion, only one of which was opposed by the child. If there are multiple medical opinions it is hard to see how the principle of protecting doctors can apply. An alternative argument would be that the courts are attempting to preserve the interests of the child in all cases, this, however, can be dispensed in a similar manner as there is frequently more than one valid opinion as to what the child's welfare demands.

It is submitted that what these cases actually represent is an attempt to apply the guiding principle of allowing treatment. This principle seeks to use all possible paths to ensure that access to the most promising form of treatment remains available. The principle of allowing treatment does not look at whether the interests of the patient favour treatment, rather it is assumed that the treatment is of value. In effect the doctrine of adolescent autonomy has provided another possible source for consent to treatment and is not designed to protect the child's autonomy or interests as was indicated by *Gillick* itself. This is further supported by the limits that are placed upon the way adolescent autonomy can be exercised. As will be seen shortly, the competent child can say yes to treatment but has no power to say no.

Exercising Autonomy:

In ***Re R (A Minor)(Wardship: Medical Treatment)***[176] the court was faced with a 15-year-old girl, with a history of family problems and disturbed behaviour, who was refusing to consent to the administration of anti-psychotic drugs. Lord Donaldson stated that consent was merely a key which unlocked the door so as to allow the doctor to treat.[177] He stated that:

[175] [1992] 4 All ER 627
[176] [1991] 4 All ER 177
[177] ibid, at 184



"*In the ordinary family unit where a young child is the patient there will be two keyholders, namely the parents, with a several as well as joint right to turn the key and unlock the door"*[178]

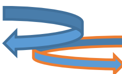
When the child is competent to consent to treatment for themselves then they can be seen as receiving their own key to the door, but just like the mature child who obtains the key to the family home, the parents are not forced to give up their keys. The result is that if the competent child refuses to consent to treatment then it is open to the doctor to seek consent from another party who has parental responsibility. There is also the possibility that the court could provide consent when both parents and child refuse to do so.

This decision seems to move a long way from the self-determination based decision of Lord Scarman in *Gillick*. Whilst Lord Scarman referred to the parent's right of determination terminating once the child had sufficient understanding to be competent, Lord Donaldson held that determination and consent were not the same.[179] It was stated that the idea of determination was wider than consent and would involve the parent being able to effectively refuse consent. This parental ability to withhold consent ceases once the child is competent to give an effective consent that cannot be overridden by the parents. Due to this the parent is no longer able to determine the future of the child, the parent can however have an important, undeniable, influence upon that future.

Re R would seem to support the idea that the guiding principle that operates in relation to adolescent autonomy is that of allowing treatment. The imagery of lock and key goes a long way

[178] ibid

[179] ibid, at 185



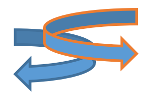
towards representing the concept of allowing a route of access through which the doctor can treat the child. The idea of multiple keyholders reinforces this, as treatment can be made lawful by numerous persons. However, an alternative view would be that what the court is really doing is seeking to protect the doctor and his clinical judgment. In justifying the distinction between determination and consent Lord Donaldson placed importance upon the fact that if the parent lost the right to consent then the doctor who incorrectly decided that the child was incompetent could be sued for trespass or even prosecuted for assault. He stated that this was an intolerable dilemma for the doctor and one that had to be avoided by the law.[180]

It has been argued by some academics that ***Re W (A Minor)(Medical Treatment)***[181] offers more support for the principle of protecting doctors. In this case Lord Donaldson expressed regret at the use of the lock and key analogy as a key could be used to lock a door as well as unlock it.[43] This demonstrates that if the lock and key analogy had been taken to its conclusion the child should be able to refuse consent, but similarly so should the parent. The image of the lock and key, therefore, failed to achieve the end originally envisaged by the court and needed to be replaced. In preference he compared consent to a flak jacket. The important difference with the flak jacket is that if given by one party it cannot be taken away be another, further to that a doctor will only need one flak jacket to be safe from the threat of litigation. The analogy of the flak jacket, which talks about protecting doctors, has led a number of critics to state that in *Re R* and *Re W* the court's main concern was accepting the clinical judgment of the doctors in question.[182] It must be remembered though that the flak jacket was an attempt to replace an alternative which produced

[180] ibid

[181] [1992] 4 All ER 627 [43]
ibid, at 635

[182] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy' (1996) 16 LS 84, p.85

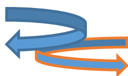


undesired consequences. The flak jacket analogy was not created simply because the court wanted to create a stronger, doctor protection centred, image, rather it came about through the need to replace the flawed analogy of the lock and key.

A much more convincing argument is that *Re W* provides support for the guiding principle of allowing treatment. The important point is that in this case the clinical judgment of the doctors was split and the course of treatment which the child favoured was in fact supported by an accepted body of medical opinion.[183] The court seems to have given no regard to any alternative course of action though and merely opted for that which posed the greatest chance of success. When there are multiple clinical opinions it becomes difficult to see the law as wholly concerned with the protection of doctors. Instead there must be some importance placed upon allowing treatment whenever possible.

The best way to approach this problem is to view the law as primarily applying the principle of allowing treatment. The principle of doctor protection is then applied so as to ensure that the desired treatment can proceed without any risk of litigation. It is submitted that this approach best represents the case law in this area when viewed as a whole. Whilst it has been argued that the flak jacket analogy is clearly an attempt to protect doctors this ignores the fact that it was designed to replace an unworkable alternative that was much more focused upon allowing treatment. The result of making the principle of protecting doctors subsidiary to that of allowing treatment is that the doctor's clinical judgment is only protected by the court if it expresses a preference for

[183] As was stated earlier, this demonstrates that the guiding principle of allowing treatment cannot be that of doctor protection as this would not provide a method of choosing between different medical opinions.



treatment. This reduced principle of doctor protection is best seen as a consequence of a desire to allow treatment rather than any real desire to protect a doctor's clinical judgment.

Many academics have argued that the right to give consent cannot logically be separated from the converse right to withhold it.[184] Whilst Douglas describes *Gillick* as a landmark decision she views *Re R* as "a disturbing example of where a court has arguably failed to hold balance between the interests of the child, the parent and/or society at large".[185] She states that the courts are attempting to move back towards the notion of parental powers as opposed to duties.[186] Thornton, who describes the case law as a retrograde step, supports this position[187] whilst Kennedy speaks less flatteringly and states that the result is to drive a coach and horse through *Gillick*.[188] Brazier and Bridge however state that whilst the judicial reasoning can be criticised the end result, saving the child's life, is harder to dispute.[189] Indeed, this could be one area of the law where the courts decide the end result first and then look for judicial reasoning to support it. The criticisms of the reasoning all assume that consent is the main factor, yet as has already been shown this is not the reality. When the cases are seen as an application of the guiding principle of allowing treatment they fit together to form a whole, *Re R* and *Re W* no longer represent a reversal from *Gillick*.

The courts have also considered the importance of the child's wishes when they desire to withhold consent. In *Re R* it was held that whilst the views and wishes of the competent child are important,

[184] For an example of such arguments see R. Thornton, 'Multiple Keyholders – Wardship and Consent to Medical Treatment' [1992] CLJ 34

[185] G. Douglas, 'The Retreat from Gillick', p.569

[186] ibid, p.570

[187] R. Thornton, 'Multiple Keyholders – Wardship and Consent to Medical Treatment', p.37

[188] A. Kennedy, 'Consent to Treatment: The Capable Person' in C. Dyer (ed), *Doctors, Patients and the Law* (Oxford: Blackwell, 1992), p.60

[189] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy', p.84 [52]
[1991] 4 All ER 177, at 187

and indeed their importance increases as his understanding increases, they do not prevent consent being obtained from an alternative source.[52] Support for this can be found in *Re M* which stated that whilst the refusal of the patient is important it is not decisive.[190] What this means is unclear, if the wishes of the child cannot be a bar to treatment then how can they be of any real importance? Perhaps Brazier and Bridge address this issue best when they state that the courts are only ever confronted with cases that involve the risk of death or severe permanent damage and that in such cases any philosophy of autonomy must yield to the pragmatism of preserving life and health.[191] Some approval of this can be found in *Re W* when Lord Donaldson states that children should be given what decision making powers are prudent but that:

"Prudence…does involve avoiding risks which, if they eventuate, may have irreparable consequences or which are disproportionate to the benefits which could accrue from taking them."[192]

As Brazier and Bridge state, the child is only free to make the wrong decision when that decision is to consent to treatment.[193] The level of importance placed upon the child's wishes, and the idea that they should be disregarded if the refusal of treatment involves too great a risk, once more reinforces the idea that in this area of the law the principle of allowing treatment is dominant.

There must be some residual role for the guiding principle of best interests though regardless of the fact that the main principle applied is that of allowing treatment.[194] The reason for this is that

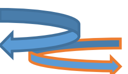
[190] [1999] 2 FLR 1097, at 1097

[191] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy', p.89

[192] [1992] 4 All ER 627, at 638

[193] M. Brazier & C. Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy', p.88

[194] Whilst the guiding principle of doctor protection has some background role to play it has already been argued that this is only a consequential role. As a result of this it offers little help in understanding which principles determine the outcome of cases. It is submitted that a similar application of doctor protection will always be present as without it there would never be any ability to apply another principle.



only treatment in the child's interests should be provided. This residual role will be looked at more fully in the next section as it applies equally to both the incompetent and competent child. In relation to the concept of adolescent autonomy the notion of best interests seems to have little influence. A child will only be seen as competent if he desires treatment, for those who wish to refuse it there is no assistance offered by adolescent autonomy.

TREATING THE INCOMPETENT CHILD:

When we turn to the treatment of the incompetent child we are really considering the majority of children. Whilst a child can be seen as competent, it has already been shown that the benchmark for this is very high. The vast majority of children will not be seen by the courts as having the requisite understanding to enable them to consent to their own treatment. Further, it has been shown that there is no ability for a competent child to withhold consent to medical treatment. The competent child who is opposed to treatment will be treated in the same manner as the incompetent child. The issues that are to be discussed here arise by virtue of the fact that the patient is a minor who cannot, or will not, provide consent.[195]

WHO CAN BE A PROXY:

When children are not competent to provide consent to their own medical treatment it becomes necessary to find some alternative method to authorise such treatment. The alternatives would be to either accept that treatment should be available without the need for authorisation or that treatment could never be provided. Neither of these extreme suggestions seems satisfactory so it becomes obvious that there must be some tool to provide the requisite authority. The main tool

[195] A large number of issues which could be discussed here apply equally in relation to adult patients who are incompetent. These issues arise by virtue of the incompetence rather than due to the status of the patient as a minor and will not be discussed here.

used for this purpose is the power of proxy consent. This allows for somebody other than the child to provide consent to the treatment.[196]

It is possible to identify a general link between the power to act as a proxy and the possession of parental responsibilities. Hence a mother and a father, who possesses parental responsibility, will be able to provide proxy consent. Yet just as parental responsibilities are not limited to the biological parents of the child, neither is the power of the proxy. In short, anybody who is in possession of parental responsibility[197] will be able to provide proxy consent to medical treatment. In relation to children who have been taken into the care of a local authority that authority will also possess parental responsibilities[198] and have the right to provide proxy consent.

The courts also retain the right to provide consent to medical treatment in relation to incompetent children. There are a number of possible methods by which the courts may provide authorisation to the medical treatment of children. The first option is to make a prohibited steps order to prevent a certain course of action being taken.[199] The second possibility is to make a specific issue order so as to give authorisation to the procedure in question.[200] Thirdly there is the option of making the child a ward of court.[201] The result of this is that the court must make all decisions relating to

[196] It should be noted that the power of proxy consent is only available in relation to children and cannot be exercised over an incompetent adult. As will be discussed in the next chapter, any suggestion that the medical treatment of an incompetent adult can be authorised by virtue of the consent of another person has been rejected.

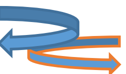
[197] The possession of parental responsibility is governed by the Children Act 1989, ss.2(1), 4, 5(6) and 12(2)

[198] Children Act 1989, s.44(4)(c)

[199] ibid, s.8(1). Whilst this would represent the opposite of providing consent to treatment it could be used to prevent one parent consenting to a non-therapeutic procedure, such as religious circumcision, which was opposed by the other parent.

[200] ibid

[201] Supreme Court Act 1981, s.41

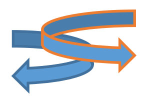


that child's life, no matter how minor. Due to this it has been stated that the courts would rather make use of the alternatives to wardship.[202] The final option is for the court to exercise its inherent jurisdiction so as to authorise the proposed medical treatment.

Kennedy and Grubb provide a number of possible justifications for the use of proxy consent in relation to children.[203] The first of these is the idea that parents represent the most appropriate repository of the power involved in proxy consent. Support for this suggestion is taken from the Australian case of ***Secretary, Department of Health and Community Services v. JWB and SMB***.[204] The second possible justification provided is that it represents the parent's right of absolute control over the child. The final suggestion offered is that parents are under a duty to provide medical treatment for their children and that proxy consent is a necessary element for the successful fulfilment of this duty. They argue that *Gillick v. West Norfolk and Wisbech Area Health Authority*[205] supports this proposition. There are a number of problems with these justifications however.

One problem that applies to all of these justifications is that the power of the proxy, as has already been stated, is not possessed solely by the parent. It is possible to overcome this hurdle though by including all people with parental responsibility under the term 'parent'. For the first justification the idea that a person is suitable to possess the power of the proxy simply because they have parental responsibility seems dubious. Parental responsibility does not ensure that a person has any real involvement in the child's life or understanding of their needs and feelings. The second

[202] I. Kennedy & A. Grubb, *Medical Law*, p.777
[203] ibid, pp.774-775
[204] (1992) 175 CLR 218
[205] [1986] AC 112



possible justification seems to be less plausible in modern society than it would have been in a more old fashioned society which regarded children as the property of their parents. The shift of judicial and parliamentary thinking from parental rights to parental responsibilities seems to make any reference to the rights of parents over children illogical. *Gillick* is an example of this shift and refers to how the powers of the parent only exist in so far as they are needed to allow the parent to carry out their responsibilities and duties towards the child.[206]

Of the three justifications suggested by Kennedy and Grubb, the final one seems to be the most supportable as it appears to fit in, better that the other two do, with the modern concept of parental responsibilities as opposed to parental powers. It also remains child focused as opposed to being concerned with the power of the proxy and the entitlement to possess such power. Whilst it could be argued that the mere existence of proxy consent indicates an application of the principle of allowing treatment, this would be a dubious assertion to make without an analysis of the exercising of the manner in which this power can be exercised.

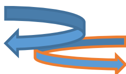
THE PROXY'S POWER:

The idea behind the existence of proxy consent is that the proxy determines what is in the best interests of the child and authorises such treatment as best serves the child's welfare. Both the courts[207] and parliament[208] have reinforced this on numerous occasions. The clearest judicial statement on this issue has come from Lord Donaldson in *Re J (A Minor)(Wardship: Medical Treatment)* when he said "the parents owe the child a duty to give or to withhold consent in the

[206] [1986] AC 112, at 170

[207] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112 and *Re B (A Minor)(Wardship: Sterilisation)* [1987] 2 All ER 206

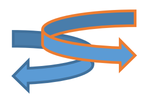
[208] Guardianship of Infants Act 1886, s.6, Guardianship of Infants Act 1925, s.1, and Children Act 1989, s.1(1) [72] [1990] 3 All ER 930, at 934



best interests of the child and without regard to their own interests".[72] Later in the same case it was stated that "the choice is one which must be made solely on behalf of the child and in what the court or parents conscientiously believe to be in his best interest".[209] These two statements make it clear that the role of the proxy is to safeguard the interests and welfare of the child in question. In *Re S (A Minor)(Medical Treatment)*[210] this position was reinforced when Thorpe J stated that the test must always remain the welfare of the child in question.[211] Wilson J has made it clear that this is not a question relating to the rights and interests of the parent, nor can the rights of the child be subsumed into those of the parent.[212] The proxy's power is designed to protect the rights and interests of the child, rights which are separate from those of the parent.

The question that needs to be addressed therefore is how should the proxy decide what is in the best interests of the child. The first point to note is that not only are we not concerned with the interests of the parent, but we are not concerned with the viewpoint of the parent either. In *Re J (A Minor)(Wardship: Medical Treatment)*[213] the child had been born prematurely, was suffering from severe brain damage and epilepsy. It was likely that the child would be deaf and blind, incapable of even limited intellectual abilities and would develop serious quadriplegia. It was also probable that the child would die before it reached adolescence. The question was whether or not the child should be ventilated or resuscitated should breathing cease, which it had already done on two occasions. Lord Donaldson stated that the life of the disabled child should not be judged in comparison to that of the normal child.[214] Further to that he pointed out that it is possible that a

[209] ibid, at 936
[210] [1993] 1 FLR 376
[211] ibid, at 380
[212] *Re C (A Child)(HIV Testing)* [2000] Fam 48, at 61
[213] [1990] 3 All ER 930
[214] ibid, at 936



handicapped child may find his quality of life acceptable whilst in the imagination of the non-handicapped person it would be intolerable.[215] This focus upon the viewpoint of the child, as opposed to that of the adult, implies that the guiding principle of best interests could apply here. However, the ability of the court to assess what the child in question would think of the life he will lead is both questionable and problematic.

Despite this difficulty the approach was supported in *Re B (A Minor)(Wardship: Medical Treatment)*[216] where the court was confronted with parents who wished to withhold consent to the treatment of their newly born child. The child suffered from Down's syndrome and had an intestinal blockage which required surgery that was opposed by the parents. If surgery were not provided the child would die within a few days. The argument proposed by the parents was that, due to the Down's syndrome, it would be kinder to the child if she were allowed to die. The court rejected this argument and held that it was in the best interests of the child to consent to the operation. Importance was placed upon the fact that if the operation was carried out the child would be able to have as happy a life as could be expected by any child with Down's syndrome.[217] It was also stated that in cases like this the question that must be asked is:

"*Whether the life of the child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is so imponderable that it would be wrong for her to be condemned to die."*

[215] ibid, at 938
[216] [1990] 3 All ER 927
[217] ibid, at 929 [82]
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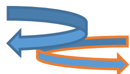

The issue of allowing children to die will be covered more fully in Chapter 5. It is, however, important to note that an extremely low standard of life needs to be reached before it can be shown that it is in the child's interests to allow him to die. This would appear to support the presumption in favour of preserving the child's life if possible, a presumption which has a large amount of judicial support although it is accepted that it is rebuttable.[218] The European

Court of Human Rights has stated that "the regulatory framework of the United Kingdom was firmly based on the duty to preserve the life of the patient, save in exceptional circumstances."[219] The result of this is to question whether we are really looking at the guiding principle of best interests. It would seem more likely that the focus upon the viewpoint of the child is a tool used by the law to prevent parents withholding consent in all but the most extreme of scenarios. Once again we see the application of the guiding principle of allowing treatment whenever possible.

An important issue to deal with in relation to children is whether or not it is possible to refuse medical treatment on the basis of beliefs.[220] The courts have firmly rejected that doctors should automatically opt for a more risky procedure due to the fact that it would be religiously acceptable whilst a safer procedure would not.[221] Lord Donaldson even went so far as to state that opposition to treatment on the basis of beliefs of any nature was irrational.[222] Whilst he pointed out that this was only a personal opinion that did not affect competency or validity, it certainly demonstrates a worrying position. Whilst an irrational refusal by a competent person will still be protected by the

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[218] For examples of such support see *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 916 and *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906, at 938

[219] *Glass v. United Kingdom* [2004] 1 FLR 1091

[220] Normally such beliefs are of a religious nature, but this need not always be the case. *Re C (A Child)(HIV Testing)* [2000] Fam 48 is an example of non-religious beliefs. Here the beliefs were as to the nature of the condition and the merits of the conventional treatments.

[221] *Re S (A Minor)(Medical Treatment)* [1993] 1 FLR 376, at 380

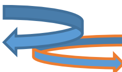
[222] *Re W (A Minor)(Medical Treatment)* [1992] 4 All ER 627, at 637

law,[223] it will soon become apparent that, in so far as children are concerned, the courts have a tendency to overrule decisions made on the basis of beliefs. This could indicate that Lord Donaldson's view represents the reality when dealing with children. The question that must be asked is whether there are any situations when beliefs will be a valid reason for refusing medical treatment on behalf of the child?

There have been a number of cases, mostly involving Jehovah's Witnesses, where parents, and the children in question, have desired to withhold consent due to such beliefs. In *Re E (A Minor)(Wardship: Medical Treatment)*[224] the court accepted that the religious beliefs were deeply, and genuinely, held by the child as well as by the parents. It was also pointed out that the child was very close to the age at which he would be able to effectively withhold consent to treatment. As a result of these considerations it was stated that the judge should be slow to intervene and override the child's beliefs.[225] Yet Ward J appears to have had little difficulty in doing exactly that. Firstly it was decided that the child's upbringing had conditioned him to believe that the suggested treatment was unacceptable, as a result of this the child's will was not fully free.[226] Some importance was also placed upon the possibility that the strength of the child's belief would diminish in the future.[227] Finally Ward J stated that:

"There is compelling and overwhelming force in the submission…that this court, exercising its prerogative of protection, should be very slow to allow an infant to martyr himself"[228]

[223] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649
[224] [1993] 1 FLR 386
[225] ibid, at 393
[226] ibid
[227] ibid
[228] ibid, at 394



As a result of these considerations, it was decided that the welfare of the child, when viewed objectively, supported only one possible conclusion; that the hospital should be at liberty to provide treatment.[229]

The ease with which Ward J appears to have dispensed with the need to respect the wishes of the child seems to reinforce the suggestion that the guiding principle at operation here is that of allowing treatment. This is especially clear from the reference to how hospitals should be at 'liberty to treat'. Whilst this statement could be seen as giving doctors the freedom to do as they wish, this freedom only exists if the doctor desires to treat the patient. There is also the clear implication that treatment should always be available. The suggestion that the child's will was not free appears to contradict the way the child was described by the court as having a deeply held and genuine belief. Whilst the decision is couched in terms of welfare and best interests, it would seem that the presumption in favour of preserving life, both its existence and quality, is what really underlies this decision.

Having already seen that the courts are willing to authorise treatment when the beliefs of the child are opposed to it, there is no surprise in the fact that they take the same approach to the parents' beliefs. In *Re C (A Child)(HIV Testing)*[230] Wilson J expresses the opinion that the courts should be slow to overrule the wishes of the parents.[231] Yet this need for caution seems to have the same impact as that in *Re E*, once more the court manages to provide consent despite the opposition of the parents. Johnson J, in *Re O (A Minor)(Medical Treatment)*,[232] authorised the treatment of a

[229] ibid
[230] [2000] Fam 48
[231] ibid, at 58
[232] [1993] 2 FLR 149

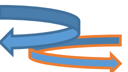
premature baby in such a way as was contrary to the parents' religious beliefs. In doing so he stated:

"*My duty…required me to give directions that will have the consequences of ensuring that whenever the medical need arise she will receive the transfusion of blood or blood products that medical advice dictates*"[233]

This seems to offer clear support for the suggestion that allowing treatment is the main guiding principle at operation in this area of the law. Whilst there is some indication from this extract that the protection of clinical judgment is to be considered as well, the focus is clearly upon the provision of treatment.

In *Re T (A Minor)(Wardship: Medical Treatment)*[234] there can be found some moderation of this preference for treatment. The patient, a child born with a life-threatening liver defect, was recommended for a liver transplant which the parents opposed on the basis that it would cause pain and distress. Despite the medical opinion that the transplant was required for the child to survive the court held that it was not in the child's best interests to authorise the treatment. In reaching this decision the court emphasised that the child would require constant after-surgery care from the parents and that the willingness and ability to provide this had to be considered.[100] Whilst it has already been stated that we are not concerned with the interests of people other than the patient, this case demonstrates that they may be of importance if they impact upon the interests of the child.

[233] ibid, at 153
[234] [1997] 1 All ER 906 [100]
ibid, at 915-916



Re T appears to cause problems for the application of the guiding principle of allowing treatment. It has already been indicated that the presumption in favour of treatment will cease to operate in extreme cases. In such cases the interests of the child must be so opposed to treatment as to overcome the presumption in favour of treatment. It is submitted that in such instances it is a negative application of the guiding principle of best interests which is decisive. Normally when a child's interests are referred to it is to look for what those interests demand. It is possible, however, to carry out the reverse analysis and look at what those interests reject. It is this use of the principle which is of importance in these extreme cases. Yet, can this really be seen as one of those extreme cases? It seems doubtful that this case is any more extreme than any of the others that have already been considered. Perhaps it is best to look at this as an anomaly.[235] The court certainly expressed the hope that treatment would be sought after the parents had time to think the matter over without the pressure of litigation.[236] This indicates that the court still focused upon treatment, even though they did not enforce it.

Solving Disputes:

The final question which must be asked is how will the courts approach cases where there are disputes, either between proxies or between a proxy and the medical profession, as to what should be done. It has been argued that:

"A doctor taking steps to administer life-saving treatment such as a blood transfusion to the child against the wishes of its parents could rely upon the common law…the current judicial climate is such that we believe a decision taken in good faith in the best interests of the child would, save in

[235] One possibility is that this is an application of the guiding principle of protecting doctors as the parents in question were members of the medical profession. Yet some doctor's thought that treatment should be given and there is no logical reason to automatically prefer the opinion of the parents.

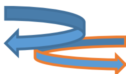
[236] ibid, at 916

very unusual circumstance, be upheld by the courts."[237] Whilst it seems reasonable to claim that in emergency situations the doctor should be able to treat the child without the parent's consent, the court's approach to this appears to be less positive than might at first be thought.

In *Re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision)*[238] Dame Butler-Sloss P stated that there are certain matters which should always be brought before the court if those with parental responsibility cannot agree. The named issues were circumcision, sterilisation and change of surname although it was accepted that this was not a conclusive list.[239] None of those issues could be classed as emergencies though, nor could they be seen as involving life-saving treatment in the majority of cases. It is important to note, however, that this dealt with disagreements between those with parental responsibilities as opposed to between a proxy and a doctor. If one proxy is willing to provide consent to medical treatment then, at least in emergency scenarios, that will probably be sufficient to make the treatment lawful. If this is true then the principle of allowing treatment appears very strong in this instance as the focus is purely upon obtaining authorisation for the treatment of the child.

When we turn to look at disputes between proxies and doctors the answer appears to come from ***R v. Portsmouth Hospitals NHS Trust, ex p. Glass***.[240] In this case Lord Woolf stated that where it was not possible for parents and doctors to agree on a course of treatment then, if the conflict relates to a grave matter, it ought to be brought before the court.[241] This has now been affirmed

[237] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002), pp.314-315
[238] [2000] 1 FLR 571
[239] ibid, at 577
[240] [1999] 2 FLR 905
[241] ibid, at 910



by the European Court of Human Rights in ***Glass v. United Kingdom***[242] where it was stated that the legal framework required such matters to be solved by the intervention of the court, except in emergencies. This seems to reject the application of the guiding principle of protecting doctors in the sense that it does not offer automatic sanction to clinical opinion.[243] The fact that disputes have to go to court says little else about which principles apply. It does, however, indicate that parents have a valid role to play and cannot be ignored when making decisions as to treatment.

Once a matter is brought before the court the question remains as to what approach will be adopted to resolve the dispute. It has been suggested that they should only overrule the parent's decision if it is unreasonable.[244] The courts have rejected this and made it clear that the reasonableness of the parent's decision is of no consequence.[245] The courts have been prepared to overrule a parent's refusal even when it was accepted that it was based on a genuinely held belief of what was in the child's best interests which was both reasonable and valid.[246] Instead the court's role is to come to its own decision of what is in the child's best interests, a decision which should not simply accept that of either doctor or parent.[247] Whilst the courts have accepted that the views expressed by the parents are important,[248] cases where a parent's desire to refuse treatment is given effect by the court are rare to say the least, and it has already been seen that the way in which the courts interpret the child's interests heavily favours the provision of treatment.

[242] [2004] 1 FLR 1091

[243] It could however be argued that it ensures certainty and, through the need for court sanction, the threat of litigation is removed. This however is as much a benefit to the patient as it is to the medical team.

[244] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.314

[245] *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906, at 916

[246] An example of such an overruling is *Re B (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 927

[247] *Re B (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 927, at 929

[248] *Re C (A Child)(HIV Testing)* [2000] Fam 48, at 58

So far the discussion has focussed upon cases where the doctors have desired to proceed with treatment and the parents have either been opposed to that treatment or uncertain as to whether it should be provided. Now it is necessary to look at how the courts approach the reverse scenario where doctors favour non-treatment but the parents are not willing to condone such a course of action. The first case which needs to be looked at, *Re J (A Minor)(Wardship: Medical Treatment)*,[249] did not involve the scenario described above, yet Lord Donaldson MR stated that:

"No one can dictate the treatment to be given to the child, neither court, parents nor doctors… The doctor can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C… The court or parents for their part can refuse consent to treatment A or B or both, but cannot insist on treatment C."[250]

Whilst this statement was obiter dicta it clearly addressed the question as to whether or not doctors can be forced to provide treatment which, in their judgement, should not be provided.

In another case of the same name[251] this question was the fundamental issue. In that case Lord Donaldson made the following statement:

"I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient."[252]

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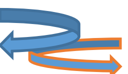
[249] [1990] 3 All ER 930
[250] ibid, at 934
[251] *Re J (A Minor)(Wardship: Medical Treatment)* [1992] 4 All ER 614
[252] ibid, at 622



Both Balcombe LJ[253] and Leggatt LJ[254] supported Lord Donaldson MR on this point, as did Sir Stephen Brown P in *Re C (Medical Treatment)*.[255] This line of cases seems to question the primacy of the guiding principle of allowing treatment. Whilst it could be seen as supporting the principle of doctor protection this is undermined by the way the courts stated that the prime and paramount consideration had to be the best interests of the child.[256] It was also stated, however, that the high respect the courts have for the sanctity of life demands that there be a strong presumption in favour of doing everything possible to preserve life unless the circumstances are exceptional.[257] Hence, it is submitted that the guiding principle operating here is still that of allowing treatment as counteracted by the principle of best interests. Whilst the principle of allowing treatment may not be as strong as originally thought, it remains the starting point of the law.

Conclusion.

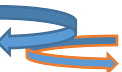
It would appear that when we look at how the law deals with the medical treatment of children the guiding principle which is applied is mainly that of allowing treatment. This may represent the concern that society has for children and the way in which they are seen as the future of humanity. As a society we are very protective of children and a child's death can be seen as a failure to offer sufficient protection. Hence, whilst other guiding principles may operate in a subservient manner, it is that of allowing treatment which takes priority in relation to children. Looking at adolescent autonomy it can be seen that the initial focus was upon the interests and rights of the child. The

[253] ibid, at 625
[254] ibid, at 626
[255] [1998] 1 FLR 384, at 389-390
[256] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 934 and *Re C (Medical Treatment)* [1998] 1 FLR 384, at 390
[257] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 934

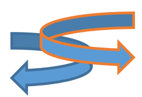
later cases disregarded this though and used adolescent autonomy as a tool through which the number of parties capable of consenting to treatment was increased. The fact that there is no competency to withhold consent to treatment reinforces this idea that it has been redesigned to give effect to the principle of allowing treatment. Once the principle of allowing treatment has been satisfied there is then a highly limited application of the guiding principle of protecting doctors designed to protect the clinical judgment of the doctor only in so far as it supports treatment.

In relation to the incompetent child, it can once more be seen that the ideas and notions involved could superficially represent a pure application of the guiding principle of best interests. Yet, once again, this merely hides the reality of the law. On closer examination it can be seen that allowing treatment is again the starting point for the court. This principle works in conjunction with that of best interests and whilst judicial reasoning appears to place this at the forefront that is not the case. There is a strong presumption in favour of treatment and it is only when the interests of the child are opposed to it to an extreme extent that the principle of best interests will be strong enough to override that of allowing treatment.

The fact that the courts tend to talk in terms of interests and rights can cause confusion as it hides the real motivation, that of allowing treatment. Whilst this motivation is admirable in relation to children, few people would like to hear of children being allowed to die due to parental opposition to medical treatment, it would be less acceptable in relation to adults. Childhood, in general, is seen as a time of learning and growth, yet such learning occurs in a controlled environment such as a school. The law's approach to the treatment of children creates a similar safe environment. Whilst the competent child can learn about how to make such decisions, his



ability to make mistakes is curtailed. Similarly the law protects the child from damage which may unwittingly result from the actions of a well-meaning parent. What is questionable is the constant attempt to hide behind the principle of best interests; whilst this concept has a long established usage it does not represent the legal reality.



MEDICAL TREATMENT OF ADULTS

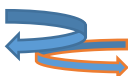
5.2 MEDICAL TREATMENT OF ADULTS

A Comparative Study With Common Law

When considering the medical treatment of adults it is necessary to distinguish between two categories of patient. Firstly there is the competent adult who has the necessary competency or capacity to decide which treatments they desire to receive. The second category of patient shall, at least for the purposes of this thesis, be referred to as the incapacitated patient and covers all patients who are incapable of providing consent to treatment. Whilst the term 'incompetent' is widely used to describe these patients it is submitted that it is too narrow to be accurate. 'Incompetent' implies that the patient lacks the capacity to understand, yet the patient could have a potential to understand that is temporarily suspended due to one of a number of possible reasons, unconsciousness for example.

Unlike in relation to children, society does not actively seek to protect adults from the consequences of their own actions. Much greater importance is placed upon the protection of an adult's freedom to determine what treatment he receives.[258] If the courts were to take a different

[258] It must be accepted, however, that there is no ability to demand treatment which the doctors are not willing to provide, see *Re J (A Minor)(Wardship: Medical Treatment)* [1992] 4 All ER 614



approach to this, in relation to the availability of medical treatment, then it would be necessary to provide some justification for this divergence from the attitudes of society. The way in which the courts approach the question of when doctors can treat competent patients will provide an important insight into how important the freedoms and rights of adults really are, and how far the law is willing to recognise and protect them.

THE COMPETENT ADULT:

The starting point when discussing the medical treatment of competent adults comes from Lord Donaldson's judgment in *Re T (Adult: Refusal of Medical Treatment)*.[259] This case involved a woman who had been brought up as a Jehovah's Witness and, whilst not a practising member of that religion, refused to consent to a blood transfusion. In relation to the right to determine what treatment an adult should receive it was stated that:

"An adult patient who… suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."[3]

This statement makes the importance of consent in relation to the medical treatment of adults clear.[260] Without such consent any form of touching, no matter how minor, will be unlawful and constitute both a criminal offence and a tort.

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[259] [1992] 4 All ER 649 [3]
ibid, at 652-653

[260] The American jurist, Cardozo J, made a statement with similar meaning in *Schloendorff v. Society of New York Hospitals* (1914) 211 NY 125 at 129-130, when he said that: "Every human of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."

The purpose of this section of the thesis is to ask three main questions. Firstly, when will an adult be held to lack the soundness of mind required to make the obtaining of his consent essential to the lawfulness of the treatment? Secondly, are there any limits placed upon what a competent adult can consent to? In essence this is asking whether or not there any treatments for which consent will be insufficient to make them lawful? Finally, are there any areas of treatment where the refusal of a competent patient will not necessarily prevent lawful treatment?

The Test For Competency:

It has already been shown that in relation to patients under the age of 16 the law presumes that they are not competent to give consent. It is then for the child to prove that he possesses the necessary competency. The courts' approach to this demonstrates that the main focus is upon allowing treatment.[261] In relation to adults the situation is practically reversed. The law presumes that adults are competent to consent to treatment[262] and if the doctors desire to treat against the patient's wishes they must show that he lacks the requisite competency. Even if the patient is found to be incompetent there is nobody who can provide consent on his or her behalf. Hence the justification for treatment must come from some other legal principle.[263]

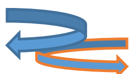
The courts have made it clear that in deciding whether or not an individual patient is competent they are not concerned with the best interests of the patient,[264] rather the sole issue is capacity. This means that the courts should not decide whether or not the patient is competent to refuse

[261] For the child who wishes to oppose treatment it is very hard to show sufficient capacity, and even if they manage to do that there is still no ability to prevent others from authorising the treatment.

[262] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 661

[263] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 552, makes it clear that the *parens patriae* jurisdiction, which used to allow the courts to consent on behalf of the patient, has been revoked.

[264] *B (Adult: Refusal of Medical Treatment), Re* [2002] 2 All ER 449, at 455



treatment based upon whether or not they view treatment as required to fulfil the patient's interests. Capacity may, however, depend upon the procedure involved. Lord Donaldson has stated that the capacity possessed must be commensurate with the gravity of the decision and that the more serious a procedure is the greater the level of capacity that will be required.[265] It could be argued that it is the consequences rather than the procedure itself which are of importance. If this is the case then a minor procedure with serious consequences would require a higher level of capacity than a serious procedure with minor consequences.[266] Skegg states that capacity to give legally effective consent depends upon the capacity to understand and come to a decision and the capacity to communicate that decision.[267] In *Re C (Adult: Refusal of Medical Treatment)*[268] the court attempted to create a definitive test for adult capacity and stated that:

"For the patient offered amputation to save life, there are three stages to the decision: (1) to take in and retain information, (2) to believe it and (3) to weigh that information balancing risks and needs."[13]

Whilst that case involved the refusal of a life saving amputation there is no reason to believe that the test was intended to be limited to that scenario. The need for understanding has been criticized on the basis that it may depend upon the amount of information provided by a doctor who may not want the patient to be found to be competent.[269] Similarly the belief requirement appears to throw great importance upon the clinical judgment of the doctor. If taken to its logical conclusion this would mean that a patient, who doubted the doctor's assertion that the procedure was the only

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[265] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 661

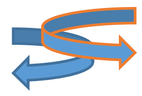
[266] *Re MB (Medical Treatment)* [1997] 2 FLR 426 could be seen as an example of this as the procedure in question was nothing more than an injection but the consequences would have been the inability to carry out a caesarean delivery and the resultant death of the unborn child.

[267] P.D.G. Skegg, *Law, Ethics and Medicine* (Oxford: Clarendon Press, 1984), p.48

[268] [1994] 1 All ER 819 [13]

ibid, at 822

[269] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics* (London: Butterworths, 6th, 2002), p.333



viable option to prevent loss of life, would be incompetent. The approach taken in *Re C*, however, goes some way to moderate this. In that case the patient was a paranoid schizophrenic who doubted the opinion of the doctors and even had delusions that he was, himself, a qualified surgeon. Despite this the court held that the patient had, in 'his own way', believed the information he had been given.[270]

Whilst the *Re C* test was unequivocally accepted in ***Re JT (Adult: Refusal of Medical Treatment),***[271] a case involving a patient who was found to be competent despite mental disabilities and severe learning problems, an adapted version created by the Law Commission[272] was utilised in *Re MB (Medical Treatment)*.[273] Butler-Sloss LJ stated that incapacity occurs when:

" (a) The patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;

(b) The patient is unable to use the information and weigh it in the balance of the process of arriving at the decision."[19]

It can be seen that the requirement that the patient believes what the doctor tells him has been removed. The impact of this will be minimal at most given the lenient way in which it was applied in *Re C*. It is submitted that in order for a patient to lack the required belief he would probably have failed to comprehend the information and retain it. The reference to the patient being 'unable' to comprehend counters the criticism of capacity depending upon what the doctor tells the patient. It is not the same to say that a patient must be able to understand the information and to say that the patient must understand all relevant information, only the latter of these alternatives depends

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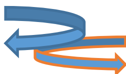
[270] [1994] 1 All ER 819, at 824

[271] [1998] 1 FLR 48

[272] Law Commission, *Mental Incapacity* (London: HMSO, 1995) Law Com No 231

[273] [1997] 2 FLR 426, at 433 [19]
ibid, at 437



upon the communication of information to the patient.[274] Whilst the test for competency is facing reform under the Mental Capacity Bill 2004, it is submitted that the effect of these reforms will be minimal.[275]

Unlike in relation to children, the courts do not seem to take every opportunity to declare that an adult patient is incompetent. *Re C* itself provides an example of this as it is extremely doubtful, due to the delusions, that the patient would have been held to be competent if he had been a child. This could be explained on the basis that when the case reached the court the patient had already begun to recover and the immediate risk of death had been diverted. The same cannot be said of *Re JT* where there was a report that the patient believed that a liver transplant would become available before she died.[276] The chance of this actually happening was slim at best and this had been explained to the patient. Regardless of this continued belief the patient was still held to be competent to withhold consent. This can be contrasted with *Re S (A Minor)(Consent to Medical Treatment)*[277] where a child was held to be incompetent due to the belief that a miracle would save her life. Similarly ***Re W (Adult: Refusal of Treatment)***[278] held that a patient would not be incompetent due to a lack of understanding as to the exact mechanism of his death should he refuse to consent. The opposite approach has been taken in relation to children who must not only

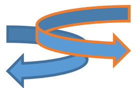
[274] The *Re MB* formulation, which was practically identical to the Law Commission's test, has subsequently been approved as the correct approach in a practice direction, *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2001] 2 FLR 158, at p.159.

[275] Under s.3(1) a patient will be seen as incompetent if they are unable to understand and retain relevant information and then use it as part of the decision making process. This appears to be the exact same test as that applied in *Re MB (Medical Treatment)*. The presumption that patients have the necessary capacity to decide for themselves is maintained under s.3.

[276] [1998] 1 FLR 48, at 50

[277] [1994] 2 FLR 1065

[278] [2002] EWHC 901

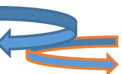


understand that they will die, but also how they will die and the suffering that will be felt by both the patient and their loved ones.[279]

This apparent reluctance to utilise all possible excuses to declare an adult patient incompetent would appear to indicate that in relation to adults we are not concerned with the principle of allowing treatment. Instead the courts are focusing upon the self-determination principle by reinforcing the need for consent unless the patient really does lack the capacity to provide it. This may be the result of the social attitude towards the freedom of adults. Unlike children,
who are viewed as being in need of protection, adults are perceived as having the right to make their own mistakes if they so wish. This freedom is generally only limited when it begins to impact upon the lives of other people.[280]

This approach to protecting the freedom of adults unless their actions impact upon others could be used to explain why the law approaches pregnant women in a different manner. *Re T* suggested that the adult's right to withhold consent to treatment may not apply to pregnant patients.[281] It will be shown later that this was incorrect though and that the foetus has no legal rights until it is born.[282] *Re MB* made it clear that a competent pregnant woman cannot be compelled to undergo treatment even if refusal would result in the death of the foetus.[283] Yet in *Re MB* the patient was

[279] *Re E (A Minor)(Wardship: Medical Treatment)* [1993] 1 FLR 386
[280] Examples of such limits can be seen in the torts of negligence, occupier's liability and nuisance. For such torts it is necessary to show that the claimant has suffered some loss as a result of the actions of the defendant before liability will exist.
[281] [1992] 4 All ER 649, at 653
[282] See below at section 4.3.2 – Legal Protection of the Foetus.
[283] [1997] 2 FLR 426, at 438



held to be incompetent due to a needle phobia which prevented her from undergoing surgery.[284] In this case, however, the woman actually desired that treatment be given but found herself unable to endure the use of needles each time treatment was initiated. Due to this fact the decision reached may seem less controversial than might be initially thought.

In *Re T* a number of reasons were given for holding that the patient lacked the capacity to withhold consent. Amongst these reasons was the fact that she was 34 weeks pregnant and anxious as to the baby's health.[31] This seems to imply that any woman who cares for her baby's health will be incompetent if they attempt to refuse treatment which will benefit the foetus. It must be noted that it was assumed that the woman cared for her child; there was no investigation into this issue. The language of *Re T* places a great deal of importance upon sanctity of life, a principle which supposedly represents the social interest.[285] The effect of these two cases is to create a façade of respect for autonomy behind which the reality of the law seeks to provide treatment so as to protect the foetus from harm. It seems that the courts will willingly view a pregnant patient as incompetent so as to offer that protection despite the fact that the foetus has no rights of its own.

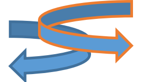
THE EXTENT OF THE POWER OF CONSENT:

The position of the law is that it is consent which makes touching of any form, medical or otherwise, lawful. Cameron states that:

"In general it is necessary before carrying out an operation or any other surgical or medical procedure or even an examination to obtain the consent, expressed or implied, of the person

[284] This case also provides a thorough discussion of a number of other cases, mostly unreported, where pregnant patients were held to be incompetent so that treatment could be authorised, see ibid, at 434-435 [31] [1992] 4 All ER 649, at 660

[285] ibid, at 661



concerned otherwise the practitioner could render himself liable to a claim for damages for assault."[286]

The courts have reaffirmed this point and made it clear that treatment without consent could constitute both a trespass and a crime.[34] An important question is whether or not there are any procedures of a medical nature to which a competent adult cannot provide consent sufficient in itself to render the procedure lawful.

There have been a number of criminal law cases looking at the ability of an adult to consent to a physical assault. In ***Attorney General's Reference (No 6 of 1980)***[287] the court stated that an essential element of the crime of assault was that it was done contrary to the wishes of the victim but that, if public interest demanded it, the existence of consent may not prevent it being a crime.[288] It was then stated that it was not in the public interest to allow the infliction of actual bodily harm for no good reason.[289] In ***R v. Donovan***[290] the court addressed the issue of caning for sexual pleasure. Swift J stated that:

"*If an act is unlawful in the sense of it being in itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it."*[39]

Similarly the courts have held that it is not possible to provide effective consent to homosexual acts of sadomasochism.[291] All of these cases accept that there are certain scenarios that will be

[286] J.A. Cameron, *Medical Negligence: An Introduction* (Edinburgh: Law Society of Scotland, 1983), p.13 [34] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 653

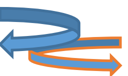
[287] [1981] QB 715

[288] ibid, at 718

[289] ibid, at 719

[290] [1934] 2 KB 498 [39] ibid, at 507

[291] *R v. Brown* [1994] 1 AC 212. Contrast this with *R v. Wilson* [1997] QB 47 where the courts saw no problem in a wife consenting to being branded by her husband, an act they saw as being little different from tattooing.



lawful if consented to. Medical procedures are generally seen as falling within this set of exceptions.

There are, nonetheless, some procedures of a medical nature which may remain unlawful regardless of the presence of consent. Skegg suggests that one such procedure would be an amputation which was not required for medical purposes.[292] This would certainly be caught by the idea that public interest does not favour the infliction of harm for no good reason. Similarly the law prohibits the circumcision of females[42] unless it is carried out for valid medical reasons.[293] Another example of how public interest makes a consensual medical activity unlawful can be found in relation to assisted reproduction and how there are a number of procedures that can never be lawful.[294]

The examples given thus far will, at most, be rare in practice, an example of more practical importance may be found in relation to the treatment of mental disorders. Under the Mental Health Act 1983, some treatments can only be carried out if the consent of the patient is accompanied by the supporting opinions of a registered medical officer as well as two appointed persons, each of whom must have consulted people who have knowledge of the patient's condition.[295] The procedures covered by these provisions are operations aimed at destroying brain tissue, or the functioning thereof,[46] and the surgical implantation of hormones to reduce the male sex drive.[296]

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[292] P.D.G. Skegg, *Law, Ethics and Medicine*, p.38. Skegg also questions whether organ donation can be lawful as it provides the donor with no medical benefit. It is certainly clear that the current position of the law is that such donation will be lawful if consent is given or if it is in the best interests of an incompetent donor. [42] Female Genital Mutilation Act 2003, s.1(1)

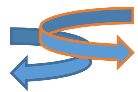
[293] ibid, s.1(2)

[294] Human Fertilisation and Embryology Act 1990, ss.3-4

[295] ss.57(2)-(3) [46]

s.57(1)(a)

[296] Mental Health (Hospital, Guardianship and Consent) Regulations 1983, r.16(1)



The special treatment of these procedures can be justified on the basis that they involve the potential to do a great deal of harm to a patient who may receive little benefit. One of the justifications for the special treatment of the mentally ill patients is that they may pose a risk to the public. It is possible, therefore, to say that the treatment of mental conditions is for the benefit of the public rather than being solely for the benefit of the patient. Despite this, the risk of severe harm to the patient demands greater safeguards than might normally apply. The limits placed upon the ability to consent to treatment seem to suggest that medical procedures should be restricted to those which do some noticeable good.[297] Where such good is lacking, or outweighed by harmful results, their availability is seriously curtailed. This may indicate that where the principle of allowing treatment is applied, which is not the case here, it is limited to treatments designed to improve the health of the patient.

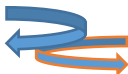
THE ABILITY TO REFUSE TREATMENT:

Competent adult patients are usually seen as being free to refuse medical treatment as they see fit. The adult's right to refuse treatment extends, at least in theory, to cover situations where death is a likely, or even certain, consequence of that refusal.[298] This ability to refuse treatment exists regardless of whether or not the decision is based upon rational reasons, irrational reasons, or is devoid of any reasons whatsoever.[299] Lord Donaldson has stated that:

[297] Lord Keith has stated that "the object of medical treatment and care is to benefit the patient", see *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 860

[298] The reality of this ability to refuse life saving treatment will be more fully considered in the Chapter 5.

[299] This is preserved under s.1(4) of the Mental Capacity Bill 2004 which refers to such decisions as 'unwise' decisions.



"*This right of choice is not limited to decisions which others might regard as sensible. It exists not withstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.*"[300]

There is no ability to disregard the refusal of a competent patient on the basis that it lacks logic unless it is so extreme as to demonstrate that the patient lacks the capacity to understand the information provided. In relation to this, Kennedy and Grubb claim that it is possible to differentiate between a religious belief, such as the Jehovah's Witness' approach to blood transfusions, and the belief that blood is a poison because it is red in colour. This distinction is made on the basis that the latter belief could be demonstrated to be indisputably incorrect.[301] In ***X NHS Trust v. Ms T***,[302] Charles J referred to the distinction suggested by Kennedy and Grubb and went on to hold that the patient, who had refused blood transfusions due to a belief that her blood was evil and would contaminate any new blood given to her, was incompetent due to that belief.

Re T (Adult: Refusal to Medical Treatment)[303] can be seen as providing three 'get-outs' through which the court may disregard the competent patient's refusal of consent to treatment. The first of these has already been looked at and questions the capacity of the patient to make the decision. The second option is to claim that there has been some undue influence placed upon the patient and that this has overridden his ability to make a decision. It does not matter how strong the influence is, what is important is the impact it has upon the patient's ability to come to his own

[300] *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649, at 653
[301] I. Kennedy & A. Grubb, *Medical Law* (London: Butterworths, 3rd, 2000), p.626. The problem with the suggested distinction is that it ignores the fact that for many people the existence of a God, and therefore the whole basis of religious beliefs, can also be demonstrated to be incorrect.
[302] [2004] EWCH 1279
[303] [1992] 4 All ER 649

decision.[304] In effect the question is whether the decision is really the patient's, albeit influenced by others, or if it is a decision which has been forced upon the patient by someone else. Finally the court may decide that the scope and basis of the refusal of consent is such that it was never intended to cover the situation in question.[56] It should be pointed out that this is not the same as assumed consent.[305] The idea of assumed consent would allow a doctor to decide that had the patient known the situation in question would arise they would have consented.

Just as there are some procedures that can never be effectively consented to, there are some for which even the competent adult will not be able to withhold consent. One example of such procedures is the treatment of contagious diseases. Under the Public Health (Control of Diseases) Act 1984 it is possible to order a person who is suffering from one of a number of 'notifiable' diseases, including cholera, typhus and smallpox,[306] to receive a medical examination if it is in the interests of the patient, the patient's family or the general public.[307] It is also possible to force the patient to enter hospital if the existing circumstances prevent proper care from being taken and there is a serious risk of others becoming infected.[308] Brazier and Harris point out that the result of this is that the patient loses any effective choice in relation to treatment, liberty and privacy due to the fact that the legislation overrides practically all individual liberties.[309] Under the Act it also

[304] ibid, at 662 [56]
ibid

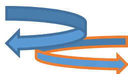
[305] This option was expressly ruled out despite the contrary suggestion in *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129, at 134. What the court decides is that the refusal does not apply and the patient must then be approached in the same manner as any other patient who is not capable of either giving or withholding consent.

[306] The full list of notifiable diseases is set down in s.10 and in the Public Health (Infectious Diseases) Regulations 1998, r.3 and sched.1

[307] s.35

[308] s.37

[309] M. Brazier & J. Harris, 'Public Health and Private Lives' (1996) 4 Med L Rev 171, p.175



becomes an offence to knowingly expose others to the possibility of infection with a 'notifiable' disease.[310] Brazier and Harris argue that this is justified as there is no real reason to treat the deliberate or reckless infection of others with such diseases differently to the deliberate infliction of violence upon others when the consequences can be just as harmful, if not more so.[311]

Two more examples can be found in the treatment of mental conditions.[312] Under the Mental Health Act 1983, s.58, any administration of medicine lasting longer than three months, or the administration of ECT[313], requires either the patient's consent or the supporting opinion of an appointed registered medical officer.[314] The officer can either certify that the patient is incompetent and cannot therefore give consent, or that the patient is competent and has refused consent but should be treated regardless of such refusal. By providing another source of consent which can override a patient's refusal the law makes that refusal pointless as it cannot prevent treatment. In emergency scenarios these special requirements are removed, similarly the requirements of s.57 explained above are also removed, and it becomes even easier to treat without the consent of the patient in question.[315]

[310] s.17

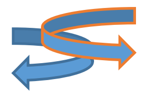
[311] M. Brazier & J. Harris, 'Public Health and Private Lives', p.177

[312] Mental Health Law is facing reform under the Draft Mental Health Bill 2004. Whilst the proposed reforms will remove the distinction between detained and informal patients, so far as the ability to treat is concerned, it has been argued that informal patients are already subject to a number of pressures which counteract their right to withhold treatment and places them in the same position as detained patients. See P. Bartlett & R. Sandland, *Mental Health Law: Policy and Practice*, p.343

[313] The application of s.58 is extended to cover ECT by the Mental Health (Hospital, Guardianship and Consent) Regulations 1983, r.16(2)

[314] The use of special safeguards for certain treatments such as ECT is preserved under the Draft Mental Health Bill 2004, Part 5.

[315] s.62



Furthermore, in relation to detained patients[316] there is also a general ability to provide treatment to the patient without their consent. Under s.63 the responsible medical officer may authorise any treatment not covered by the special requirements already set out so long as it is a treatment of the mental condition for which the patient has been detained.[317] Whilst this may seem to be quite a narrow power of compulsory treatment the courts have consistently interpreted it in a broad manner and given the doctors greater freedom to treat without consent than might be initially thought. It should be noted that the definition of treatment under the Mental Health Act 1983 is quite broad and includes nursing, care, habilitation and rehabilitation.[318] The courts have taken this even wider though and included procedures such as force-feeding,[319] seclusion[320] and even detainment[321] so long as it can be described as preventing the condition from deteriorating. In ***B v. Croydon Health Authority*** it was stated that the definition of treatment was wide enough to include a range of acts ancillary to the core treatment of the disorder.[322]

[316] Under the Mental Health Act 1983, s.3 a patient can be admitted to hospital for treatment if he suffers one of a number of mental conditions of a degree or nature that make treatment appropriate. The treatment must, generally, provide hope of either alleviating the condition or preventing it from deteriorating further. It is also a requirement that admission is necessary for the patient's safety or health, or the safety of others, and that treatment would not be provided without the patient being detained.

[317] The Draft Mental Health Bill 2004, s.4, creates a Mental Health Tribunal and proposes a whole new scheme for governing the availability of such treatments. Under s.14 the first stage is that the Secretary of State will be requested to determine whether or not a patient should be examined. In order for a patient to be liable for examination he must satisfy a number of conditions laid out in s.9: 1) he must be suffering from a mental disorder which is of a degree or nature that warrants treatment, 2) there must be appropriate treatment available which is necessary to protect either the patient or others and, 3) unless the risk posed to others is serious, there must be no possibility of treatment apart from under the Bill. If an examination is ordered then, under s.15, it must determine that the same conditions have been satisfied and whether or not detainment is necessary. According to s.16 this will make the patient liable for assessment as either a resident patient or a non-resident patient. Under s.25 the assessment must once again determine whether the conditions are satisfied and what treatment is necessary or whether further assessment is needed. An application to the Tribunal must be made under s.35 in order to authorise treatment or further assessment.

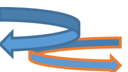
[318] s.145(1)

[319] *B v. Croydon Health Authority* [1995] 1 All ER 683

[320] *R (on the application of Colonel Munjaz) v. Ashworth Hospital Authority* [2002] EWHC 1521

[321] *Reid v. Secretary of State for Scotland* [1999] 2 AC 512

[322] [1995] 1 All ER 683, at 687



The courts have also interpreted the need for the treatment to be aimed at the specific mental disorder for which the patient has been detained in a broader manner than might be expected. In ***R (On the Application of B) v. Ashworth Hospital Authority*,**[323] Dyson LJ seemed to limit this expansion by making it clear that the ability to provide treatment under s.63 only extended to treatment of the condition for which the patient was liable to be detained. At the same time though it was decided that if the treatment of another condition could be seen as necessary for the proper treatment of the condition for which the patient was detained then the treatment would be available.[76] Hence, if a patient can be detained for the treatment of condition A, but the treatment of condition B will help that of A, then no consent will be required for the treatment. ***B v. Croydon Health Authority*** stated that alleviating the symptoms of the condition is as much a part of the treatment as relieving the underlying cause. [324] In this case a refusal to eat was classified as a symptom of the mental condition so force-feeding was seen as treatment available under the act. Again this can be seen as making it easier to treat a patient who refuses consent to treatment.

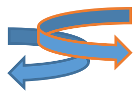
In ***Tameside and Glossop Acute Services Trust v. CH***[325] the court allowed a non-consensual caesarean section to be classed as treatment of the mental condition. The justifications for this were that an ancillary reason for the procedure was to prevent deterioration in mental health, that it was necessary to allow proper treatment of the mental condition and that necessary medication could not be administered during the pregnancy.[326] It has been argued that as the court in the case was provided with only two alternatives, namely an adult suffering from a mental condition and a

[323] [2003] 4 All ER 319 [76] ibid, at 333

[324] [1995] 1 All ER 683, at 688. This is also supported by *Re KB (Adult)(Mental Patient: Medical Treatment)* (1994) 19 BMLR 144

[325] [1996] 1 FLR 762

[326] ibid, at 773



dead baby, or a healthy mother caring for a healthy child, it is hardly surprising that they permitted the treatment.[327] This seems to ignore the fact that the court could, if they had wished to do so, have simply held that the patient was incompetent and declared the treatment lawful without the need for any recourse to the Mental Health Act 1983. This judgment has the effect of deliberately widening the range of procedures covered by s.63. Not only will acts ancillary to the core treatment be available, but so will treatments for which the mental condition is only an ancillary concern and the real purpose is wholly unrelated to the mental condition for which the patient is liable to be detained.

Whilst the proposed reforms of Mental Health law represent a whole new method of providing treatment for mental disorders, the effect upon the ability to treat is less than might initially be thought. There is no reason to believe that the new definition of treatment[328] will be interpreted to be narrower than that provided under the existing legislation. Further to that, the basis for the ability to treat without consent is still the risk of harm to the patient or others. Similarly there are still restrictions placed upon those treatments which can be seen as causing more harm than good. Hewitt argues that a consolidation of the case law would probably achieve the same end result as the suggested reforms[329] and it is submitted that this assertion is correct. The shared element of contagious diseases and compulsory treatment of mental health patients is the perceived threat posed to people other than the patient. This is also seen in the approach taken in relation to the competency of pregnant women: if the foetus is threatened it becomes more likely that capacity

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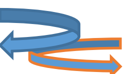
[327] P. Bartlett & R. Sandland, *Mental Health Law: Policy and Practice* (Oxford: Oxford University Press, 2nd, 2003), p.355

[328] Draft Mental Health Bill 2004, s.2(7)

[329] D. Hewitt, 'Between Necessity and Chance' (2004) 154 NLJ 584, p.585



will be lacking. It would appear therefore that whilst the principle of self-determination is generally applied in relation to competent adults, underlying this there is a desire to protect people from harm. So long as the patient is the only person who is affected by the decision as to whether or not to accept treatment the law will not intervene. However, the law tries to prevent such choices harming, or adversely affecting, others who have no choice in the matter.[330] In relation to the extent of the ability to consent this is demonstrated in the limits upon what can be consented to. In relation to the ability to refuse consent it can be seen in an application of the principle of allowing treatment when the failure to do so may cause harm to others. Whilst a patient will generally be allowed to harm himself by refusing treatment, the law will not allow the infliction of such harm upon others, nor will it allow the use of treatments which can provide no benefit to the patient.

THE INCAPACITATED ADULT:

The traditional method, adopted by most academic authorities, of approaching the issues raised in relation to patients who are incapable of giving consent is to separate them into two distinct groups. The first group covers those patients who are usually competent but are, for some reason or other, incapacitated at the time when the need for consent to be obtained arises. A typical example of such a patient would be a victim of a traffic accident who may be incompetent because of the accident and therefore unable to consent to any treatment that is required as a result of that accident. Alternatively the incompetency could be induced through the abuse of alcohol or drugs, or even due to excessive fear on the part of the patient. In relation to such patients the need for emergency

[330] Whilst it would be possible to argue that relatives are always subject to adverse emotional effects the law will not view these as sufficient to justify an overriding of the wishes and freedoms of the patient who wishes to refuse treatment.

treatments can cause problems as there is nobody to authorise such treatments on the patient's behalf. The second group would cover people who can be described as long-term incapacitated patients. Such patients include those with learning difficulties that prevent the sufficient level of competency ever being achieved. In essence these patients are those who would persistently fail to meet the competency tests set out above. It is worth remembering, however, that a patient could be competent in relation to one form of treatment yet incompetent in relation to another form.

An alternative, and more workable, method of viewing incapacitated patients is in the form of a continuous scale. At the one extreme there is the fully competent adult patient who has the absolute right to refuse or accept treatment. At the opposite end of the scale you find the patient in a persistent vegetative state and the long-term unconscious patient, who are not only incapable of giving effective consent but cannot even express their wishes and desires relating to treatment. Between these two extremes there can be found a wide variety of patients of varying abilities to understand the proposed treatment and provide consent.[331] If it is possible to look at the patients concerned with involuntary treatment as belonging to a continuous scale then it may also be possible to view the way the law treats such patients as a scale. It would certainly be true to say that there is no suggestion that doctors should be able to provide all treatments that can be seen as being in the interests of a short-term incapacitated patient[332] but that a wider range of treatments must be made available as the length of incapacity increases.[333] The advantage of this is that it allows the law to be seen as a whole rather than attempting to fit individual patients into fixed

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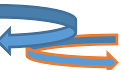
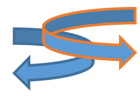
[332] P.D.G. Skegg, *Law, Ethics and Medicine*, p.101
[333] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 566



categories. It also accepts that such categorisation is extremely difficult given the fact that, in practice, doctors are faced with a range of scenarios, each slightly different to the other, rather than a finite set of distinct possibilities.

It is necessary at this point in the thesis to identify the broad types of patient that will need to be dealt with in relation to the treatment of incapacitated patients. A number of these patient types have already been indicated in the above discussion, yet it is useful to mention them again for reasons of clarity. The first type of patient in the spectrum of incapacity is the adult with reduced capacity. The lack of capacity could occur for any number of reasons, including a temporary loss of ability through the influence of some chemical substance. Depending upon the level of capacity required for the procedure in question this reduced capacity may become a temporary incompetence which will render the patient unable to give effective consent. The second type of patient that will be encountered will be the short-term unconscious adult. It is possible to liken this patient to the temporarily incompetent as there is the almost certain prospect of capacity returning some time in the not too distant future and this may impact upon what treatment will be available whilst the incapacity exists. The third type of patient will cover those suffering from mental conditions. Whilst the existence of a mental condition will not necessarily mean that the patient will lack capacity to decide what treatment to accept, such incapacity may be one result of that condition.[334] The fourth type of patient is the permanently incompetent who, unlike the temporary incompetent, has no realistic hope of capacity returning, or developing, and this will impact upon the ability to treat. Finally, the fifth type are patients who are either in a persistent

[334] P.D.G. Skegg, *Law, Ethics and Medicine*, p.56



vegetative state or are in a long-term unconscious condition. Such patients will be totally incapable of expressing their desires and opinions, let alone providing legally effective consent.

Treating The Incapacitated Patient:

It is important to make it clear at the outset, that this section of the discussion is only concerned with the treatment of physical conditions. When it comes to mental conditions the capacity of the patient has little, if any, effect upon the law. If the requirements of the English Mental Health Act (1983[335] are satisfied then the incapacitated patient suffering from a mental condition will be treated, for that condition, in the same way as the competent adult with the same condition. It is in relation to the treatment of physical conditions that the approach to treatment may differ depending upon capacity. It has already been shown, however, that the way the courts interpret the provisions of the Mental Health Act 1983 of England result in a very wide application of the ability to treat without consent. It is therefore possible that some physical treatments will be brought within the scope of the treatment of mental conditions. This section will ignore this possibility and focus purely upon the common law ability to provide treatment of physical conditions when the patient lacks the capacity to provide consent.

In relation to short-term incapacitated patients, especially those who are unconscious, there is a distinct lack of English case law. Despite this Lord Brandon has confidently stated that:

"The common law would be seriously defective if it failed to provide a solution to the problem to such an inability to consent. In my opinion, however, the common law does not fail."[336]

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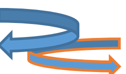
[335] Namely that the patient poses a risk to himself or to others. If this is not the case then the principles which apply will be the same as those relating to all other forms of treatment not caught by the Mental Health Act 1983 as discussed below.

[336] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 551 [90]
[1933] 3 DLR 260



It is possible to refer to two Canadian cases which probably represent the approach the English courts would take in similar situations. In ***Marshall v. Curry***[90] the patient was undergoing a consensual hernia operation. Whilst the patient was unconscious the surgeon decided that it was necessary to remove one of the patient's testicles. The question was whether or not the surgeon had been justified in carrying out this procedure despite the fact that no consent had been given. The court reinforced the principle that consent should always be obtained prior to treatment and stated that consent should not be implied in such scenarios.[337] It was suggested to the court that it was possible to see the doctor as the representative of the patient and that because of this he had the authority to consent on the behalf of the patient. Chisholm CJ rejected this proposition, stating:

"*I think it is better, instead of reverting to a fiction, to put consent altogether out of the case, where a great emergency which could not be anticipated arises, and to rule that it is the surgeon's duty to act in order to save the life or preserve the health of the patient… Is it not better to decide boldly that apart from any consent the conditions discovered make it imperative on the part of the surgeon to operate.*"[338]

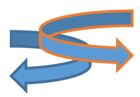
The court held that in this case the surgeon's actions had been justified due to the essential need to proceed with the treatment and the fact that it would have been unreasonable to postpone until consent could be obtained.

In ***Murray v. McMurchy***[339] the Canadian courts were confronted with a patient who had undergone a caesarean operation to deliver her child. During the caesarean procedure the walls of the uterus were found to contain a number of tumours. Due to this the surgeon tied the fallopian tubes to

[337] ibid, at 274

[338] ibid, at 278

[339] [1949] 2 DLR 442. The case of *Devi v. West Midlands Regional Health Authority* [1980] CLY 687 provides an English Equivalent of this Canadian case where the same result was reached



prevent the hazards of future pregnancies. Looking at the question of whether the surgeon possessed the necessary authority MacFarlane J stated that:

"If it were necessary in the sense that it would be, in the circumstances, unreasonable to postpone the operation until a later date, I would say that… the surgeon would have that authority… There are times under circumstances of emergency when doctors must exercise their professional skill and ability without the consent that is required in the ordinary case."[340]

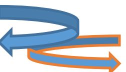
In this case the court held that the surgeon had not been justified in proceeding without the patient's consent. Whilst it was accepted that any future attempts at conceiving a child would be subject to increased risks it was made clear that this was not a situation where there was a necessity for an immediate decision.[341] A similar English case, ***Williamson v. East London and City Health Authority***,[342] involved a doctor who, whilst replacing a leaking breast implant, discovered lumps and performed a mastectomy. It was held that whilst the procedure was necessary, consent should have been obtained. In *Marshall* the testicle was diseased and dangerous to the patient's health. The same cannot be said of *Murray* or *Williamson* where the risks for the patients involved were not immediate. Rather the patients could be informed of the risks involved and given the opportunity to consent to the procedures being performed at a later date.

The approach developed in the above cases is known as the doctrine of necessity and has been applied to a broader range of incapacitated patients than those with which the initial cases were concerned. A great deal of focus has been placed upon the idea that the postponement of treatment must be unreasonable. Skegg states that this is a preferable approach to simply saying that the

[340] ibid, at 444

[341] ibid, at 454. It is interesting to note that the existence of future risks was accepted despite there being medical doubts as to the surgeon's diagnosis.

[342] (1998) 41 BMLR 85



need for consent can be disregarded whenever it is necessary to do so.[343] It is submitted that, in relation to short-term incompetents, in order for it to be unreasonable to postpone there must be an immediate need for treatment. Both Canadian judges went to some length to explain that the ability to proceed without consent was an exception to the normal position. This exception was justified because of the immediate necessity of the procedure. In *Marshall v. Curry* the judge referred to the need for the procedure to be carried out as being imperative.[344] In ***Murray v. McMurchy*** the justifying situation was described as being one of emergency.[345] The need for an emergency scenario under English law was confirmed by Lord Goff, in ***F v. West Berkshire Health Authority*****,**[346] who stated that in the case of a person of sound mind there would ordinarily have to be such an emergency before the doctrine of necessity would authorise an action which would otherwise be unlawful.[347] The result of this focus upon the need for an emergency is that the guiding principle of self-determination remains foremost despite the fact that the patient cannot provide the consent required to protect his autonomy. By insisting upon the need for an emergency the courts have ensured that the patient's right to self-determination is protected so long as there is no immediate risk. This is further supported by the fact that necessity cannot authorise a treatment to which the patient is known to be opposed, or one which goes beyond that required before the patient recovers his capacity to decide.[348]

In ***F v. West Berkshire Health Authority*** the House of Lords applied the doctrine of necessity to a long-term incompetent. The patient in question was a 36-year-old woman suffering from severe

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[343] P.D.G. Skegg, *Law, Ethics and Medicine*, p.104
[344] [1933] 3 DLR 260, at 278
[345] [1949] 2 DLR 442, at 444
[346] [1989] 2 All ER 545
[347] ibid, at 565
[348] ibid, at 566

mental disabilities, which meant she had a mental age of between four and five. Medical staff wanted to sterilise the patient as she had entered into a sexual relationship and it was thought that any resultant pregnancy would have a disastrous effect upon her condition.

Lord Brandon said:

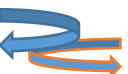
"In my opinion, the solution to the problem which the common law provides is that a doctor can lawfully operate on, or give treatment to, adult patients who are incapable, for one reason or another, of consenting to his doing so, provided that the operation or other treatment concerned is in [their] best interests."[349]

Whilst this statement was made in relation to the treatment of all incapacitated patients it has already been shown that in relation to the short term incapacitated adult there needs to be some form of emergency. In relation to more long-term incompetents there is no such requirement. Lord Goff made this clear when he stated that:

"*In the case of a mentally disordered person, as in the case of a stroke victim, the permanent state of affairs calls for a wider range of care than may be requisite in an emergency which arises from accidental injury."*[350]

Lord Goff also stated that where the state of affairs giving rise to the incapacity is permanent or semi-permanent there is no point in waiting for the patient to recover so that consent can be obtained.[351] The effect of this is that as the length of the incompetency increases it becomes ever easier to justify the treatment in question and the requirement that there must be an urgent need

[349] ibid, at 551
[350] ibid, at 566
[351] ibid, at 567



for treatment is reduced. Consequently, the longer a patient is likely to be incompetent the closer we get to allowing any treatment that is in the interests of the patient.[352]

This application of the doctrine of necessity, and the increased importance of best interests, to long-term incompetents was reinforced in ***Tameside and Glossop Acute Services Trust v. CH***.[107] In that case Wall J stated that where a patient is incapable of making a rational decision about the suggested treatment the law must ensure that the patient's interests are protected.[353] It is important to note the shift away from referring to the patient's rights. Here we are not concerned with the right of the patient not to be treated without his consent. Rather we are looking at what will provide the most benefit to the patient. Whilst this may

take into account what the patient desires it has already been shown, in relation to children, that this will not be determinative. Wall J then stated that where the patient could not communicate a decision then treatment would be lawful so long as it was:

"(a) Necessary to save the life or preserve or prevent a deterioration in the physical or mental health of the patient, and

(b) In the patient's best interests."[354]

[352] Under the Mental Capacity Bill 2004, s.1(5), all patients who lack capacity will be treated according to their best interests. Whilst this may appear to undermine the argument presented in this thesis it is submitted that this is not the case. According to s.4, the possibility of regaining capacity remains important, as do the ascertainable wishes of the patient. The result of this is that there is no reason to believe that the approach taken by the courts will be different, to any real extent, to that currently adopted. Whilst the terminology used by the courts may differ, with necessity being used less frequently, the outcomes will probably be the same. [107] [1996] 1 FLR 762

[353] ibid, at 768

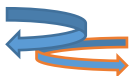
[354] ibid, at 679

The increased focus upon best interests in relation to long-term incompetent patients appears to reflect the approach taken by the courts in relation to the treatment of minors. In support of this Butler-Sloss has stated that:

"In considering the scope of best interests it seems to us that they have to be treated on similar principles to the welfare of the child since the court and the doctor are concerned with a person unable to make the necessary decision for himself."[355]

In the previous chapter, however, it was argued that whilst the courts talk about best interests in relation to children they are actually applying the principle of allowing treatment. A similar approach for adults can be seen in ***Airedale NHS Trust v. Bland***[356] when Lord Goff stated that in relation to treatments which will prolong the life of the patient the best interests will usually require that treatment be given.[357] It is possible therefore to argue that the approach of the courts in relation to adult incompetents begins by focusing upon the principle of self-determination but moves through best interests and towards allowing treatment as the length of incompetency increases. This could be justified on the basis that the longer the patient is incompetent the less important it is to respect his right to autonomy and freedom of choice. For a patient who has no mental ability to make decisions there can be no real need to respect his right to make those decisions. An alternative justification would be that as the patient approaches a permanent state of incapacity he becomes, in terms of mental ability, more like a child and, therefore, the law treats him in a similar manner.

[355] *Re MB (Medical Treatment)* [1997] 2 FLR 426
[356] [1993] 1 All ER 821
[357] ibid, at 868



One important issue that remains to be discussed is the ability to provide non-therapeutic treatments. The majority of cases dealing with incompetent adults involve the use of sterilisation for non-therapeutic purposes. The Canadian court, in ***Re Eve***,[358] indicated that such procedures could never be lawful without the consent of the patient. La Forest J said that:

"The grave intrusion into a person's rights and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can be gained from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person."[114]

The English courts have rejected this extreme approach though and have accepted that in certain circumstances the procedure can be in the interests of the patient and would therefore be lawful.[359] Heilbron J, however, suggested that sterilisation should be the last option and that other procedures, including abortion, would be preferable.[360] This provides further support for the idea that the principle of allowing treatment does not authorise treatments which can be seen as doing more harm than good. This can be seen in the way that the courts are prepared to leave the decision of whether or not to provide a therapeutic sterilisation in the hands of the medical profession.[361] Conversely, they have stated that in relation to nontherapeutic treatments the courts should always be consulted.[362]

[358] (1986) 31 DLR (4th) 1 [114] ibid, at 32

[359] For examples of cases where treatment was deemed to be lawful see; *Re B (A Minor)(Wardship: Sterilisation)* [1987] 2 All ER 206, *Re D (A Minor)(Wardship: Sterilisation)* [1976] 1 All ER 326, *Re M (A Minor)(Wardship: Sterilisation)* [1989] 1 FLR 182, *Re P (A Minor)(Wardship: Sterilisation)* [1988] 2 FLR 497. Whilst these cases all relate to minors the principles of law are the same for adult patients

[360] *Re D (A Minor)(Wardship: Sterilisation)* [1976] 1 All ER 326, at 334. This need to look at the availability of less restrictive treatment options is maintained under s. 1(6) of the Mental Capacity Bill 2004.

[361] *Re GF (Medical Treatment)* [1992] 1 FLR 293, at 295

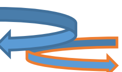
[362] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 551-552

The link between the approach taken to the treatment of adults and children has already been identified. In relation to children it was submitted that the application of the principle of allowing treatment gave way to the principle of best interests in extreme circumstances. It is submitted that the same applies to adults and that non-therapeutic treatments constitute one of the extreme scenarios where it is possible for best interests to indicate that treatment should not be carried out. It is possible to see *Re A (Male Sterilisation)*[363] as an example of this. The patient involved was a 28-year-old Down's syndrome sufferer whose mother was worried that he might impregnate somebody. Whilst the court accepted that concern for the welfare of the girls who may become pregnant was admirable[364] they declared that the treatment would be unlawful. The basis for this declaration was that the treatment in question carried no obvious benefit for the patient. The court rightly pointed out that for men there are no direct physical consequences from sexual activity that could be prevented by way of sterilisation.[365]

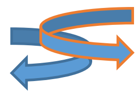
Conclusion.

It is possible to view the ability to treat adult patients as a scale based upon the capacity of the patient in question.[366] In relation to an adult with full capacity the guiding principle of self-determination applies. This is represented by the need for the consent of the patient in order for treatment to be lawful. The ability of the patient to consent to treatment is limited only by the idea that treatment must provide the patient with some benefit. A refusal of consent will be determinative unless there is a risk of harm being caused to others in which case the principle of

[363] [2000] 1 FLR 549
[364] ibid, at 556
[365] ibid, at 557
[366] Figure 3 in Appendix A provides a representation of this scale.



allowing treatment will be the law recognizes that there must be some ability to make treatment available without consent and the focus of the law moves towards an application of the guiding principle of allowing treatment. For the short-term incompetent there is recognition that the condition is temporary and therefore an emergency is required to override the need for consent. In relation to the permanent incompetent the ability to treat is almost absolute and becomes the same as for children. This results in an application of the principle of allowing treatment with the notion of best interests acting to prevent treatment in extreme cases.



HUMAN RIGHTS SITUATIONS IN MEDICAL PRACTICE

5.3 HUMAN RIGHTS SITUATIONS IN MEDICAL PRACTICE

Rights:

Heavily linked to the moral debates central to many of the issues relevant to the availability of treatment are rights based arguments. The link between morality and rights is shown by Feldman when he states that a commitment to any right must be based upon a belief about the range of aspirations which it is proper or desirable for people to pursue.[367] In modern society the patient is more aware than ever before of the rights that they have and they are thus more likely to invoke rights based arguments.[368] Whilst the courts do not always give judgments in terms of rights, essentially it is rights that are being dealt with.[369] An example of this is *Re T (A Minor) (Wardship: Medical Treatment)*.[370] Whilst the judgment was phrased in terms of the child's interests and the practicalities of post-operative care, it could just as easily be seen as looking at the child's right to treatment when conflicting with the parent's right to determine what treatment the child should receive. Hence the importance of rights to this discussion cannot be denied and any attempt to look at medical law without looking at the rights involved would be fundamentally flawed. For one to obtain a remedy in law, they must first of all possess a right as the Latin maxim goes that; "*Ubi jus ibi remedium.*" A right is a legal entitlement, a benefit/ privilege recognized by law. It is an entitlement to something, whether to concepts like justice and due process or to ownership of property or some interest in property, real or personal[371]. For example, a person has a right to institute and withdraw a case and a right to legal representation which includes a state afforded lawyer in criminal capital offences as visible in ***Kwoyelo v. Uganda Communication***[372] where a party was availed with a legal representation at state expense but he declined the offer/right.

[367] D. Feldman, *Civil Liberties and Human Rights in England and Wales* (Oxford: Oxford University Press, 2nd, 2002), p.6

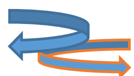
[368] S.A.M. McLean, *A Patient's Right to Know*, p.4

[369] ibid, p.84

[370] [1997] 1 All ER 906

[371] https://dictionary.law.com accessed on 24th Dec, 2021

[372] 431/12 [2018] ACHPR 129



Whilst a person need not be autonomous in order to have rights worthy of protection by the law[373] it is certainly true to say, at least in relation to medical law, that the rights we have are intended to protect the dignity and autonomy of ;human beings. Yet autonomy and dignity are not clearly defined terms and can contradict each other.[374] Whilst dignity can exist on a number of levels,[375] different authors use autonomy to refer to different things.[376] The same is true of the notion of rights itself which Feldman divides into five categories: Liberty, Liberties, Civil Liberties, Fundamental Liberties and Human Rights.[377] This classification set is only one of many suggested ways of grouping the interests covered in relation to rights.

Halpin states:

"*One can find 'right' being used to signify some position of benefit or advantage that has been determined as applying to a particular individual, but one can also find it employed to signify a claim to such a position that has yet to be determined, and even to signify a claim for such a position that has failed to be established.*"[378]

Throughout this discussion such arguments in favour of disputed rights will be encountered. For example, does a woman have the right to have a baby and if so what treatment must the medical profession offer to assist in the fulfilment of that right? Perhaps the most hotly debated issue that will be encountered is the suggestion that there is a right to die entailed in the accepted right to life. This issue is at the heart of the euthanasia debate and the subject cannot be discussed without its acknowledgement.[379] There are also the contentious issues of fetal and paternal rights in relation to pregnancy and abortion. One of the main tasks the law must undertake is the clarifying of such issues in order that people may be more fully aware of what rights they have.

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[373] M. Minow, *Interpreting Rights* (1987) 96 Yale Law Journal 1860, p.1885

[374] This would be the case where a dignified death relied upon the use of pain control methods which the patient was opposed to. In such instances autonomy will probably be seen, by society at least, as more important than dignity.

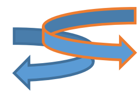
[375] D. Feldman, *Civil Liberties and Human Rights in England and Wales*, p.125. The suggested levels are; the dignity of the species as a whole, the dignity of groups within the species, and the dignity of individuals.

[376] G. Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), p.5. Whilst some authors see it as the ability to decide for-oneself without any constraints, others, including Dworkin, accept that this is unrealistic and argue that what is needed is freedom to rule oneself according to moral and social rules.

[377] D. Feldman, *Civil Liberties and Human Rights in England and Wales*, pp.3-5

[378] A. Halpin, *Rights & Law Analysis & Theory* (Oxford: Hart Publishing, 1997), p.3

[379] Adam Peter Bunting- LLM (University of Birmingham)- Guiding Principles In Medical Law: The Ability To Treat- pg. 4



Court remedies

Malpractice litigation leads to awards of remedies which are civil and criminal in nature. Civil awards are monetary compensation- damages and criminal law punishments may also awarded to punish the offender.

Compensation.

Claim for damages is based on the principle that if a person has committed a civil wrong, he must pay compensation by way of damages to the person wronged. A plaintiff[380] who has suffered injury is entitled to damages for pain and suffering and loss of expectation. [75] The general objective for the award of damages is to compensate the plaintiff for the losses, by either awarding pecuniary and non-pecuniary damages as compensation for the defendant's tort. More specifically, the assessment process is said to aim firstly at restitution, punitive and deterrent respectively.

The general principle as derived from the words of Lord Blackburn[381] in **Livingstone Vs Rawyards Coal Co.** *"that the sum of money which will put the party who has been injured or who has suffered in the same position as he would have been in if he had not sustained the wrong for he is now getting his compensation or reparation".*

In cases of personal injury, the concept of restitution is clearly inappropriate since the principles apply to losses which are capable of reasonably precise calculation in monetary terms.[382] Compensation in cases of personal injuries is understood in a sense of providing the plaintiff with some solace for his or her misfortune.[383] As such the guiding principle can be expressed only in such vague terms as awarding what is "fair" and "proper".

Categories Of Damages.

Special damages; are particular damages which results from specific circumstances of the case and of the plaintiff's claim to be compensated for, which the plaintiff ought to plead for them in his pleadings so as not to raise surprise claims at the trial.[384] Hence special damages must be specifically pleaded and proved. They must be explicitly claimed on the pleadings and at the trial, it must be proved by evidence both that the loss incurred and that it was the direct result of the defendant's conduct. [385] Matters pertaining to hospitalization, treatment and management, the need for further medical care, the disabilities, and pecuniary losses (past and future) are special damages

[380] Black's Law Dictionary defines a plaintiff to mean a party who brings a civil suit in a court of law. Page 1188 [75] Winfield and Jolowiz on Tort 11th Edition at page 600

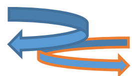
[381] (1880) 5 App. CAS 25,29

[382] Clerk and Lindsell on Tort,16th Edition at pg

[383] Per Harman L.J in Warren Vs. King (1964)1 WLR 10

[384] Supra FN. 63 at page 253

[385] Joseph Musoke Vs Departed Asian Property Custodian Board and Anor Civil Appeal (1990-1994) 1 EA 416 [81] Pereshello Vs United Paint (1969) 1



which must be pleaded.[81] As such the guiding principle can be expressed only in such vague terms as awarding what is "fair" and "proper".

General damages.

The law presumes to flow from the wrong complained of and which need not be specifically pleaded though they should be averred that such a person has suffered damage.[386] General damages are awarded on the notion that there is no medium exchange of happiness and no market for expectation of life. The monetary evaluation on non-pecuniary losses is philosophical and policy exercises more than a legal or logical one. The award must be fair and reasonable, fairness being gauged by earlier court decisions. Money cannot provide true restitution, however it can provide for proper care and this is the paramount concern of the courts while awarding damages for personal injury as there must be adequate future care. The sheer fact is that there is no objective yardstick for translating non pecuniary losses such as pain and suffering and loss of amenities into monetary terms. There general damages are awarded at the discretion of the court.

Criminal punishment awards for professional medical malpractice.

According to section 227 of the Penal Code Act[387] , any person who by any rash or negligent act not amounting to manslaughter causes death of another is liable to imprisonment not exceeding 7 years or a fine not exceeding seventy thousand or both.

In ***Uganda V Namubiru Rosemary***[388], the accused was a senior nurse who pricked herself with a needle and then injected with the same needle yet she was HIV Postive. She was sentenced to three years imprisonment.

Defences to a malpractice litigation.

The defendant can raise the number of defences to escape malpractice litigation.

Contributory negligence.

The defendant hospital or medical practitioner can prove that he was not entirely responsible for the injury but the injury also happened due to the plaintiff's negligence. In ***Jenkins V Bogalusa Community Medical Care***[389], a patient being treated for arthritis was told not to get out of bed without ringing for assistance. However, he did not but instead tried to get out and fell down fracturing his hip and subsequently died of embolism. It was held that he was partly responsible for his own death.

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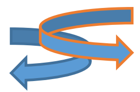
[386] Clerk and Lindsell on Tort, Sweet & Maxwell, 16th Edition, Page 253

[387] Penal Code Act Cap 120

[388] Uganda V Namubiru Rosemary. [HCT-00-CR-0050-2014]

[389] 340 su (1976)



Denial / Traverse.

Except where res ipsa loquitur is successfully pleaded, the burden of proving medical malpractice lies on the plaintiff. The defendant may totally deny the plaintiff's version of the story and leave the patient to prove his or her claim. The defendant will argue that he was never in any relationship with the patient and that he did not treat or diagnoise him.

Voluntary assumption of risks.

The defense of voluntary assumption of risk means that nno injury is done to one who voluntarily consents. The defence is expressed in a latin maxim, "volenti non fit injuria". The medical practitioner must prove that he informed the patient about the risks involved and that the patient freely consented .

Time limit.

The law gives a time limit within which to bring different causes of action. According to **section 3 (1) of the limitation Act[390],** the actions of tort must be brought before the courts of law within 6 years since the cause of action arose otherwise the suit abates because of being time barred. In other words, delay defeats equity so the person is obliged to institute a claim in the shortest time possible.

Where the defendant is a government hospital or scheduled corporation, the **Civil Procedure Miscellaneous Provision Act,[391]** sets limits within which an action can be brought against the government, local government and scheduled corporations in tort cases for two years[392].

Peer acceptance.

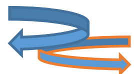
Peer acceptance is greatly associated with the Bolam test. The test requires the defendant to bring a team of experts in the same field. Where the experts prove that the defendant's action met the right criteria for that is used in treating and diagnosis or operation, the defendant will escape liability. The evidence Act enjoins courts to admit expert evidence to exonerate the defendant if correctly brought into the eyes of the court.

Strengthening Professional Ethics for Medical practitioners.

Professional ethics for medical practitioners fundamentally depends upon well-functioning health systems. According to guidelines set out by the OHCHR, systems must be "integrated, responsive, and accessible. Governments should scale up their investment in these systems, as well as scale up transparency and participatory priority-setting for drug spending.

Governments should also erect strong regulatory systems to ensure medicines are safe, effective, and of assured quality. A well formulated and comprehensive National Medicines Policy (NMP),

[390] Cap 80 laws of Uganda.
[391] Cap 72
[392] Section 3



as laid out by WHO, can guide governments to set priorities for the national pharmaceutical sector that satisfy their human rights obligations. A national essential medicines list outlines the most clinically- and cost-effective medicines for priority diseases. When used within a health system, a national essential medicines list can help limited drug budgets achieve the greatest public health impact. In line with the principle of progressive realization, governments should continuously increase the public funding available for essential pharmaceuticals, especially considering many of the most marginalized populations either pay out of pocket or make do without these medicines.

SPECIAL INTEREST IN THE MEDICAL SECTOR.

People Living With HIV and AIDS.

HIV/AIDS is a global epidemic. HIV/AIDS disproportionately affects people living in developing countries and persons living in poverty. This distribution is deeply rooted in social, economic, and gender inequalities. HIV is treated with antiretroviral (ARV) therapy, which is a combination formula of at least three antiretroviral drugs that maximally suppress the HIV virus and halt the progression of the HIV disease.

ARV therapy is effective as life-saving treatment and as protection against HIV/ AIDS. Although there is not yet universal access in many countries, treatment has been successful in extending life expectancy, decreasing HIV transmission, and promoting community activism and empowerment around HIV/AIDS and the protection of human rights. According to the **Global Commission on HIV and the Law, "Legal strategies, together with global advocacy and generic [drugs], resulted in a 22-fold increase in ART access between 2001 and 2010."** These legal strategies included framing lack of access to ARV as a breach of human rights. Civil society action, such as that of the Treatment Action Campaign in South Africa, held national governments accountable to their legal obligations in international law and their domestic constitutions. These strategies can be replicated to access treatment for other epidemics.

Children and young people.

Children and young people are also among the worst affected by the HIV epidemic, in large part due to mother-to-child transmission and slow progress in the prevention, diagnosis, and treatment of HIV in children specifically. Children face unique challenges that prohibit them from enjoying the right to health, including access to child-friendly drugs.

Children require dosages that are reflective of their age, physical condition, and body weight. Though it is common for healthcare providers to split adult dosages into halves or quarters for children's use, these makeshift tablets risk inaccurate dosing, thereby reducing the efficacy and/or safety of the treatment.

Adult sized medicines are also often unpalatable and difficult to digest for children. Oral solutions and syrups are more tolerable, and yet medications in these forms are usually unavailable, too

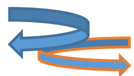
expensive, or unsuitable for use in low-income settings. For diseases requiring several treatments per day—HIV/AIDS is one example—a fixed dosage combination approach is ideal.

Violation of Women's rights in the health care system and Health Professional malpractice.

Women are particularly vulnerable to violations of their rights in seeking access to medicines, especially for sexual and reproductive health care services. In Uganda, there is shortage of prophylactic uterotonics, a drug that helps to prevent and treat Postpartum Haemorrhage (PPH). PPH, defined as a blood loss of 500 ml or more within 24 hours after birth, is the leading cause of maternal mortality globally. Without access to prophylactic uterotonics during the third stage of labor, scores of women in low-income countries suffer from long-term disability, contract severe maternal conditions associated with substantial blood loss, and/or die preventable deaths. It is therefore unsurprising that the provision of essential medicines for sexual and reproductive health is a "core" duty of the state in the CESCR's General Comment 22 on the right to sexual and reproductive health.

Women and girls who have been trafficked for prostitution are especially vulnerable to HIV/AIDS and sexually transmitted infections and require access to medicines on a non-discriminatory basis. In its General Recommendation on "Women and Health," the Committee to Eliminate Discrimination Against Women ("CEDAW") noted: The issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. . . . States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls. In some cases, discrimination against women in their pursuit of medicines can be blatant. For instance, as health personnel who deliberately refuse to give pain-relieving medicines, others are not given special attention during childbirth and delivery.

The **Special Rapporteur on the right to health states**, "Stigma and discrimination against women from marginalized communities, including indigenous women, women with disabilities and women living with HIV/AIDS, have made women from these communities particularly vulnerable to such abuses. Female patients from marginalized populations have the right to seek health care, and goods that promote health (i.e. medicines), in a manner that is non-discriminatory and respects their dignity.



Health violations and medical malpractice among Prisoners/ Detained Persons.

The right to health in prison lies at the nexus of positive and negative rights in the sense that, having deprived prisoners of their liberty and their ability to provide for their own health, states bear a positive obligation to protect their right to life and their right to health. Prison environments render their occupants more susceptible to certain diseases.

For example, although many prisoners living with HIV contracted their infections before imprisonment, the risk of infection while in prison is high due to high-risk sexual and other behaviors, like sharing needles. High-risk sexual behaviors, including unprotected sex and sexual violence, rape, and coercion, are common in prison and increase prisoners' vulnerability to HIV. Unsafe drug injection, blood exchange, and the use of non-sterile needles/cutting instruments for tattooing are also common and increase HIV vulnerability. Poor prison conditions, including overcrowding, malnutrition, poor security, and lack of health facilities and staff, contribute to the spread of HIV and violate prisoners' human rights.

In addition, prisoners are by definition not free individuals who can go to the pharmacy, and they are dependent on others to physically provide medicines. Prisoners also often have little or no means to finance medicines, so they must be funded by the prison system. Both of these obstacles routinely obstruct prisoners from realizing their right to access medicines. For instance, due to high costs, it has been documented that prison systems have withheld newer medications, including drugs for Hepatitis C, from patients in need.

The prison population includes vulnerable groups with special needs, including prisoners with mental health care needs, elderly prisoners, and prisoners with terminal illness. These vulnerable populations may require special attention to ensure that their rights to health and life with dignity are realized.

Older Persons.

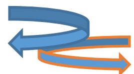
Older persons are a vulnerable group and more susceptible to issues related to non-communicable diseases (NCDs) and pain management control. NCDs, such as cancer, heart disease, and diabetes, affect many people—but especially older people. NCDs prevention and treatment can also demand a chronic (and expensive) course of medicine that may not be available or affordable for this population. Because government-funded medicines are often the only source of treatment for this population, many of these patients must pay out-of-pocket to access medicines for their chronic conditions. These sometimes catastrophic expenses can force older patients to have to choose between medicines they need and their financial stability.[13 The problem becomes even more acute when one considers the new, expensive medicines with proven therapeutic value to treat cancer. This raises an ethical and economic dilemma for industrialized and developing countries alike of how to afford these high-cost, therapeutically-innovative medicines.

In developing countries, the affordability and accessibility of chronic and/or expensive pharmaceuticals is especially limited, and in many cases, unaffordable medicines leave older people with pain control as the only viable treatment. However, opioids needed to control pain are subject to additional regulation that restricts their much-needed use.

The United Nations Committee on Economic, Social and Cultural Rights states that, with regard to the realization of the right to health of older persons, “attention and care for chronically and terminally ill persons is important sparing them avoidable pain and enabling them to die with dignity.

Persons Living With Neglected Diseases.

Neglected diseases are diseases for which there is a lack of sufficient medical innovation, resulting in inadequate, ineffective, or non-existent means to prevent, diagnose and treat them. The lack of sufficient medical innovation is often caused by a lack of market incentives to invest in products that will predominantly be directed towards populations with little or no purchasing power.Neglected diseases are demonstrative of entrenched global inequities that perpetuate disparities in the enjoyment of the right to health between the rich and the poor. For example, although the situation has improved, drug development efforts have largely focused on diseases with a higher return than those that afflict predominantly poor populations.



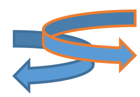
THE LAW RELATING TO MENTAL HEALTH IN UGANDA

5.4 MENTAL HEALTH

Mental health is a critical component of the right to health. The need to promote mental health is recognized in legal and policy frameworks. The World Health Organization (WHO) defines mental health as a state of well - being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively an fruitfully, and is able to make a contribution to her or his community.

The care of people with mental and brain disorders is a growing public health concern. These disorders are highly prevalent and exert a high emotional toll on individuals, families, and society. Worldwide, community-based epidemiological studies have estimated rates of lifetime prevalence of mental disorders among adults ranging from 12.2% to 48.6%, and 12-month prevalence rates ranging from 8.4% to 29.1%. These rates do not include neurological conditions affecting the brain. The WHO has estimated that in their lifetime, approximately 450 million individuals worldwide suffer from neuropsychiatric disorders. The WHO has reported that the treatment gap for serious disorders is 76 to 85% for low- and middle-income countries and also states that shortages of health care professionals have been shown to be the main factor that limits the delivery of mental health care in most of these countries. Evidence-based data are needed on the effectiveness of treatment by traditional healers to help us understand their role in reducing the burden of mental illnesses.

Mental health includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness'. The WHO has also noted that mental health intervention, including psychosocial, care management, and pharmacological



strategies, have proved effective. Interventions reduce severity of symptoms and improve daily functioning in work, social, and community life.

Uganda therefore recognizes the need to participate in International environmental law. ***Article 123 of the Constitution*** provides that the president may make treaties, conventions, agreements or other arrangements between Uganda and any international organizations in respect of any matter. The article further adds that parliament shall make laws to govern ratification of any treaty, conventions, agreements or other arrangement.

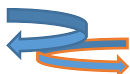
All treaties in Uganda are ratified according to the procedure laid down by the Ratification of Treaties Act (Cap 204). The Act provides for the following modes of ratification in Section 3; Ratification by cabinet, Ratification by parliament where the treaty has the effect of amending the constitution, or where the treaty relates to armistices, neutrality or peace. At present, there is no specialized international convention to address the concerns of individuals with disabilities or the subgroup of people with mental disabilities.

Internationally the modern era of human rights law commenced with the adoption of the Universal Declaration of Human Rights (UDHR) in 1948. ***Article 1*** adopted by the United Nations in 1948, provides that "all people are free and equal in rights and dignity" this provision establishes the fact that people with mental disabilities are protected by human rights law by virtue of their basic humanity.

Convention on the Rights of Persons with Disabilities ; The purpose of the Convention on the Rights of Persons with Disabilities is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity under Article1. Under the Convention, Persons with disabilities include those who have long - term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The principles of the present Convention on Rights of Persons with Disabilities include:

i. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;



ii. Non - discrimination; iii. Full and effective participation and inclusion in society; Respect for difference and acceptance of disability as part of human diversity and humanity; Equality of opportunity; iv. Accessibility; Equality between men and women; and v. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities under Article 3.

The convention creates general obligations under which the state parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities including those with mental disabilities without discrimination of any kind based on disability. Under this convention, state parties undertake to inter alia adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized under the Convention; take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities.

International convention on economic, social, and cultural rights; Article 12 establishes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

This right to the highest attainable standard of mental health entails a right on the part of people with mental disabilities to services that are (a) available (b) accessible (c) acceptable and of (d) appropriate and good quality. To be appropriately available, services must be provided in "sufficient quantity" by "trained medical and professional personnel." The requirement that services be "acceptable" means that they must be provided in a manner that is culturally appropriate and respectful of medical ethics. For services to be of appropriate quality, they must also be culturally acceptable, medically appropriate, and provided in a safe and clean environment.

International convention on civil and political rights : The rights and freedoms, which are guaranteed by the ICCPR and are relevant for promotion of mental health include, self –determination under Article 1; life under Article 6 ; liberty and security of the person; freedom from arbitrary arrest or detention; fair hearing; privacy; family rights; and equality before the law.

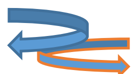
According to the **ICCPR article 10**, all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person and no person shall be subjected to torture, cruel, inhuman or degrading treatment or punishment under **article 7**.

In Price v United Kingdom, (2001) EHRR 1285 the European Court on Human Rights considered whether the treatment of the applicant contravened article 3 of the European Convention, which like article 7 of the ICCPR prohibits torture, cruel, inhuman and degrading treatment. The applicant who had a physical disability and moved in a wheel chair was jailed for contempt of court. Her cell was not adopted for PWDs and she was forced to sleep in a wheel chair. She had difficulty accessing her toilet. In order to access the toilet, she had to undress in front of male guards. It was held that her treatment constituted degrading treatment under the Convention. It also noted that the ill treatment must attain the minimum level of severity.

In ***Ireland v United Kingdom (1978) 2 EHRR 162,*** The court noted that inhuman and degrading treatment depends on all the circumstances of the case, including the nature and context of the treatment, the manner and the method of its execution, its duration, „its physical or mental effects and, in some cases, the [victim's] sex, age, and state of health.

Human and Peoples Rights (ACHPR), and the African Charter on the Rights and Welfare of the Child (ACRWC) : The Committee on the Rights of Persons with Disabilities and Committee on Economic, Social and Cultural Rights are tasked with monitoring States" implementation of the CRPD and CESCR respectively. In executing this mandate, the Committees have adopted General Comments to comprehensively interpret specific provisions of the Conventions. These include CESCR General **Comment No. 5** on Persons with Disabilities, CESCR General ***Comment No. 14 o***n the right to the highest attainable standard of health, CESCR General ***Comment No. 20*** on Non - discrimination in economic, social and cultural rights, the CRPD General Comment No. 1 on Equal recognition before the law, CRPD General Comment No. 2 on Accessibility, and CRPD General Comment No. 3 on Women and Girls with Disabilities.

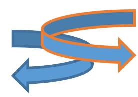
The CRPD is of particular note. Legislation passed pertaining to persons with mental disabilities must be in line with Articles 5 (Equality and Non - discrimination); 12 (Equal Recognition before



the law); 13 (Access to Justice); 14 (Liberty and Security of Persons); 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment); 16 (Freedom from exploitation, violence and abuse); 17 (Protecting the Integrity of the Person); and 25 (Health) of the CRPD.

And Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused. Principle 20 ; Criminal offenders : This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness. All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons ‟ rights under the instruments noted in paragraph 5 of Principle 1. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Ugandan Laws The 1995 Constitution of Uganda : The Constitution of the Republic of Uganda, 1995 emphasizes the inherent nature of human rights and fundamental freedoms thus they must be respected, upheld and promoted by all organs of Government and person. In addition to other human rights and freedoms, Uganda's Constitution Articles 32 and 35 recognizes the rights of PWDs. However, the Constitution under Article 23(1) (g) restricts the liberty of the so - called persons of unsound mind „for the purposes of the care or treatment of that person or protection of the community‟. Parliament has also enacted a fairly progressive legislation, i.e. The Persons with Disabilities Act which obliges the state and other actors to create an environment conducive to PWDs realizing their full potential. The Act aims at providing legal protection of PWDs pursuant to articles 32 and 35 of the Constitution. „Disability‟ is defined under Section 2 of the Persons with Disabilities Act as „a substantial functional limitation of daily life activities caused by physical, mental or sensory impairment and environmental barriers resulting in limited participation.



Given that the definition of disability includes mental or sensory impairments, it can be confidently stated that the Act applies to PWMDs. The Mental treatment Act Chapter 279, Laws of Uganda 2000; it came into force, this Act was passed to make provision for the care of persons of unsound mind and for the management of mental hospitals in Uganda. This Act has served as the National legislation on Mental Treatment up today and a revised version of the colonial Mental Treatment Ordinance of 1935.

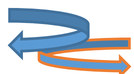
It focuses largely on issues to do with the „detention" of people with mental illness, thereby failing adequately to promote and protect their rights either within the healthcare context or in the community. The implicit perspective of the Act is that mental illness is a disgrace rather than a sickness. It does not provide for the rights of persons with mental illness in the community and concentrates on those in mental hospitals.

The objects of the Mental Health Bill, which is a product of wide stakeholder consultation and follows a rights - based approach to mental health are to: provide for community care and treatment for people with mental illness; provide for the admission in, for the treatment and for the discharge from, health units and mental health units of persons with mental illness; ensure that people with mental illness are enabled to seek treatment voluntarily; ensure the safety and human rights of people with mental health problems and the people who come into contact with them; and establish the Mental Health Advisory Board.

The Bill defines mental illness as a recognizable and persistent disturbance in the behavior, thoughts, feelings, perceptions, mood, volition, orientation, awareness and memory of an individual that impairs the ability to cope with daily tasks and that impairs judgment or behavior to a significant extent under Section 2 of the Bill.

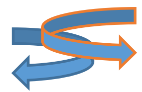
The Bill further highlights key values such as human rights promotion and protection, deinstitutionalization, integration of mental health care and community care, quality and safety, social inclusion, and inter - sect oral collaboration.

The Health Sector Development Plan : The Health Sector Development Plan (HSDP) 2015/16 – 2019/20 emphasizes the importance of a human rights - based approach to health. It states that the right of everyone to enjoy the highest attainable standard of physical and mental



health is recognized in Uganda. Second National Development Plan : The Second National Development Plan (NDP II) 2015/16 – 2019/20 is aligned with the 2030 Agenda for Sustainable Development. Sustainable Development Goal 3 on Health calls upon the government to ensure healthy lives and promote well - being for all at all ages with a specific target on promotion of mental health and well-being. This reiterated in the Common African Position of the African Union 2014 which highlights mental health a key priority area.

In conclusion, mental health is a fundamental sector in medical science since one's mental ability is what determines and governs over their decision which also affects the state of activities performed in the day to day living; in leadership, employment and their general performance in society at large. This means that more emphasis need to be placed in developing institutions responsible for ensuring access to proper mental health treatment and care.



ABORTION

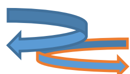
5.5 ABORTION

Introduction

Despite the many cases of abortion being handled incognito by health officers, there still remains no law modulating conduct of the same. This has made abortion unsafe (however illegal) and so many women have died in the due course. The existing law only prohibits abortion generally under the heading "killing the unborn child." It appears that this strictness of law fails to admit that there is an actual rampart practice of abortion which calls for regulation or otherwise a strict follow up for legal implementation purposes but instead, the situation is left largely in moral and religion's hands to administer. It also appears that by custom today, a successful doctor in Uganda is considered one who is most known and owns a private clinic for doing illegal abortion. Yet amongst youths today, the most appreciated female student at college may be one who has done several abortions and is still standing amid the common talk _ "*sitya loss*[393]*.*" Actually, the forbidding law is in force but the implementers are in sleep. Isn't the situation one that requires immediate attention? The issue at hand today, is whether the law on Abortion is effective in terms of enforcement and if not whether there is need for legalization or amendment to the current law relating to position and its implication. Quite often, we hear in the news that women have interrupted their pregnancy voluntarily either with the help of doctors or medicine taken on their own. Often clandestine abortion has caused more damage than good. Many women have lost their lives. Often, we ask the question whether abortion should be legalized. The youth shows their concerns on this issue.

Under the penal Code, abortion is illegal and is not allowed even if the life of the mother or the child is threatened. Nevertheless, due to strict legal parameters, clandestine illegal abortions are being performed in all corners of the island, allegedly by untrained doctors, nurses, midwives and

[393] Phrase in Luganda, translated as "I don't fear making loss"



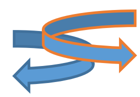
"wise women" and mostly under unsafe conditions. There exist various reasons why women opt for abortion such as" I remain a follower of Jesus. And I believe that as an abortion provider I am doing God's work. I am protecting women's rights, their human right to decide their future for themselves, and to live their lives as they see fit.

Different writers have opined that people who pass the new laws [to restrict access to abortion] concern themselves with fetuses, but these are humans I am caring for-real people, not merely biological organisms with the potential to become such. These individuals have full, messy imperfect lives—and hopes and dreams that will or won't come true. Aren't they entitled to the authors of their own stories, find their own victories and happiness, make their own mistakes, without a congress of legislators dictating what they must do? This is a question of debate.

Rather than judge them, I give them what they came here for—as expertly, safely, quickly, and painlessly as I can—and I send them home so they can resume the lives they want, and not lives that some authority may want for them. Other writers argue that "Contraception can fail. The best plans do not always work out. And when that happens, abortion is an essential part of health care. Abortion allows women to plan and space their pregnancies, which improves their physical, psychological and economic well-being. Evidence shows that people who are able to obtain an abortion are better able to maintain a positive future outlook and achieve their aspirational life plans. Conversely, evidence clearly demonstrates that if a pregnant person seeks an abortion and access to that care is delayed or denied, they are at greater risk of experiencing adverse health and economic outcomes. For people with certain health conditions, an unintended pregnancy can be devastating, if not dangerous. And even with a planned pregnancy, unexpected tragedies can arise. Imagine the woman who gets a cancer diagnosis and must decide between continuing the pregnancy or life-saving chemotherapy. And what about the parents who discover in the second trimester that the fetus has severe anomalies and has no chance of living outside the womb? Abortion is essential health care for them...Abortion is health care. It is life-saving. And when it is needed, it must be successful. A study needs to investigate the position of commercial sex traders under the current legal provisions provided for in our statute books; its ineffectiveness and if there is any need for reform.

Background.

Abortion is the ending of pregnancy by removing a fetus or embryo before it can survive outside the uterus. An abortion that occurs spontaneously is also known as a miscarriage. An abortion may be caused purposely and is then called an induced abortion, or less frequently, "induced



miscarriage". The word abortion is often used to mean only induced abortions. A similar procedure after the fetus could potentially survive outside the womb is known as a "late termination of pregnancy".

When allowed by law, abortion in the developed world is one of the safest procedures in medicine. Modern methods use medication or surgery for abortions. When performed legally and safely, induced abortions do not increase the risk of long-term mental or physical problems. In contrast, unsafe abortions (those performed by unskilled individuals, with hazardous equipment, or in unsanitary facilities) cause 47,000 deaths and 5 million hospital admissions each year. The World Health Organization [1] recommends safe and legal abortions be available to all women.

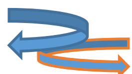
Around 56 million abortions are performed each year in the world, with about 45% done unsafely. Abortion rates changed little between 2003 and 2008, before which they decreased for at least two decades as access to family planning and birth control increased. As of 2008, 40% of the world's women had access to legal abortions without limits as to reason. Countries that permit abortions have different limits on how late in pregnancy abortion is allowed

Abortion is one of the most sensitive and controversial topics today. Many women and girls continue to get rid of unwanted pregnancies in unsafe ways and get serious medical and psychological complications, and equally many lose their lives. Many women and girls use abortion as the illegal method of family planning.

The State of Abortion in Uganda

Except under special circumstances accorded to some women, abortion is illegal in Uganda, but common due to rampant unintended pregnancies. Over 775,000 women in Uganda become pregnant unintentionally every year. Over 297,000 illegal abortions are carried out in Uganda annually and nearly 85,000 women are treated for complications. Abortion is most common among youths. It occurs at a rate of 54 per 1,000 women aged 15-49.

According to World Health Organization, 150,000 women in Uganda suffer from abortion-related complications annually. Many fear visiting the hospital thinking they might be arrested. The above figure is just the number which is recorded in the health facilities. There are many cases that undergo abortions and have died in the villages silently because of the stigma attached to it, and the constant victimization done by way of the colonial law which condemns abortion. Thus, there are high numbers of unregistered abortions.



Every day Mulago Hospital receives 10-15 women suffering from abortion-related complications. Abortion is the fourth killer of women in Uganda and a total of 297,000 abortions are done every year, according to the United Nations Population Fund country representative. About 7,200 women die yearly, and more than 144,000 survive death, but develop serious complication in the process of giving life, including obstetrics fistula, according to UNFPA. In Uganda, every year about one million teenagers get pregnant, and 40 per cent of them resort to abortion, because they did not plan to have a child. This paper was first presented at the Open Talk Debate on 10 October, 2015, at Fair Way Hotel, Kampala, Uganda, and republished in the December 2015 edition of the IHEYO Youth Speak newsletter By Kato Mukasa.[394]

Legal Frame Work On Abortion in Uganda

Ugandan law allows abortion under some circumstances, but laws and policies on abortion are unclear and are often interpreted inconsistently, making it difficult for women and the medical community to understand what is legally permitted.

The Ugandan Constitution states in Article 22(2)[395] on protection of life, that "No person has the right to terminate the life of an unborn child except as may be authorized by law." This means that abortion is permitted if the procedure is authorized by law, but many of the medical workers cannot perform abortions because of failure to interpret the law.

Under the 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, pregnancy termination is permissible in cases of fetal anomaly, rape and incest, or if the woman has HIV.

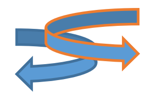
According to the Penal Code, a doctor who thinks that an abortion is justified to save the life of the mother, must write to the director general of medical services in the health ministry, seeking approval to terminate the pregnancy, who also convenes a medical team to scrutinize the case. The bureaucratization of this process alongside a life in danger may be dangerous, as a medical doctor waits for an approval.

Most frequently asked questions concerning abortion include;

When does a human being begin to have rights? Does a fetus qualify as a human being or does it have rights just like a new born baby? At what months would a fetus qualify as a human being and

[394] Youth Speak newsletter By Kato Mukasa

[395] Article 22(2)



does it have special rights over and above the rights of its mother? Putting the ingredients of murder in perspective, does an abortion truly amount to murder? Why does the law leave out young people
(girls), even in extreme cases, where women are allowed to abort?

Medical Effects of Unsafe Abortion

Many young girls suffer from obstetric fistula and obstructed labor often due to small size of the birth canal amongst these children. Many other young girls are suffering from sepsis gangrene, pyometia, pelvic inflammatory diseases, infertility, obstetric fistula, embolism, ectopic pregnancy, incomplete cervix and incomplete removal of products, just because government has failed to legalize abortion to be performed in hospitals by qualified medical workers.

Teenagers are at the forefront of carrying out abortions and HALEA has established that teenagers fear pregnancy, since teenage pregnancy contributes to loss of economic potential due to foreshortened education, lost opportunities and constrained life options.

Medical figures from Mulago Hospital (2014)[396] indicate that, in Uganda, one in six women suffer severe morbidities — anemia, infertility, pelvic pain and obstetric fistulas, which lead to ill health caused partly by deliveries and unsafe abortions carried out in rural areas. Recent studies have shown that the cost to the healthcare system of treating complications from unsafe abortion is $130 (Shs330,
000) per patient.

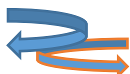
An Evaluation of Abortion's legality

Despite large reductions in pregnancy-related deaths in Uganda over the past two decades (the maternal mortality ratio dropped from 684 per 100,000 live births in 1995 to 343 per 100,000 in 2015), the high number of maternal deaths there remains a public health challenge.

Unsafe abortion continues to contribute significantly to this public health problem: A 2010 report by the Ugandan Ministry of Health[5] estimated that 8% of maternal deaths were due to unsafe abortion.

Ugandan law explicitly allows abortion to save a woman's life. However, the 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights go even

[396] Mulago Hospital (2014)



further— permitting abortion under additional circumstances, including in cases of fetal anomaly, rape and incest, or if the woman is HIV-positive.

Yet, existing laws and policies on abortion are interpreted inconsistently by law enforcement and the judicial system, which makes it difficult for women and the medical community to understand when abortion is permitted.

Because of this ambiguity, medical providers are often reluctant to perform an abortion for any reason, out of fear of legal consequences.

Induced Abortion

In Uganda, an estimated 314,300 abortions took place in 2013. This translates to 14% of all pregnancies—or a rate of 39 per 1,000 women aged 15-49, down from 51 per 1,000 in 2003.

The abortion rate for Uganda is slightly higher than the estimated rate for the East Africa region as a whole, which was 34 per 1,000 women during 2010—2014,

Within Uganda, abortion rates vary widely by region, from 18 per 1,000 women in the Western region to 77 per 1,000 in Kampala.

Availability of Post abortion Care

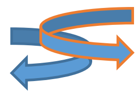
Of the 2,300 health care facilities across Uganda that can provide post abortion care, an estimated 89% treat post abortion complications.

In 2013, 93,300 women were treated for complications from unsafe abortion. This translates to an annual treatment rate for complications from unsafe abortion of 12 per 1,000 women aged 15—49, slightly down from 15 per 1,000 in 2003.

Despite a decline in this treatment rate, injuries and illness resulting from unsafe abortion remain a critical challenge for the Ugandan health system.

High Cost of Abortion and Post abortion Care

The amount women pay for a clandestine abortion varies. In 201 1—2012, the average out-of-pocket cost for an unsafe procedure, treatment of complications prior to arriving at a health facility or both was US$23. In 2003, an abortion was estimated to cost a woman US$25—88 if performed by a doctor, US$14-31 if performed by a nurse or midwife, US$ 12—34 if performed by a traditional healer and US$4—9 if self-induced.



The cost to the health care system of treating complications from unsafe abortion was, on average, nearly US$131 per patient in 2010.

In total, post-abortion care is estimated to cost nearly US$14 million annually in Uganda. Two-thirds of this amount—US$9.5 million—is spent on nonmedical costs (overhead and infrastructure), and the remaining US$4.4 million is spent on drugs, supplies, labor, hospitalization and outpatient fees.

Most direct medical costs of postabortion care arise from treating incomplete abortion; however, a significant proportion is spent treating more serious complications, such as sepsis, shock, lacerations and perforations

Most abortions are the result of unintended pregnancy. In Uganda, 52% of pregnancies are unintended, and about a quarter of these unintended pregnancies end in abortion each year.

Between 2003 and 2013, the proportion of married women aged 15—49 using a modern contraceptive method increased from 14% to 26%; however, the proportion of unmarried sexually active women aged 15—49 using a modern method remained stagnant at 38% during this period.

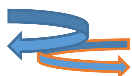
Meeting women's contraceptive needs is a critical strategy to help women avoid unintended pregnancies. In Uganda, four out of 10 married women and almost half of sexually active women of reproductive age have an unmet need for modern contraception that is, they want to avoid a pregnancy, but are either not practicing contraception or are using a traditional method, which can have high failure rates.

Conclusion

Ensure that free or affordable public-sector family planning services reach all women especially those who are poor and young to reduce unmet need for contraception and lower the incidence of unintended pregnancy. Programs should offer comprehensive family planning services including counseling and a wide range of contraceptive methods to enable women to choose the best methods for themselves, to use methods effectively and to switch methods when desired.

Expand and improve the quality of post-abortion care services to treat the often serious health complications resulting from unsafe abortion. Health authorities should allocate greater resources to post-abortion care and prioritize incorporating counseling and provision of contraceptives into this care.

Clarify Uganda's abortion law and policies, and raise awareness of the content and scope of Uganda's abortion law among the medical community, the judicial system and women.



Kampala- Two Makerere University law dons have petitioned the Constitutional Court challenging its failure to pass laws aimed at legalizing abortion, an omission that has seen increased unsafe abortions and its associated consequences including death.

Prof Ben Twinomugisha and Dr Rose Nakayi together with a civil society organization, Center for Health, Human Rights and Development (CEHURD)[397] have asked court to order the Executive and Legislative arms of government to pass a law regulating termination of pregnancies to reduce maternal mortality rates that arise from unsafe abortions.

The law dons in their petition filed on March 3, contend that the existing legislation only permits abortion in exceptional circumstances such as a life of a mother at risk, but doesn't protect young girls and married women who may get unwanted pregnancies hence resorting to unsafe abortion methods.

The petitioners argue that other African countries like Kenya, Rwanda, Ethiopia, Ghana and Tunisia, which are similar in social and economic circumstances as Uganda, deliberately developed laws to protect the rights of women by prescribing circumstances under which a woman is allowed to terminate her pregnancy.

"We do not see any reason as to why Uganda should not borrow a leaf from its neighbors and take an essential step to protect the lives of women who continue dying day by day due to unsafe abortions," reads part of the petition.

The petitioners contend that the Constituent Assembly resolved to create a framework provision on termination of pregnancy on which basis the Parliament of Uganda would then formulate, discuss and enact a law on termination of pregnancy.

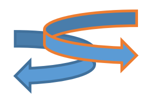
They also contend that since the enactment of the Constitution, no effort has been made by the law to effect Article 22(2) of the Constitution by creating a law on termination of pregnancy.

"By omitting to create a law on termination of pregnancy the State continues to contravene the constitutional directive made by Article 22(2) and the obligation of the parliament," reads part of the petition.

The trio is seeking for the interpretation of Article 22(2) of the Constitution which provides that no person has the right to terminate the life of an unborn child except as may be authorized by law.

They also want an interpretation which provides that subject to the provisions of the Constitution, Parliament shall have powers to make laws on any matter for the peace, order development and

6 [397] Center for Health, Human Rights and Development (CEHURD)



good governance of Uganda. Abortion is only permitted to save the life of the woman, to preserve physical health, and to preserve mental health.

Under the Ugandan Penal Code of 15 June 1950 (sections 136-138, 205 and 217) the performance of abortions is generally prohibited. Any person who, with intent to procure the miscarriage of a woman, unlawfully administers any noxious thing or uses any means is subject to imprisonment for fourteen years. A pregnant woman who undertakes the same act or consents to its performance is subject to seven years' imprisonment. Any person who unlawfully supplies means to procure an abortion knowing that it is unlawfully intended for that purpose is subject to three years' imprisonment.

Nonetheless, Section 217 of the Code[398] provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother's life if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. A legal abortion must be performed by a registered physician.

WHAT IS ABORTION?

Abortion is when a pregnancy is ended so that it doesn't result in the birth of a child. Sometimes it is called 'termination of pregnancy'.

BPAS cares for women with an unplanned or unwanted pregnancy. We treat thousands of women who've decided that abortion is the right choice for them, and give advice and counselling to women who don't know what to do next.

There are two types of abortion treatment, 'Medical' and 'Surgical' abortion:

Medical abortion: Some women feel that a medical abortion is a more natural process. There are two types of medical abortion. Abortion pill (also known as early medical abortion) up to 10 weeks

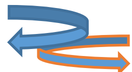
Abortion pill from 10 weeks up to 24 weeks

Surgical abortion

Surgical abortion involves a quick, minor operation. There are two types of surgical abortion:

Vacuum aspiration up to 15 weeks.

[398] Section 217 of the Code



Dilatation and evacuation between 15 and 24 weeks

Under the penal Code, abortion is illegal and is not allowed even if the life of the mother or the child is threatened. Nevertheless, due to strict legal parameters, clandestine illegal abortions are being performed in all corners of the island, allegedly by untrained doctors, nurses, midwives and "wise women" and mostly under unsafe conditions. There exist various reasons why women opt for abortion such as failure in contraceptive use, desire to continue their education, inability to meet the basic needs of their prospective babies/ children, poor health conditions or being unprepared to become mothers at that particular period of time in their lives.

Brief Historical Background of Abortion

"French Periodical Pills". An example of a clandestine advertisement published in a January 1845 edition of the Boston Daily Times.

Since ancient times abortions have been done using herbal medicines, sharp tools, with force, or through other traditional methods. There is evidence to suggest that pregnancies were terminated through a number of methods, including the administration of abortifacient herbs, the use of sharpened implements, the application of abdominal pressure.

Some medical scholars and abortion opponents have suggested that the Hippocratic Oath forbade Ancient Greek physicians from performing abortions; other scholars disagree with this interpretation, and state the medical texts of Hippocratic Corpus contain descriptions of abortive techniques right alongside the Oath.

Aristotle, in his treatise on government Politics condemns infanticide as a means of population control. He preferred abortion in such cases, with the restriction that it must be practiced on it before it has developed sensation and life; for the line between lawful and unlawful abortion will be marked by the fact of having sensation and. being alive". In Christianit)ß Pope Sixtus V (1585—90) was the first Pope to declare that abortion is homicide regardless of the stage of pregnancy; the Catholic Church had previously been divided on whether it believed that abortion was murder, and did not begin vigorously opposing abortion until the 1 9th century. A 1995 survey reported that Catholic women are as likely as the general population to terminate a pregnancy, Protestants are less likely to do so, and Evangelical Christians are the least likely to do so. Islamic tradition has traditionally.

Permitted abortion until a point in time when Muslims believe the soul enters the fetus, considered by various theologians to be at conception, 40 days after conception, 120 days after conception, or

quickening. However, abortion is largely heavily restricted or forbidden in areas of high Islamic faith such as the Middle East and North Africa.

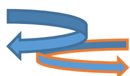
In Europe and North America, abortion techniques advanced starting in the 17th century. However, conservatism by most physicians with regards to sexual matters prevented the wide expansion of safe abortion techniques. Other medical practitioners in addition to some physicians advertised their services, and they were not widely regulated until the 19th century, when the practice (sometimes called restellism) was banned in both the United States and the United Kingdom. Church groups as well as physicians were highly influential in anti-abortion movements. In the US, abofiion was more dangerous than childbirth until about 1930 when incremental improvements in abortion procedures relative to childbirth made abortion safer. Soviet Russia (1919), Iceland (1935) and Sweden (1938) were among the first countries to legalize certain or all forms of abortion. In 1935 Nazi Germany, a law was passed permitting abortions for those deemed "hereditarily ill", while women considered of German stock were specifically prohibited from having abortions. Beginning in the second half of the twentieth century, abortion was legalized in a greater number of countries.

Types of Abortion

Induced abortion

Approximately 205 million pregnancies occur each year worldwide. Over a third are unintended and about a fifth end in induced abortion. Most abortions result from unintended pregnancies. In the United Kingdom, I to 2% of abortions are done due to genetic problems in the fetus. A pregnancy can be intentionally aborted in several ways. The manner selected often depends upon the gestational age of the embryo or fetus, which increases in size as the pregnancy progresses. Specific procedures may also be selected due to legality, regional availability, and doctor or a woman's personal preference.

Reasons for procuring induced abortions are typically characterized as either therapeutic or elective. An abortion is medically referred to as a therapeutic abortion when it is performed to save the life of the pregnant woman; prevent harm to the woman's physical or mental health; terminate a pregnancy where indications are that the child will have a significantly increased chance of premature morbidity or mortality or be otherwise disabled; or to selectively reduce the number of fetuses to lessen health risks associated with multiple pregnancy. An abortion is referred to as an elective or voluntary abortion when it is performed at the request of the woman for non-medical



reasons. Confusion sometimes arises over the term "elective" because "elective surgery" generally refers to all scheduled surgery, whether medically necessary or not.

Spontaneous abortion

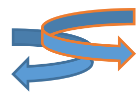
Spontaneous abortion, also known as miscarriage, is the unintentional expulsion of an embryo or fetus before the 24th week of gestation. A pregnancy that ends before 37 weeks of gestation resulting in a live-born infant is known as a "premature birth" or a "preterm birth". When a fetus dies in utero after viability, or during delivery, it is usually termed "stillborn". Premature births and stillbirths are generally not considered to be miscarriages although usage of these terms can sometimes overlap.

The most common cause of spontaneous abortion during the first trimester is chromosomal abnormalities of the embryo or fetus, accounting for at least 50% of sampled early pregnancy losses. Other causes include vascular disease (such as lupus), diabetes, other hormonal problems, infection, and abnormalities of the uterus. Advancing maternal age and a woman's history of previous spontaneous abortions are the two leading factors associated with a greater risk of spontaneous abortion. A spontaneous abortion can also be caused by accidental trauma; intentional trauma or stress to cause miscarriage is considered induced abortion or feticide.

Safe abortion

The health risks of abortion depend principally upon whether the procedure is performed safely or unsafely. The World Health Organization defines unsafe abortions as those performed by unskilled individuals, with hazardous equipment, or in unsanitary facilities. Legal abortions performed in the developed world are among the safest procedures in medicine. In the US, the risk of maternal death from abortion is 0.7 per 100,000 procedures, making abortion about 13 times safer for women than childbirth (8.8 maternal deaths per 100,000 live births). In the United States from 2000 to 2009, abortion had a lower mortality rate than plastic surgery. The risk of abortion-related mortality increases with gestational age, but remains lower than that of childbirth through at least 21 weeks' gestation. Outpatient abortion is as safe and effective from 64 to 70 days' gestation as it is from 57 to 63 days. Medical abortion is safe and effective for pregnancies earlier than 6 weeks' gestation.

There is little difference in terms of safety and efficacy between medical abortion using a combined regimen of mifepristone and misoprostol and surgical abortion (vacuum aspiration) in early first trimester abortions up to 9 weeks gestation. Medical abortion using the prostaglandin analog



misoprostol alone is less effective and more painful than medical abortion using a combined regimen of mifepristone and misoprostol or surgical abortion.

Unsafe abortion

"Abortions performed by either trained or self-taught midwives not only maim the woman, they also often lead to death."

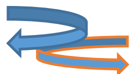
Women seeking to terminate their pregnancies sometimes resort to unsafe methods, particularly when access to legal abortion is restricted. They may attempt to self-abort or rely on another person who does not have proper medical training or access to proper facilities. This has a tendency to lead to severe complications, such as incomplete abortion, sepsis, hemorrhage, and damage to internal organs.

Unsafe abortions are a major cause of injury and death among women worldwide. Although data are imprecise, it is estimated that approximately 20 million unsafe abortions are performed annually, with 97% taking place in developing countries. Unsafe abortions are believed to result in millions of injuries. Estimates of deaths vary according to methodology, and have ranged from 37,000 to 70,000 in the past decade; deaths from unsafe abortion account for around 13% of all maternal deaths. The World Health Organization believes that mortality has fallen since the 1 990s. To reduce the number of unsafe abortions, public health organizations have generally advocated emphasizing the legalization of abortion, training of medical personnel, and ensuring access to reproductive-health services. However, the Dublin Declaration on Maternal Health, signed in 2012, notes, "The prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women."

A major factor in whether abortions are performed safely or not is the legal standing of abortion. Countries with restrictive abortion laws have higher rates of unsafe abortion and similar overall abortion rates compared to those where abortion is legal and available. For example, the 1996 legalization of abortion in South Africa had an immediate positive impact on the frequency of abortion-related complications, with abortion-related deaths dropping by more than 90%.

Abortion Should Not Be Regarded As A Crime

Tariq avers that abortion is the deliberate termination of a human pregnancy, most often performed during the first 28 weeks of one's pregnancy. "When you analyse in depth the current situation,



aboftion should not be regarded as a crime in certain circumstances. Nowadays, we can easily find out any abnormality of a foetus through amniocentesis test. In this case, a woman has the right to decide if she wants to give birth to an abnormal child or if she wants to abort the foetus. If a young girl is raped, do you think she will be capable of giving birth to her baby and raise the latter by herself? She might not be physically and mentally capable of doing do, as she just went through a traumatic experience. In these situations, an abortion would definitely be a wise decision." However, as advocated by Tariq, abortion should not be practiced in all cases. "Strict rules should be made regarding teenage pregnancy and abortion for teenagers should be regarded as a crime with strict consequences. With severe rules and regulations in relation to abortion, it can be practiced wisely without giving rise to teenage pregnancy or any other similar issues."

Kirtee Ashvin Gobin supports the view that abortion should be legalized in Mauritius. "All the religious groups are against legalization while those in favour claim it is the right of a woman to decide. There are several reasons why abortions should be legal and we should leave it to a woman to decide. Only a woman may decide to seek an abortion when the health of the foetus is at risk or the health of the woman is in danger. Even in case of incest or rape, it is up to the woman to decide what she wants."

She further adds that "a woman should not be expected to give birth to a child if there is something seriously wrong with the baby, such as missing limbs or other serious health complications. There is no point to put the life of a woman in danger. Even for rape, the woman has no right to endure more psychological issues."

Since 1973, a woman's right to an abortion has been protected by the Supreme Court. However, the court has also declared that states may impose certain kinds of regulations that limit access to surgical abortions. According to the National Abortion and Reproductive Rights Action League, a majority of states currently enforces at least one of the following restrictions: 24- to 48-hour waiting periods before women can undergo the procedure, counseling emphasizing the drawbacks of abortion, obligations for minors to notify their parents or obtain their consent before having an abortion, and bans on the procedure at public facilities.

Those who support these restrictions maintain that such statutes reflect the average American's concerns about abortion. Gallup polls, for example, reveal that more than 70 percent of Americans support a prohibition on abortion after the first trimester of pregnancy—including 46 percent of those who identify themselves as strongly pro-choice. While most citizens believe that abortion should be available during the first three months of pregnancy, many also agree that a woman

should not have an abortion to avoid inconveniences such as interruptions to her education or career.

Abortion Should Be Restricted (Michael W. McConnell)

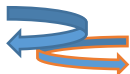
In the viewpoint that follows, Michael W. McConnell maintains that the Supreme Court's legalization of aboftion is based on faulty reasoning. For example, the court has stated that a woman's decision to abort is based on a constitutional "right of privacy," yet no such right can be found in the Constitution, McConnell explains. The court also claims that it cannot resolve the question of when life be- gins, but it implicitly denies that the fetus is a person by re- fusing to protect its life. A majority of Americans, however, oppose abortions after the first trimester and support parental notification laws, waiting periods, and other moderate restrictions on abortion. The Supreme Court misrepresents the will of the people by allowing women to have abortions for any reason, the author concludes. McConnell is a professor of constitutional law at the University of Utah.

On January 22, 1973, the U.S. Supreme Court handed down its decision legalizing abortion throughout the country. The day before Roe v. Wade[399], abortion was flatly illegal in almost all states, though a few had recently relaxed their laws. On the day after Roe, women suddenly had a constitutional right to get an abortion for any reason, a right that effectively applied at any time during the nine months of pregnancy. (In theory, states could still ban abortion in the last three months unless it was necessary for the health of the woman—but the court defined "health" so broadly as to make this limitation meaningless.) The number of abortions quickly soared to almost 1.5 million every year, roughly 30% of all pregnancies.

Roe v. Wade is the most enduringly controversial court decision of the twentieth century, and rightly so. Rather than putting the issue to rest, the court converted it into the worst sort of political struggle one involving angry demonstrators, nasty confirmation battles and confrontational sound bites, With ordinary politicians, who are masters of compromise, out of the picture, the issue became dominated by activists of passionate intensity on both extremes of the spectrum.

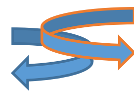
The reasoning of Roe v. Wade is an embarrassment to those who take constitutional law seriously, even to many scholars who heartily support the outcome of the case. As John Hart Ely, former

[399] Roe v. Wade



dean of Stanford Law School and a supporter of abortion rights, has written, Roe "is not constitutional law and gives almost no sense of an obligation to try to be."

The court's reasoning proceeded in two steps. First, it found that a "right of privacy" exists under the Constitution, and that this right is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy." Since this meant that the right to abortion is constitutionally protected, a state could interfere with the right only if it has a "compelling state interest" for doing so.



Conflicting areas of the law and Abortion Should abortion be legal?

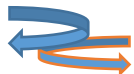
Willie Parker, MD, MPH, Abortion Provider and Board Chair of Physicians for Reproductive Health, wrote in his 2017 book Life's Work: A Moral Argument for Choice:

"l remain a follower of Jesus, And I believe that as an abortion provider I am doing God[t] s work. I am protecting women's rights, their human right to decide their future for themselves, and to live their lives as they see fit. The people who pass the new laws to restrict access to abortion concern themselves with fetuses, but these are humans I am caring for real people, not merely biological organisms with the potential to become such. These individuals have full, messy imperfect lives—and hopes and dreams that will or won't come true. Aren't they entitled to the authors of their own stories, find their own victories and happiness, make their own mistakes, without a congress of legislators dictating what they must do?

Rather than judge them, I give them what they came here for as expertly, safely, quickly, and painlessly as I can and I send them home so they can resume the lives they want, and not lives that some authority may want for them. Jeanne Mancini, MTS, President of March for Life Education and Defense Fund, wrote in an Oct. 26, 2016 What about Equal Rights for Unborn Women?

But I am tired of the damaging and erroneous idea that abortion is a positive thing for women. I have met so many women that profoundly grieve having been involved in an abortion. I've talked to a dad who lost his daughter to legal abortion. There is study after study showing the negative consequences of abortion be it emotionally or physically.

Because of the cause of 'reproductive rights,' approximately 30 million females are missing in the United States today future Olympic athletes, scientists, doctors, artists, teachers, sisters, mothers, daughters, lawmakers, and maybe even a President. Women deserve the truth about this issue. Abortion is profoundly anti-woman. Choosing life is empowering, not taking the life of your precious little one.



Role of women activists and civil society on call for legalization Of Abortion American Medical Association (AMA)

Donna Schaper, D. Min, Senior Minister of Judson Memorial Church in New York City, stated in her Dec. 4, 2013 article for the Huffington Post titled "Most Women under 40 Haven't Heard the Prochoice Moral Argument":

"Women are moral agents. Women are capable of making soulful, moral decisions about their own bodies. Assuming that a woman cannot decide for herself if and when to bear a child demeans women. Mandatory childbearing makes the woman a hostage to the will of others those unfamiliar with her story, her life experience and her needs, and may have disastrous consequences for the children. Medical choices, like terminating a pregnancy, are medically available. Other life sustaining medical procedures are not considered immoral. Why the complaint against abortion?

Our faith tradition teaches soul competency, a Baptist principle that is violated in restricting the right to choose an abortion. Our forebears suffered greatly, even to the point of death, to express their conviction that no one stands between the individual and God.

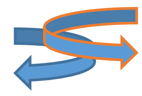
As Christians, as Baptists, we wearily say, the right to choose a medical procedure is also a woman's right. It has to do fundamentally with the freedom of our soulš to practice our religion and morality in our own ways."

"I am pro-choice because, as a lifelong Republican, I believe that individual rights should be paramount—and that this extends to the rights of individuals to make personal decisions about reproduction. As a mother, of course I am pro-life, and I believe that the government's role in creating and enforcing reproductive health legislation is to protect individuals' ability to access all options. While this is the truly Republican thing to do, it is also the right thing to do. The government must not be involved in personal healthcare decisions. Those who oppose contraception and abortion are free to make that choice for themselves and their families, but not for others.

Sep. 2012 - Democratic Party

The National Abortion Federation Il , a nonprofit association of abortion practitioners, stated in its article "Pro-Choice and Proud," published on its website ProChoice.org (accessed Apr. 29, 2014):

Between the 1880s and 1973, many thousands of women died or suffered serious medical problems after attempting to self-induce their abortions or going to untrained practitioners who performed abortions with primitive methods or in unsanitary conditions. During this time, hospital emergency room staff treated thousands of women who either died or were suffering terrible effects of



abortions provided without adequate skill and care. However, since the legalization of abortion, the risk of death resulting from abortion is many times less than a woman's risk of death during pregnancy and childbirth.

The ability to access safe and legal abortion has been critical for many women as they seek to define and live their lives with dignity. Honoring women means honoring their choices, including the choice of whether and when to have children. Women are capable of making intelligent and conscientious decisions about their own lives and families. Women deserve the autonomy and dignity to act in accordance with their personal convictions, and to decide what is best for their own lives and families. Women should be trusted and respected to exercise the choices about their bodies and lives that are best for them, and not be forced by the government into personal reproductive decisions that are against their will.

Apr. 29, 2014 - National Abortion Federation (NAF)

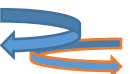
Barack Obama, JD, 44th US President, issued the following statement on Jan. 22, 2014, published on White House.

Today, as we reflect on the 41st anniversary of the Supreme Court decision in Roe v. Wade we recommit ourselves to the decision's guiding principle: that every woman should be able to make her own choices about her body and her health. We reaffirm our steadfast commitment to protecting a woman's access to safe, affordable health care and her constitutional right to privacy, including the right to reproductive freedom. And we resolve to reduce the number of unintended pregnancies, support maternal and child health, and continue to build safe and healthy communities for all our children. Because this is a country where everyone deserves the same freedom and opportunities to fulfill their dreams. "

Jan. 22, 2014 - Barack Obama, JD

Apr. 29, 2014 - American Medical Women's Association (AMWA)

NARAL (National Association for the Repeal of Abortion Laws) Pro-Choice America, wrote the following in its Jan. I, 2014 article "Roe v. Wade and the Right to choose published on its website ProChoiceAmerica.org: By striking down laws that forced women to resort to back-alley abortion, Roe saved many women's. Since abortion was legalized in 1 973, the safety of the procedure has



increased dramatically. The number of deaths per 100,000 legal abortion procedures declined from 4.1 to 0.6 between 1973 and 1997.

In addition, Roe has improved the quality of many women's lives. Although most women welcome pregnancy, childbirth, and the responsibilities of raising a child at some period in their lives, few events can more dramatically constrain a woman's opportunities than an unplanned pregnancy. Because childbirth and pregnancy substantially affect a woman's educational prospects, employment opportunities, and self-determination, restrictive abortion laws narrowly circumscribed women's role in society and hindered women from charting their paths through life in the most basic of ways. In the 40 years since Roe, the variety and level of women's achievements have reached unprecedented heights. "

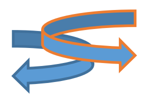
Technological advancement

In the following viewpoint, Henry Morgentaler contends that legal abortion has led to a reduction in violent crime.

In both Canada and the United States, the number of assaults, rapes, and murders has been decreasing since the early 1990s, Morgentaler explains. Because women have had access to legalized abortion since 1973, fewer unwanted children have been born. Unwanted children are Inore likely to be neglected and abused and, therefore, to grow into adults who commit acts of violence, he points out. Since less of these children are being born, the crime rate has decreased, he concludes. Morgentaler, a physician, is a prominent Canadian abortion provider.

Challenges in the existing law on Abortion

I would also like to address the potential problem of women seeking "back-alley," or illegal abortions if abortion is not kept legal. What is interesting about this argument is that Roe v. Wade basically made people who were previously considered illegal abortionists, now legal abortionists! As quoted in Roe v. Wade: The state is constitutionally barred, however, from requiring review of the abortion decision by a hospital committee or concurrence in the decision by two physicians other than the attending physician. The Constitution also prohibits a state from requiring that the abortion be in a hospital licensed by the Joint Committee on Accreditation of Hospitals or indeed that it be a hospital at all." By virtually eliminating state regulation of abortions, the Court simply let illegal "back-alley" abortionists to go legal, with their procedures unchanged.



It should also be remembered that a death occurs every time an abortion is performed—the death of an unborn child. Women have control over choosing an illegal abortion that they know could be harmful. The unborn has absolutely no control when the mother chooses to abort. In addition, abortion is a surgical procedure, and even though it is legal, it still puts many women at risk. Many women suffer post-abortion complications, such as severe muscle damage and damage to the uterine wall, which can lead to scarring, future miscarriages, ectopic pregnancies, and other future medical problems. In addition, induced abortion approximately triples the risk of suicide; women who carry full-term have about 1/2 the risk of suicide as the general female population.

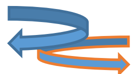
Abortion has not always been so safe. Between the late 800's and 1973, when abortion was illegal in all or most states, many women died or had serious medical problems after attempting to induce their own abortions or going to untrained practitioners who performed abortions with primitive instruments or in unsanitary conditions. Women streamed into emergency rooms with serious complicationsperforations of the uterus, retained placentas, severe bleeding. cervical wounds, rampant infections, poisoning, shock, and gangrene.

Around the world, in countries where abortion is illegal, it remains a leading cause of maternal death. In fact, many of the doctors who perform abortions in the' United States today are committed to providing this service under medically safe conditions because they witnessed and still remember the tragic cases of women who appeared in hospitals after botched, illegal abortions.

EFFECTS OF ABORTION

In 1973, the United States Supreme Court struck down every federal, state, and local law regulating or restricting the practice of abortion. This action was based on the premise that the states no longer had any need to regulate abortion because the advances of modern medicine had now made abortion ‹'relatively safe." Therefore, the Justices concluded, it is unconstitutional to prevent physicians from providing abortions as a "health" service to women.

National abortion policy is built upon this judicial "fact" that abortion is a "safe" procedure. If this "fact" is found to be false, then national policy toward abortion must be re-evaluated. Indeed, if it is found that abortion may actually be dangerous to health of women, there is just cause for governments to regulate or prohibit abortion in order to protect their citizens. This is especially true since over 1.5 million women undergo abortions each year.



Since the Court's ruling in 1973, there have been many studies into the aftereffects of abortion. Their combined results paint a haunting picture of physical and psychological damage among millions of women who have undergone abortions.

National statistics on abortion show that 10% of women undergoing induced abortion suffer from immediate complications, of which one-fifth (20%) were considered major.

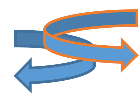
Over one hundred potential complications have been associated with induced abortion. "Minor" complications include: minor infections, bleeding, fevers, chronic abdominal pain, gastro-intestinal disturbances and vomiting. In a series of 82 abortions which occurred under closely regulated hospital conditions, 27 percent of the patients acquired post-abortion infection lasting 3 days or longer.

While the immediate complications of abortion are usually treatable, these complications frequently lead to long-term reproductive damage of much more serious nature. For example, one possible outcome of abortion related infections is sterility. Researchers have reported that 3 to 5 percent of aborted women are left inadvertently sterile as a result of the operation's latent morbidity. The risk of sterility is even greater for women who are infected with a venereal disease at the time of the abortion.

In addition to the risk of sterility, women who acquire post-abortal infections are five to eight times more likely to experience ectopic pregnancies. Between 1970-1983, the rate of ectopic pregnancies in USA has risen 4 fold. Twelve percent of all maternal deaths due to ectopic pregnancy. Other countries which have legalized abortion have seen the same dramatic increase in ectopic pregnancies.

Cervical damage is another leading cause of long term complications following abortion. Normally the cervix is rigid and tightly closed. In order to perform an abortion, the cervix must be stretched open with a great deal of force. During this forced dilation there is almost always caused microscopic tearing of the cervix muscles and occasionally severe ripping of the uterine wall, as well.

According to one hospital study, 12.5% of first trimester abortions required stitching for cervical lacerations. Such attention to detail is not normally provided at an outpatient abortion clinic. Another study found that lacerations occurred in 22 percent of aborted women. Women under 17 have been found to face twice the normal risk of suffering cervical damage due to the fact that their cervixes are still "green" and developing.



Whether microscopic or macroscopic in nature, the cervical damage which results during abortion frequently results in a permanent weakening of the cervix. This weakening may result in an" incompetent cervix" which, unable to carry the weight of a later "wanted" pregnancy, opens prematurely, resulting in miscarriage or premature birth. According to one study, symptoms related to cervical incompetence were found among 75% of women who undergo forced dilation for abortion.

Cervical damage from previously induced abortions increases the risk of miscarriage, premature birth, and complications of labor during later pregnancies by 300 — 500 percent. The reproductive risks of abortion are especially acute for women who abort their first pregnancies. A major study of first pregnancy abortions found that 48% of women experienced abortion-related complications in later pregnancies. Women in this group experienced 2.3 miscarriages for every one live birth. Yet another researcher found that among teenagers who aborted their first pregnancies, 66% subsequently experienced miscarriages or premature birth of their second, "wanted" pregnancies.

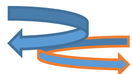
When the risks of increased pregnancy loss are projected on the population as a whole, it is estimated that aborted women lose 100,000 "wanted" pregnancies each year because of latent abortion morbidity. In addition, premature births, complications of labor, and abnonnal development of the placenta, all of which can result from latent abortion morbidity, are leading causes of handicaps among newborns. Looking at premature deliveries alone, it is estimated that latent abortion morbidity results in 3000 cases of acquired cerebral palsy among newborns each year. Finally, since these pregnancy problems pose a threat to the health of the mothers too, women who have had abortions face a 58 percent greater risk of dying during a later pregnancy.

The Psychological Effects of Abortion

Researchers investigating post-abortion reactions report only one positive emotion: relief. This emotion is understandable, especially in light of the fact that the majority of aborting women report feeling under intense pressure to "get it over with.

Temporary feelings of relief are frequently followed by a period psychiatrists identify as emotional "paralysis," or post-abortion "numbness. Like shell-shocked soldiers, these aborted women are unable to express or even feel their own emotions. Their focus is primarily on having survived the ordeal, and they are at least temporarily out of touch with their feelings.

Studies within the first few weeks after the abortion have found that between 40 and 60 percent of women questioned report negative reactions. Within 8 weeks after their abortions, 55% expressed guilt, 44% complained of nervous disorders, 36% had experienced sleep disturbances, 31% had



regrets about their decision, and 1 1% had been prescribed psychotropic medicine by their family doctor. In one study of 500 aborted women, researchers found that 50 percent expressed negative feelings, and up to 10 percent were classified as having developed "serious psychiatric complications.

Thirty to fifty percent of aborted women report experiencing sexual dysfunctions, of both short and long duration, beginning immediately after their abortions. These problems may include one or more of the following: loss of pleasure from intercourse, increased pain, an aversion to sex and/or males in general, or the development of a promiscuous life-style.

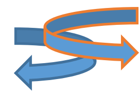
Up to 33 percent of aborted women develop an intense longing to become pregnant again in order to ¿make up" for the lost pregnancy, with 18 percent succeeding within one year of the abortion. Unfortunately, many women who succeed at obtaining their "wanted" replacement pregnancies discover that the same problems which pressured them into having their first abortion still exist, and so they end up feeling "forced" into yet another abortion.

In a study of teenage abortion patients, half suffered a worsening of psychosocial functioning within 7 months after the abortion. The immediate impact appeared to be greatest on the patients who were under 17 years of age and for those with previous psychosocial problems. Symptoms included: self-reproach, depression, social regression, withdrawal, obsession with need to become pregnant again, and hasty marriages.

The best available data indicates that on average there is a five to ten year period of denial during which a woman who was traumatized by her abortion will repress her feelings. During this time, the woman may go to great lengths to avoid people, situations, or events which she associates with her abortion and she may even become vocally defensive of abortion in order to convince others, and herself, that she made the right choice and is satisfied with the outcome. In reality, these women who are subsequently identified as having been severely traumatized, have failed to reach a true state of "closure" with regard to their experiences.

Repressed feelings of any sort can result in psychological and behavioral difficulties which exhibit themselves in other areas of one's life. An increasing number of counselors are reporting that unacknowledged post-abortion distress is the causative factor in many of their female patients, even though their patients have come to them seeking therapy for seemingly unrelated problems.

Other women who would otherwise appear to have been satisfied with their abortion experience, are reported to enter into emotional crisis decades later with the onset of menopause or after their youngest child leaves home.



Numerous researchers have reported that post-abortion crises are often precipitated by the anniversary date of the abortion or the unachieved "due date. These emotional crises Inay appear to be inexplicable and short-lived, occurring for many years until a connection is finally established during counseling sessions.

A 5 year retrospective study in two Canadian provinces found that 25% of aborted women made visits to psychiatrists as compared to 3% of the control group.

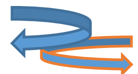
Women who have undergone post-abortion counseling report over 100 major reactions to abortion. Among the most frequently reported are: depression, loss of self-esteem, self-destructive behavior, sleep disorders, memory loss, sexual dysfunction, chronic problems with relationships, dramatic personality changes, anxiety attacks, guilt and remorse, difficulty grieving, increased tendency toward violence, chronic crying, difficulty concentrating, flashbacks, loss of interest in previously enjoyed activities and people, and difficulty bonding with later children.

Among the most worrisome of these reactions is the increase of self-destructive behavior among aborted women. In a survey of over 100 women who had suffered from post-abortion trauma, fully 80 percent expressed feelings of "self-hatred." In the same study, 49 percent reported drug abuse and 39 percent began to use or increased their use of alcohol. Approximately 14 percent described themselves as having become "addicted" or "alcoholic" after their abortions. In addition, 60 percent reported suicidal ideation, with 28 percent actually attempting suicide, of which half attempted suicide two or more times.

ABORTION IN UGANDA

Abortion in Uganda is illegal unless performed by a doctor who believes pregnancy places the woman's life at risk. The Ugandan Ministry of Health estimates that as of 2008, 26% of all maternal deaths result from abortion complications. This is aggravated by legal, socioeconomic, and geographical barriers to safe abortion, which compel women to use unsafe abortion methods and deter them from seeking post-abortion medical care. Contraception is not commonly used, leading to Uganda's need for family planning.

Laws on women's sexual reproduction and abortion



The legal status of abortion in Uganda is unclear because it provides for some exceptions while criminalizing the procedure in most cases. The Ugandan Constitution, in Article 22(2)[400] states: "No person has the right to terminate the life of an unborn child except as may be authorized by law.
However, what is authorized by law remains poorly understood.

The Penal Code of 1950, Section 141 on "Attempts to procure abortion" states:

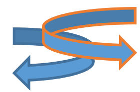
Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen year.

Section 142 lays out a punishment of seven years for an attempt to procure a miscarriage.

Nonetheless, under other provisions of the Penal Code an abortion may be performed to save the life of a pregnant woman. Section 217 of the Code provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother's life if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. In addition, Section 205 of the Code provides that no person shall be guilty of the offence of causing by willful act a child to die before it has an independent existence from its mother if the act was carried out in good faith for the purpose of preserving the mother's life.

Uganda, like a number of Commonwealth countries, whose legal systems are based the English common law, follows the holding of the 1938 English Rex v. Bourne[401] decision in determining whether an abortion performed for health reasons is lawful. In the Bourne decision, a physician was acquitted of the offence of performing an abortion in the case of a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future ab01tion cases performed on the grounds of preserving the pregnant woman's physical and mental health. The liberalization and legality of abortion in Uganda has been complicated by the use of rape as a weapon of war and terror by rebel groups in the region. In Uganda, an abortion is permitted to save a woman's life, preserve the physical health of the woman, and to preserve the mental health of

[400] Article 22(2) _ 1995 constitution of the Republic of Uganda.
[401] Rex v. Bourne



the woman. An abortion is not permitted in terms of rape or incest, fetal impairment, economic or social reasons, or by request. A legal abortion has to be performed by a licensed and registered physician with the consent of two physicians prior to the medical procedure.

Government family planning

In 1988, the Ugandan government launched a comprehensive program in response to the country's high fertility and growth rates, which adversely affected per capita incomes and threatened the sustainability of social services. The major goal was to increase the contraceptive rate from 5 percent to 20 percent by 2000. The services for birth control in Uganda are now accessible at clinics and are operated by the Family Planning Association of Uganda. Contraceptives like condoms helped to reduce the rate of HIV/AIDS in Uganda, but there are still a significant number of unwanted pregnancies leading to abortion.

There was direct support provided in the government's policy on contraceptive use, and since 1995, 8 percent of married women aged 15 to 49 use contraception. The total fertility rate from 1995 to 2000 was 7.1, and the age specific fertility rate per 1,000 women aged 15 to 19 from 1995 to 2000 was 180. The government has shown a lot of concern for the morbidity and mortality resulting from induced abortion, but there has been a number of complications in childbearing and child birth. In Uganda, the female life expectancy at birth from 1995 to 2000 was 40.4 percent.

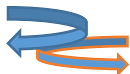
Movements

Movements such as Pro-Life Uganda (Pro-Life Uganda) and Pro-Choice Uganda (Pro Abortion) fight for their belief that either a woman has the right to choose what happens to her and her body (Pro-
Choice Uganda), or the fetus' life is sacred and everyone deserves to live (Pro-Life Uganda). There was a movement that took place that involved the Pro-Life organization.

Negative consequences of Abortion.

Whether you see yourself as either for or against abortion, it is important to clearly understand the facts surrounding this very difficult issue.

Some people argue that having abortion legal makes it "safe" for women and that the overturn of Roev. Wade would have a devastating impact on women's health.



The idea that legalized abortion makes abortion "safe" is untrue. There is strong evidence that there are many complications - physical, emotional and psychological - which can occur as a result of an abortion or multiple abortions.

National statistics show that 10% of women undergoing induced abortion suffer from immediate complications, of which one-fifth (2%) were considered major.

Over one hundred potential complications have been associated with induced abortion. "Minor" complications include: minor infections, bleeding, fevers, chronic abdominal pain, gastro-intestinal disturbances, vomiting, and Rh sensitization. The nine most common "major" complications are infection, excessive bleeding, embolism, ripping or perforation of the uterus, anesthesia complications, convulsion, hemorrhage, cervical injury and endotoxic shock.

A nationally recognized expert on the topic of post-abortion syndrome, and a sufferer of the syndrome, Vera Faith Lord, spoke with us for our radio/podcast program.

Sterility

Long-term damage can occur from the immediate complications. One such example, identified by Dr. David Reardon, post-abortion expert, is sterility. "Researchers have reported that three to five percent of aborted women are left inadvertently sterile as a result of the operation's latent morbidity. The risk of sterility is even greater for women who are infected with a venereal disease at the time of the abortion.

Premature Births

After induced abortions, premature future births are more likely. Why? During an abortion procedure, the cervix is artificially opened before it is ready to deliver the baby, and often the cervical muscle is torn. The cervical muscle must be stretched to allow the surgeon to enter the uterus to complete the abortion. If the cervical opening and muscle are torn, depending upon the extent of the tear and damage to the cervix, the muscle becomes weakened. Babies as they develop rest head down, preparing for birth. If the muscle is damaged, it may open prematurely to allow the baby to be born before he/she is fully developed.

Mental Problems

In a study of post-abortion patients only eight weeks after their abortion, researchers found that 44% of patients complained of nervous disorders, 36% had experienced sleep disturbances, 31%

had regrets about their decisions, and 11 % had been prescribed psychotropic medicine by their family doctor.

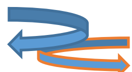
Research further shows that women who have had abortions are significantly Inure likely than others to subsequently require admission to a psychiatric hospital. At especially high risk are teenagers, separated or divorced women, and women with a history of more than one abortion.

Guilt is what an individual feels when she has violated her own moral code. For the woman who has come to believe, at some point either before or after the abortion, that she consented to the killing of her unborn child, the burden of guilt is relentless. There is little consolation to offer the woman who has transgressed one of nature's strongest instincts: the protection a mother extends to her young. In fact, many post-abortive women believe that any unhappy events that have occurred since the abortion were inevitable because they "deserve it.

Anxiety

Anxiety is defined as an unpleasant emotional and physical state of apprehension that may take the form of tension (inability to relax, irritability, etc.) physical responses (dizziness. pounding heart, upset stomach, headaches, etc.), worry about the future, difficulty concentrating and disturbed sleep. The conflict between a woman's moral standards and her decision to abort generates much of this anxiety. Very often, she will not relate her anxiety to a post-ãbortion syndrome abortion, and yet she will unconsciously begin to avoid anything having to do with babies. She may make excuses for not attending a baby shower, skip the baby aisle at the grocery store and so forth.

Temporary Feelings of Relief Temporary feelings of relief are frequently followed by a period psychiatrists identify as emotional "paralysis" or post-abortion "numbness." Like shell-shocked soldiers, these aborted women are unable to express or even feel their own emotions. Their focus is primarily on having survived the ordeal, and they are at least temporarily out of touch with their feelings. In a study of teenage abortion patients, half suffered a worsening of psychosocial functioning within 7 months after the abortion. The immediate impact appeared to be greatest on the patients who were under 17 years of age, and for those with previous psychosocial problems. Symptoms included: selfreproach, depression, social regression, withdrawal, obsession with need to become pregnant again, and hasty marriages.



Grief

No matter when the abortion occurred — a few days or many years ago, the women who underwent the procedure never forget the abortion experience, and grieve for their unborn children. The grief of losing a child never ends, but for those who chose to abort, the grief, combined with guilt, make the experience very difficult to forget or forgive. Most women report that when the anniversary date of the abortion comes, they remember it as if it were yesterday.

In addition, grief over an abortion is not limited to just the woman who had the abortion. Grief extends to the aborted baby's father, siblings of the aborted child, grandparents, aunts, uncles, and extended family.

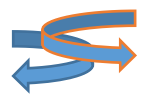
And the impact of that grief can even extend to partners — husbands, fiancées, boyfriends and future partners unless the abortion experience and the associated grief are resolved. "Nearly half of women in one study said abortion had "significantly altered" their relationship with their partner. 13 Breakups are common, even among couples with previously stable relationships. Abortion is significantly linked with a two-fold increased risk of alcohol abuse among women. Abortion followed by alcohol abuse is linked to violent behavior, divorce or separation, auto accidents and job loss.

Abortion and Breast Cancer

Dr. Joel Brind, an endocrinologist and biologist, and a leading expert in discussing the link between breast cancer and abortion, reports the following findings:

The first evidence of a link between abortion and breast cancer was published in April 1957 in the well-known Japanese Journal of Cancer Research, (no. 48) which is published in English. So the "news" of a link is not new. The cells in the breasts that develop for lactation are called TEBs (terminal end buds) and are undifferentiated until the end of a pregnancy. If pregnancy does not occur these cells tend to grow and are susceptible to becoming cancerous. The fully developed cells, called lobules, that result from full-term pregnancy are more or less immune to cancer.

Carcinogenesis is a two-stage process: l) exposure to a carcinogen that damages cell DNA and 2) a tumor promotion stimulus that makes cells grow. When TEB cells are exposed to a carcinogen they tend to become cancerous, whereas mature cells likewise exposed can be injured, but will not become cancerous.



In the case of induced abortions, however, the level of estrogen exposure is much higher, for two reasons. One is that, since the unborn child is viable, there is the same increase in estrogen levels that is found in healthy pregnancies. The second is that whereas spontaneous abortions usually occur in the first trimester, induced abortions are generally performed in the second or third trimester. Even one interrupted pregnancy means several weeks of exposure to abnormally high levels of estrogen. In a pregnancy that is carried to term, on the other hand, other hormones take over in the final stages, negating the effects of the earlier exposure to estrogen by differentiating cells for lactation and killing unneeded cells.

Dr. Frank Joseph, M.D., also investigated the abortion-breast cancer link. Some of his observations are summarized below:

The American Cancer Society (ACS) reports that one of every seven women in the United States will develop breast cancer.

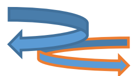
Breast cancer has risen dramatically in America (by 50%) since 1973, when abortions were legalized. ***Roe v. Wade*** and is also increasing worldwide. Recent studies have pointed out a dramatic relationship between the rate of abortion and the rising incidence of breast cancer. In fact, as the rate of abortion rises in America, so does the rate of breast cancer, with those women who have aborted having significantly higher rates.

Of the 1.3 million abortions done annually in the United States and accounting for the increased risk posed by abortion, researchers estimate that the 800,000 first-time abortions performed annually would thus generate roughly 25,000 excess cases of breast cancer each year, as the first group of wornen exposed to legal abortion advances in age.. ..Given the margin of error, the researchers predicted that excess cases of breast cancer would be between 9,000 and 40,000 per year, due to the impact of induced abortion.

However, the ACS (American Cancer Society) refuses to include induced abortions as a breast cancer risk. They say the link is inconclusive, but they are wrong. The evidence is overwhelming.

Abortion does not violate human rights

In the following viewpoint, Brian Elroy McKinley argues that although abortion destroys a potential human life, it is not murder. The embryo or fetus is not a separate human being because it is not able to survive outside the woman's body, he maintains. Only when a baby can live independently from its mother's body can it be granted full human rights. Until that point,



McKinley claims, a fetus' rights should not supersede the rights of a woman to protect and control her body. McKinley is an Internet consultant who resides in Colorado.

As you read, consider the following questions:

What do an ameba and a human zygote have in common, according to McKinley?

In the author's opinion, what is the difference between a human and a person?

In the context of McKinley's argument, what is the difference between physical dependence and social dependence?

All of the arguments against abortion boil down to six specific questions. The first five deal with the nature of the zygote-embryo-fetus growing inside a mother's womb. The last one looks at the morality of the practice. These questions are:

Is it alive?

Is it human?

Is it a person?
Is it physically independent?
Does it have human rights?
Is abortion murder?

Let's take a look at each of these questions. We'll show how anti-abortionists use seemingly logical answers to back up their cause, but then we'll show how their arguments actually support the fact that abortion is moral.

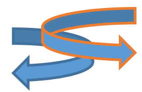
Is It Alive?

Yes. Pro-Choice supporters who claim it isn't do themselves and their cause a disservice. Of course it's alive. It's a biological mechanism that converts nutrients and oxygen into energy that causes its cells to divide, multiply, and grow. It's alive. But being alive does not give the zygote full human rights— including the right not to be aborted during its gestation.

Is It Human?

Yes. Again, Pro-Choice defenders stick their feet in their mouths when they defend abortion by claiming the zygote- embryo-fetus isn't human. It is human. Its DNA is that of a human. Left to grow, it will become a full human person.

Is It a Person?



No. It's merely a potential person.

Webster's Dictionary lists a person as "being an individual or existing as an indivisible whole; existing as a distinct entity.

Of course we've already seen that a simple hair follicle is just as human as a single-cell zygote, and, that unique DNA doesn't make the difference since two twins are not one per- son. It's quite obvious, then, that something else must occur to make one human being different from another. There must be something else that happens to change a DNA-patterned body into a distinct person. (Or in the case of twins, two identically DNA-patterned bodies into two distinct per- sons.)

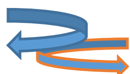
Abortion should be decriminalized

Criminal law and the threat of punitive sanctions should never be used to control or remove women's and girls' ability to make autonomous decisions around their own reproductive health and lives. The result of criminalization is that women and girls can be reluctant to seek abortion information or services, and healthcare providers can be reluctant to provide them even in circumstances permitted by law. The effect of criminal regulation — the threat of prosecution and the interference with quality healthcare — is known as the "chilling effect". Another con- sequence is the stigmatization of women or girls who do travel for abortions, who, despite the constitutional freedom to do so, may they feel like they are effectively criminals when they re- turn. That women have not been prosecuted for having abortions is no valid excuse for having such criminal offences in Irish law.

As noted earlier, several UN treaty monitoring bodies have stated concern at Ireland's criminalization of abortion. Most recently, the UN Committee on the Rights of the Child (the body monitoring implementation of the Convention on the Rights of the Child) called Ireland to decriminalize abortion in all circumstances and review its legislation with a view to ensuring children's access to safe abortion and post-abortion care services; and ensure that the views of the pregnant girl are always heard and respected in abortion decisions.

Decriminalization means that abortion is no longer regulated by criminal legislation, and is not a criminal offence in itself. It means women and girls would never be subject to a criminal

Sanction, and healthcare providers' practice would be other medical procedure. We urge the Assembly to consider recommending the decriminalization of abortion in all circumstances (for women seeking services and healthcare regulated in the same way as any workers providing



abortion services), while still enabling incidents of malpractice to be addressed, as with any other health service, through general criminal law or medical disciplinary procedures.

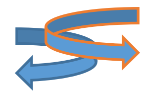
Abortion services must be provided without discrimination. Governments are prohibited from engaging in discrimination of any kind in their health-related laws, policies and practices. In addition to constituting gender discrimination in themselves, restrictive abortion laws have a disproportionate impact on women and girls from disadvantaged and marginalized groups who do not have the means to seek a safe and legal abortion in another country. Thus the gender discrimination inherent in restrictive abortion laws is often compounded by discrimination on other grounds such as age, socioeconomic status, migrant or refugee status.

Ireland's current constitutional provision for a "freedom to travel" to another jurisdiction to access abortion services abroad shirks the State's positive duties, which require it to ensure women and girls can access their human rights on a basis of equality. Moreover, multiple forms of discrimination intersect to make the "freedom" to travel entirely unrealizable for women and girls without the means to take this route. This has been highlighted by multiple UN Committees in their Concluding Observations on Ireland, including the Human Rights Commit- tee, CEDAW, CESCR and CRC Committees.

The CESCR Committee's General Comment 22 on the right to sexual and reproductive health is an important new normative document on abortion adopted in 2016, and clarifies the obligation for States to adopt positive measures to address inequalities:

In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distributions of power based on gender, ethnic origin. age, disability and other factors. Poverty and income inequality, systemic discrimination, and marginalization based on grounds identified by the Committee are all social determinants of sexual and reproductive health, which also have impacts on the enjoyment of an array of other rights as well... Therefore, to realize the right to sexual and reproductive health,

States parties must address the social determinants as manifested in laws, institutional arrangements and social practices that prevent individuals from effectively enjoying in practice their sexual and reproductive health.



As with the denial of any basic health service, when abortion is made inaccessible, marginalized women and girls are effectively denied a procedure that is safe and effective, and to which they have a right[402].

COMMON REASONS WHY WOMEN DO ABORTION

This part is borrowed from Sraboni Basu's _ 10 common reasons why women do abortion[403])

Abortions are most often a result of unwanted pregnancies. Love Matters brings you 10 common reasons why women choose abortion.

Failed contraceptive Research shows this is one of the most common reasons for abortion. All contraceptives have a failure rate, so even when you use it perfectly, there's always a small chance of pregnancy.

Financial status

A study released by Guttmacher Institute in 2005 states additional financial responsibility that comes with a baby as a reason why single women or couples go for an abortion.

Marital status and social norms

Social norms in many parts of the world shun children born out of wedlock. To avoid the social stigma, fear of familial rejection and abuse resulting from having a child out of wedlock, unmarried women might choose abortion as a safe way out.

Relationship problems

Guttmacher Institute's study also suggests that women might not want to continue with a pregnancy if their relationship with their partner is at a precarious stage or if the husband or partner is not in the favour of a child. Career or education Very often, single women or couples choose abortion as the baby might interfere with their career or educational plans.

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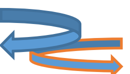
[402] See Amnesty International, "The total abortion ban in Nicaragua: Women's lives and health endangered, medical professionals criminalized" (AMR 43/001/2009); Amnesty International insert Ur "On the brink of death: Violence against Women and the abortion ban on El Salvador" (AMR 29/003/2014) Amnesty International.

[403] https://lovemattersafrica.com Accessed on December 29, 2021



Not wanting to expand the family

Women who already have children and do not want any •more go with the decision to abort. A research from the Department of Health, UK says that this is more common among older women.

Medical conditions

Cases where tests reveal genetic or birth defects in the foetus, usually are aborted, especially if detected in early pregnancy says another research. Also, women with serious health conditions might be advised to undergo abortion fearing for the child's and their own health. Victims of severe drug or alcohol abuse opt for abortion fearing the impact of abuse on the health of the baby. It is important to understand that abortion performed at unsafe places may lead to medical complications, even death.

Age

An Indian study suggests that highest number of abortions are chosen by women under 20 years. Women who are too young or too old to bear a child go for abortion thinking of the social, medical and financial implications.

Incest or abuse

Victims of rape or incestuous sexual acts usually prefer to do abortion .

Female foeticide

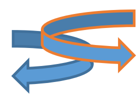
In certain parts of the world, sadly, the woman is forced or coerced by her immediate family or partner to abort if tests reveal a female baby. It is also known as sex-selective abortion.

An abortion is a deeply personal and strong life decision that a woman takes. Supporting her throughout the process will only help her come out of it stronger and healthier.

When is abortion legal?

Some societies ban abortion almost completely while others permit it in certain cases.

Such societies usually lay down a maximum age after which the foetus must not be abofted, regardless of the circumstances. At various times some of the following have been allowed in some societies:



Abortion for the sake of the mother's health including her mental health abortion where a pregnancy is the result of a crime such as crimes like rape, incest, or child abuse abortion where the child of the pregnancy would have an ' unacceptable quality of life' such as cases where the child would have serious physical handicaps, serious genetic problems, serious mental defects abortion for social reasons, including: poverty, mother unable to cope with a child (or another child), mother being too young to cope with a child abortion as a matter of government policy as a way of regulating population size as a way of regulating groups within a population as a way of improving the population. .

Most opponents of abortion agree that abortion for the sake of the mother's health can be morally acceptable if there is a real risk of serious damage to the mother. Abortion for social reasons is usually least acceptable to opponents.

Birth control and disability

Abortion as a substitute for contraception

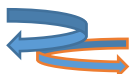
Some methods of contraception in fact amount to abortion during the very earliest stage of a pregnancy. This section only deals with abortion after the first week of pregnancy. Some societies have used abortion as a substitute for adequate provision of contraception, or quite deliberately to regulate population size. In 1965, a United Nations Conference on World Population in Belgrade said that abortion was the chief method of birth control in the world at that time.

Most western supporters of abortion rights do not support abortions carried out for such reasons - or at least not as explicit public policy. However some doctors do argue that abortion should be part of a country's contraception policy.

They say that a society that believes that people should plan their families must allow women to end unwanted pregnancies, in order to deal with failures of birth control.

Abortion and disability

Some ethicists dislike the argument that abortion should be allowed where the baby, if born, would suffer from physical or mental handicaps. They say that allowing this as a reason for abortion is offensive to disabled people; because it implies that they, and their lives, are less worthwhile than



the lives of 'normal' people. And some people with disabilities that could be put forward as grounds for abortion argue that they would much rather be alive than have been killed in the womb.

Section I(l)(d) of the UK's 1967 Abortion Act allowed termination of a pregnancy at any time if there was a significant risk of the baby being born seriously disabled. Under other circumstances abortion has to take place during the first 6 months of the pregnancy.

The Disability Rights Commission criticized this section in the following words:

The Section is offensive to many people; it reinforces negative stereotypes of disability and there is substantial support for the view that to permit terminations at any point during a pregnancy on the ground of risk of disability, while time limits apply to other grounds set out in the Abortion Act, is incompatible with valuing disability and non-disability equally.

In common with a wide range of disability and other organizations, the DRC believes the context in which parents choose whether to have a child should be one in which disability and non-disability are valued equally.

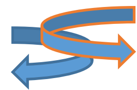
Disability Rights Commission

Other ethicists argue that whether or not people with disabilities are upset by this argument is irrelevant. They say that the argument is wrong because it attacks the principle that all human beings are equally valuable in their own ways. They say that it is just plain wrong to say that one life is less valuable than another. Other, pro-life, campaigners have objected to this argument on the grounds that it pelmits eugenic abortion - abortion to eliminate disabling genes from the human race

Abortion and eugenics

Abortion has been used in the past to stop the growth of population groups, or racial groups regarded as genetically 'inferior'. This is now regarded as a most serious breach of human rights and a criminal act.

Abortion has been used in the past to stop people with various genetic defects from having children. When this is done as a matter of public policy it is now regarded as a most serious breach of human rights and a criminal act.



Abortion and gender selection

In some countries, particularly India there is a major problem with female foeticide deliberately aborting foetuses that would be born as girls.

For sociological and economic reasons parents in some cultures prefer to have boy babies. When parents can discover the gender of the foetus in advance, they sometimes request the termination of a pregnancy solely because the foetus is female. While selective abortion for gender preference is illegal in India, the low proportion of female births relative to male births, together with other evidence, makes it certain that female foeticide is practised on a large scale.

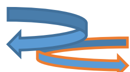
The interpretation and international legal frame work on abortion

Human rights are basic rights and freedoms to which all people are entitled, regardless of nationality, sex, national or ethnic origin, 'race', religion, language, or other status. Human rights are the cornerstone of the rule of law and an essential instrument with which states can ensure that all people are able to live in dignity and freedom.

Human rights include civil and political rights, such as the right to life, freedom from torture and other ill-treatment, and freedom of expression; and social, cultural and economic rights including the right to health, or to receive an education. Human rights are set out in international treaties. These international human rights treaties are negotiated and adopted by the member States of the United Nations (UN), including Ireland. States may decide to sign and ratify these treaties, whereupon they become legally bound by these treaties under international law.

The Universal Declaration of Human Rights (UDHR) [16] is the foundation of the international system of protection for human rights. It was adopted by the UN General Assembly [17] on 10 December 1948. The 30 articles of the UDHR establish the civil, political, economic, social, and cultural rights of all people. It is a vision for human dignity that transcends political boundaries and authority, committing governments to uphold the fundamental rights of each person.

Legally binding human rights treaties were subsequently adopted by the UN. The International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights were adopted in 1966, and both ratified by Ireland in 1989. These, together with the UDHR, form the core basis of international human rights law — together they are known as



the International Bill of Rights. Treaties setting out the particular rights of specific groups were later adopted, such as the UN Convention on the Elimination of Discrimination against Women or the UN Convention on the Rights of the Child.

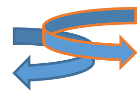
International human rights law lays down obligations which States are legally bound to respect. By acceding to these treaties, States assume obligations and duties under international law to respect, to protect and to fulfill human rights, and undertake to ensure that their domestic laws are compatible with their treaty obligations and duties.

The International Human Rights Framework

Despite decades of jurisprudence and standards providing clarity and insight, pervasive myths about what the human rights framework does and does not say in relation to abortion persist, fueling a debate in Ireland that can be challenging to understand. This section lays out some of the basis for the right to access legal abortion as it is framed in the context of international human rights law and standards.

The right of women and girls to access sexual and reproductive health information and services (including with regard to abortion), is firmly grounded in international human rights law. Specific health services that States are required to provide are not specifically enumerated in human rights treaties, and the same is true with abortion services. Nevertheless, the right of women and girls to have access to safe and legal abortion services is based on the interpretation and application of a wide range of human rights (enshrined in human rights treaties and national Constitutions and laws).

The UN Human Rights Committee, which monitors the International Covenant on Civil and Political Rights (ICCPR), in its General Comment no. 28 on the Equality of Rights Between Men and Women states that regulation of abortion implicates pregnant women's right to life; the right to privacy; and freedom from cruel, inhuman and degrading treatment.40 In economic, social and cultural rights terms, many aspects of reproductive rights, including access to abortion information and services, stem directly from the right to the highest attainable standard of physical and mental health.



The right to health: abortion services and information

The right to reproductive health is well established as an integral part of the international human right to health. Abortion is a core element of this right. The right to access abortion services is explicitly detailed by UN treaty monitoring bodies tasked with interpreting the content and meaning of rights enshrined in the core human rights treaties.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) [18] is the core provision on the right to health, and provides for "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Articles 2(2) and 3 of the ICESCR [19] provides that all rights, including the right to health.

"The right to health contains both freedoms and entitlements.

The freedoms include the right to control one's own health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health,"

It also outlines the basic requirements of health services provided as part of the right to health.

General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR) outlines key government's obligations in achieving the full realization of the right to health, which includes reproductive health. It explains that the right to health as it applied to the delivery of health services has four essential and interrelated elements:

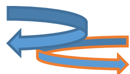
Availability - achieved by integrating health services into the existing health system

Accessibility - includes economic accessibility but also guarantees of non-discrimination

Acceptability - requires respect for medical ethics, as well as requirements that services must be delivered in a manner that is respectful of culture and gender-sensitive

Quality - indicates that services should be delivered to the highest quality that available resources can facilitate States must respect, protect and fulfill the right to health, i.e.:

- Respect: refrain from denying or limitedness to health services



- Protect: ensure equal access to health care and facilities provided by third par- ties and ensure that service providers meet standards and codes of conduct
- Fulfill: enable individuals to realize their right to health

The right to health is also outlined in ***Article 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW)***[404] , which commits States parties to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to farnily planning". The UN Committee on the Elimination of Discrimination against Women monitors the CEDAW Convention. This Committee's General Recommendation 24 on Article 12 of the Convention (Women and Health) clarifies that "access to health care, including reproductive health, is a basic right under the [CEDAW] Convention.

The right to health includes access to health information, education and other means to enable women and girls to exercise their equal right to decide freely and responsibly on whether and when to have children, and the number and spacing of their children. The UN CEDAW Committee also frames denial of access to abortion services as not only a violation of the right to health, but a denial of the principle of equality and non-discrimination as prohibition or criminalization of abortion denies access to a health service which only women need.

In 2016, the ***UN Committee on Economic, Social and Cultural Rights adopted General Comment on the right to sexual and reproductive health***. This important new General Comment reinforces how intertwined the right to reproductive health, including access to abortion services, is with a range of other human rights:

"The right to sexual and reproductive health is also indivisible from and interdependent with other human rights. It is intimately linked to civil and political rights underpinning the physical and mental integrity of individuals and their autonomy, such as the rights to life; liberty and security of person; freedom from t01ture and other cruel, inhuman or privacy and respect for family life; and non-discrimination and equality.

For example, lack of emergency obstetric care services or denial of abortion often leads to maternal mortality and morbidity, which in turn constitutes a violation of the right to life or security, and in certain circumstances, can amount to torture or cruel, inhuman or degrading treatment.

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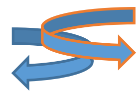
[404] Article 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW)



National legal frame work

Unplanned pregnancy is the root cause of most abortions. Preventing unintended pregnancy, and thereby the abortions that often follow, would eliminate nearly all inju1Y and death resulting from unsafe abortion. More than half of pregnancies in Uganda are unintended, and nearly a third of these end in abortion.

Ugandan women, on average, give birth to nearly two children more than they want. This difference— which represents one of the highest levels of excess fertility in Sub-Saharan Africa— illustrates just how difficult it is for women to meet their fertility desires.

The high levels of unintended pregnancy and unplanned births in Uganda can be attributed primarily to nonuse of contraceptives by women who do not want a child soon.

Married women's use of modern contraceptives has increased significantly in recent years, nearly doubling (from 14% to 26%) between 2000 and 2011. How- ever, modern contraceptive use remains too low to address the high rate of unintended pregnancy.

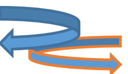
In 2011, one in three married women had an unmet need for contraception— they wanted to space or stop childbearing but were not using any method of contraceptives.

Despite their higher use of contraceptives, sexually active unmarried women have a greater level of unmet need than do married women. Unsafe abortion is common, but level of risk varies

The only national estimate of abortion incidence in Uganda comes from a 2003 study that reported an annual abortion rate of 54 abortions per 1,000 women of reproductive age, or one abortion for every 19 such women. This rate is far higher than the average rate for Eastern Africa (36 abortions per 1,000 women).

Ugandan women from all socioeconomic and demographic backgrounds have abortions. Their experiences, however, vary considerably. Compared with their poorer counterparts, women who are well off generally have access to a wider range of abortion providers and are more likely to use doctors, nurses and clinical officers, some of whom are able to provide relatively safe procedures.

However, since abortion is legally restricted in most cases, even skilled providers must work in clandestine environments, which often compromises the safety of the procedures they perform and frequently leads them to charge a high premium for their services.



Poor and rural women, whose access to skilled providers is limited by financial constraints and geographic distance, often resort to abortions performed by untrained providers using unsafe methods or attempt to self-induce an abortion.

Conclusion

Ugandan law allows abortion under some circumstances, but laws and policies on abortion are unclear and are often interpreted inconsistently, making it difficult for women and the medical community to understand what is legally permitted.

The Ugandan Constitution states that abortion is permitted if the procedure is authorized by law.

According to the 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, pregnancy termination is permissible in cases of fetal anomaly, rape and incest, or if the won-Ian has HIV. However, because interpretations of the law are ambiguous, medical providers may be reluctant to perform an abortion for any reason for fear of legal consequences.

A COMPARATIVE STUDY WITH OTHER COUNTRIES: ABORTION IN ENGLAND.

Abortion On Demand:

An English writer, Douglas argues that no woman should be forced to take on the responsibility and risk of pregnancy, for the benefit of a foetus, unless she is willing to do so.[405] Further to that, it has been argued that access to safe, legal abortions on demand is a prerequisite for the full and equal participation of women in society.[406] The important question is whether or not the law actually allows abortion on demand. Under the Abortion Act of England 1967 an abortion is available so long as the continuation of pregnancy would involve greater risk to the life of the mother[78], create a risk of grave permanent injury[407] or involves a foetus which would be severely handicapped.[408] If the foetus is less than 24 weeks old then a risk of injury to mental or physical health will also suffice.[409] It is generally accepted that pregnancy will always carry greater risks than non-pregnancy and it could therefore be argued that abortion on demand is available.

There is, however, a recent case which indicated that an abortion will not always be the best course of action. In *Re SS (Medical Treatment: Late Termination)*[410] a schizophrenic woman wanted a termination but frequently changed her mind due to her mental condition. The court held that due to the fact that the foetus was now 23 weeks old it was not in the best interests of the patient to

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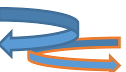
[405] G Douglas, *Law, Fertility and Reproduction*, pp.17-18
[406] S. Sheldon, *Beyond Control: Medical Power and Abortion Law* (London: Pluto Press, 1997), p.1 [78] s.1(1)(c)
[407] s.1(1)(b)
[408] s.1(1)(d)
[409] s.1(1)(a)
[410] [2002] 1 FLR 445



allow the abortion to proceed. This decision was based on the fact that none of the expert witnesses could say that a termination would be less damaging and traumatic that a normal delivery.[411] This was despite the fact that the child would have to be taken into care immediately, partially due to the risk that the mother would kill it, and that this would be extremely distressing for the mother.

Whilst this case was based around the premise of only treating mentally incompetents in a way which is in their best interests it also serves to show that it will not always be the case that an abortion will be less risky than the continuation of the pregnancy. It is somewhat doubtful what application this will have in relation to the competent patient who can be treated without the involvement of the courts. In ***Re SS*** it was not really possible to say that she consented to the termination, hence the courts fell back upon best interests. For the competent patient the issue of consent, both consent to termination and refusal of consent to continued pregnancy, is likely to be decisive. Whilst the abortion will only be available if the requirements for good faith opinions held by the doctors are satisfied, it is consent which will be the ultimate factor. If the patient desires to have an abortion then, bearing in mind the undeniable risks that are inherent in pregnancy, it is unlikely that at least one of the grounds for abortion will not be satisfied, especially if it is within the first 24 weeks. Hence, so long as the patient is competent, the starting point is the same as for general treatments, namely self-determination. If the patient is not competent then whilst allowing treatment and best interests will both apply it is the latter which will be decisive. The restrictions placed upon when an abortion will be lawful indicate that there is also a tertiary application of the principle of best interests so as to prevent treatments which would harm the

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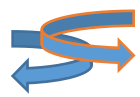
[411] ibid, at 452



foetus. The same has already been seen in relation to assisted reproduction and the competency of pregnant women.

So long as two doctors have a good faith opinion that one of the grounds is satisfied it is highly probable that an abortion will be available. Whilst the courts are willing to look at whether or not the opinion was formed in good faith it is highly unlikely that they will be asked to do so, only one case to date has done so.[412] In that case it was held that it was not necessary to show that the opinion was one which could not have been reached by other doctors, as an illogical opinion could still be held in good faith.[85] It was important however that the medical evidence indicated that the decision was not reached in good faith.[413] This would appear to be an application on the guiding principle of protecting the judgment of doctors. It is, at current, a one-off case however which appears to fall outside of the general pattern identified. It should also be looked at in context; the validity of the doctor's opinion is only an issue if the patient desires an abortion.

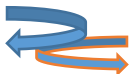
Sheldon argues that the way in which the Abortion Act 1967 is interpreted by doctors is being constantly liberalised.[414] Abortions which would have originally been refused are now being routinely performed. According to Tooley the most important question which must be asked is 'which patients should we select for termination?'[415] A case which will be of great importance, once it has been decided, involves a claim against the police for failing to bring charges against a

[412] *R v. Smith* [1974] 1 All ER 376 although the forthcoming Cleft Palate case will also have an impact here. [85] ibid, at 381

[413] ibid

[414] S. Sheldon, *Beyond Control: Medical Power and Abortion Law, p.2*

[415] The Medical Protection Society, *The Abortion Act 1967* (London: Pitman Medical, 1969), p.9



doctor for carrying out what is alleged to have been an illegal abortion.[416] The abortion in question was carried out under s.1(1)(d) which relates to children who will be seriously handicapped. The child in question would have had a cleft palate if the pregnancy had come to full term. The case argues, and understandably so, that this does not qualify as a serious handicap. It could be argued that, in some instances, doctors may demonstrate a tendency to accept, or even promote, an exaggeration of the seriousness of the child's condition. This would be supported by the way Harvard referred to a child with Down's Syndrome as being 'seriously deformed'.[417] This tendency could reinforce the importance of the patient's refusal to continue with the pregnancy. The decision of the court in this case will be of great importance as it will establish whether or not the courts are willing to analyse the validity of the opinions formed by doctors and go beyond simply asking whether that opinion was formed in good faith. If the case succeeds then the interests of the foetus may be of increased importance in the future.

Rights of a Foetus

A great deal of debate focuses upon the question of what the foetus is and when it attains interests worthy of legal protection. Whilst Catholics argue that this is the case from the moment of conception, others argue that this only happens upon birth. The more moderate argument, one that is both more acceptable and supportable, is that the foetus is under constant development from the moment of conception until the moment of birth and that at some point during this development it becomes worthy of protection. The problem is that nobody seems to be able to agree when this

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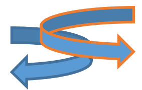
[416] S. Womack, 'Curate's Victory on Cleft Palate Abortion' *The Telegraph*, 2nd December 2003. This case has been delayed so as to await the outcome of a police investigation, see E. Day, 'Curate Postpones Cleft Palate Late Abortion Action' *The Telegraph*, 9th May 2004.

[417] J.D.J. Harvard, 'Legal Regulation of Medical Practice – Decisions of Life and Death: A Discussion Paper' (1982) J Roy Soc Med 351, p.354



should happen. One suggestion is that the ability to breathe is what matters,[418] yet Fortin discards this as just one development amongst many and argues in favour of the development of brain activity.[419] The problem with Fortin's argument is that the suggested alternative to the ability to breathe is just another single development amongst many. It seems reasonable to say that the protection offered to the unborn child should increase as the pregnancy approaches completion. Mason supports this when he states that the "rights of the potential 'creature in being' vis-à-vis the actual human being must increase as its potential approaches fruition".[420] This also recognises the undeniable fact that the interests of the foetus must be weighed against the rights of the mother. Thus, the further the foetus is from being a fully-fledged human, the fewer legally protected interests it should have. The ability to breathe becomes an important stage in this development because it is at this point that, according to the law, the child is capable of being born alive. Douglas submits that the law reflects a compromise which recognises the gradually increasing significance of the foetus as it develops but also gives weight to the fact that such development occurs in the womb of a living woman rather than an 'electrically powered incubator'.[94]

When considering what status the law attaches to the foetus it is essential to look at ***Attorney General's References (No. 3 of 1994)***.[421] Whilst this case was not directly concerned with medical law it addresses the status of the foetus during pregnancy. Lord Mustill rightly discarded the suggestion that the foetus was identical to the mother and defined the relationship between the mother and foetus as follows:

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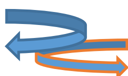
[418] *C v. S* [1988] QB 135

[419] J.E.S. Fortin, 'Legal Protection for the Unborn Child' (1988) 51 MLR 54

[420] K. Mason, 'Abortion and the Law' in S.A.M. McLean (ed), *Legal Issues in Human Reproduction*, p.57 [94] G Douglas, *Law, Fertility and Reproduction*, p.28

[421] [1998] Cr App R 91



"There was, of course, an intimate bond between the foetus and the mother, created by the total dependence of the foetus on the protective physical environment furnished by the mother, and on the supply by the mother through the physical linkage between them of the nutriments, oxygen and other substances essential to foetal life and development. The emotional bond between the mother and her unborn child was also of a very special kind. But the relationship was one of bond, not of identity. The mother and the foetus were two distinct organisms living symbiotically, not a single organism with two aspects. The mother's leg was part of the mother; the foetus was not."[422]

Hence the foetus must be seen as distinct from the mother who carries it, yet totally reliant upon her in every way. This seems to accurately represent the status of the foetus, whilst it is not a part of its mother it cannot survive on its own. Having denied that the foetus was a part of the mother Lord Mustill then went on to reject the possibility that the foetus was a person, instead he described it as a unique organism.[97] The way the law deals with the foetus reflects this unique nature of its existence.

Legal Protection of The Foetus In England.

Mason argues that it is necessary to differentiate between any rights possessed by the foetus *per se* and any rights of the resultant child which take account of its foetal existence.[423] It is also possible to identify a third area, that of quasi-rights of the foetus. This category, as will be explained later, covers the legal provisions which offer protection to the unborn foetus without providing it with accepted human rights. Through a combination of these three categories it can be seen that the interests of the foetus gain more respect as it develops and approaches its birth. This explains why, when a foetus is involved, the principle of best interests is applied so as to protect that foetus.

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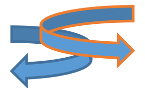
[422] ibid, at 99 [97]
ibid

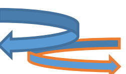
[423] J.K. Mason, *Medico-Legal Aspects of Reproduction and Parenthood* (Aldershot: Dartmouth, 2nd, 1998), p.144



Looking at the existence of legal rights possessed by the foetus *per se* there are a number of cases which serve to illustrate the approach of the courts to this issue. The starting point appears to be the possible qualification created by Lord Donaldson in *Re T*.[424] This indicated that the only possible qualification to the need for consent from a competent adult would be in the case of a pregnant woman who refuses treatment which is necessary to safeguard the health of the foetus. In ***Re S (Adult: Refusal of Treatment)***,[425] Stephen Brown LJ agreed to give a declaration dispensing with the need for the consent of a competent woman so that the doctors could carry out a caesarean section to deliver her baby. Whilst there have been a number of other cases authorising non-consensual caesarean sections they have all related to incompetent patients. The main problem with the judgment of Stephen Brown LJ is that it contains no reasoning and is based on no valid authority.

The position has now been made clear by *St George's Healthcare NHS Trust v. S*.[426] Judge LJ accepted the complexity of the situation when he stated that the interests of the foetus could not be disregarded on the basis that in refusing treatment the woman is only refusing treatment for herself.[102] Despite that, it was still held that whilst pregnancy increases the personal responsibility of a woman it does not diminish her entitlement to undergo medical treatment, neither is the right to refuse treatment diminished simply because that refusal may seem repugnant.[427] Whilst the result of this decision is to prohibit non-consensual treatment of pregnant women, it should be noted that Judge LJ seemed to express some disgust at the mother's refusal of consent. The court

[424] [1992] 4 All ER 649
[425] [1992] 4 All ER 671
[426] [1998] 3 WLR 936, the same result was also reached in *Re MB (Medical Treatment)* [1997] 2 FLR 426 [102] [1998] 3 WLR 936, at 953
[427] ibid, at 957



was keen to emphasis that the viable foetus was not lifeless and was certainly human.[428] Essentially the court accepted that there was a hierarchy of rights and interests that had to be respected. Whilst the foetus has the need of medical assistance that need cannot prevail over the rights of the parent.[429]

The fact that this appeal took place after the baby had been delivered by a caesarean section permitted by the original court could indicate that the best interests of the child were protected in practice whilst the mother's autonomy was theoretically reinforced.[430] Alternatively it could be argued that judgments sought to protect the doctor's clinical judgment as to what was required. At first instance the doctors were permitted to carry out the treatment they deemed necessary. Once that procedure had taken place the appeal held that the rights of the mother should have been respected. At that point though it was too late to make any practical difference, the procedure had been carried out and the child was born. It is submitted that it is the first argument that is correct and that whilst those interests no longer override adult autonomy they are still important. This has been seen in relation to the competency of pregnant women.

Another case of importance here is *Re F (In Utero)*,[107] which involved an attempt by a local council to make a foetus a ward of court so that they could ensure its safe delivery and upbringing. May LJ held that the court had no jurisdiction to grant the order yet expressed that if the jurisdiction had existed it would have been used in this case.[431] The main reason for the refusal of the request to make the foetus a ward of court was the fact that it would, of necessity, have required the liberties

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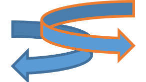
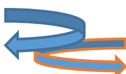
[428] ibid, at 952
[429] ibid, at 957
[430] After the appeal decision though this option would no longer be available to first instance courts hearing future cases as the court would be bound, by this decision, to respect the mother's refusal of consent. [107] [1988] Fam 123
[431] ibid, at 138



of the mother to be restricted.[432] The general position, therefore, appears to be that the foetus has no legal rights until it is born. This has been confirmed by the cases of *Paton v. British Pregnancy Advisory Service Trustees*[433] and *C v. S.*[434] The former of these cases provides the most definitive explanation when it states that in English law it is not possible for the foetus to have rights of its own until it is born and has a separate existence from the mother.[435] This reinforces the suggestion that it is the autonomy of the pregnant woman that is the main focus of the law. This is protected through an application of the guiding principle of self-determination and the need for the woman's consent prior to any treatment.

Despite the fact that the courts have refused to accept that the foetus is capable of possessing rights which can be relied upon during the pregnancy, there are a number of statutory provisions which do offer some degree of protection. These are what were referred to earlier as quasi-rights of the foetus which, whilst they are not rights as such, do offer some protection. Under the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929 the foetus received absolute protection subject only to the right to life of the mother.[436] Whilst the law on abortion now provides a defence against these provisions they still serve to indicate the value the law places upon the foetus. In addition there are two other legislative provisions worth noting. Firstly, no research can be carried out on an embryo, or foetus, older than 14 days.[437] Further to that, an abortion based upon the fact that the mother is under risk of injury to physical or mental health,

[432] ibid, at 135
[433] [1979] QB 276
[434] [1988] QB 135
[435] [1979] QB 276, at 279
[436] Infant Life (Preservation) Act 1929, s.1(1)
[437] Human Fertilisation and Embryology Act 1990, ss.3(3)(a), 3(4)



although not grave injury or death, can only be carried out if the foetus is under 24 weeks old.[438] Whilst the level of protection offered by these provisions is limited they indicate that the foetus does have some interests which the law is concerned in protecting.

Whilst the courts have refused to accept that there are any rights which can be exercised by the foetus there is the possibility that some events that occur during the pregnancy can give rise to an action by the child after birth. As Lord Hope stated:

"For the foetus, life lies in the future, not the past. It is not sensible to say that it cannot ever be harmed, or that nothing can be done to it which can ever be dangerous. Once it is born it is exposed, like all other living persons, to the risk of injury. It may also carry with it the effects of things done to it before birth which, after birth, may prove to be harmful."[439]

This gives rise to the idea that the rights of the newborn child can take into account events occurring during the foetal existence. One example of rights operating in this manner is found in *Re D (A Minor)*[440] where the courts accepted that the activities of the mother during the pregnancy could result in the child being made a ward of court as soon as it is born.[441] The House of Lords made it clear that it was permitted to look at events taking place prior to the child's birth in deciding what was now in its best interests. Hence it can be seen that whilst the interests of the foetus cannot override the autonomy of the mother during pregnancy, as that would effectively give the foetus rights stronger than those which would be possessed by the child after birth, they are still

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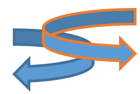
[438] Abortion Act 1967, s.1(1)(a)

[439] *Attorney General's Reference (No.3 of 1994)* [1998] Cr App R 91, at 116

[440] [1987] AC 317

[441] Another example of this, whilst not relevant to the availability of treatment, is statutory and is found in the Congenital Disabilities (Civil Liability) Act 1976. Section 1 provides that if a child is injured in the womb then that child will be capable of claiming damages once it has been born. Heilbron J stated that such claims crystallise upon the birth of the child, it is only at this date that the child acquires the status of legal persona and can exercise a legal right, see *C v. S* [1988] QB 135, at 140.



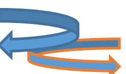
of importance to the law. It is for this reason that, when treatment will affect a foetus, the principle of best interests will be applied to help determine the availability of that treatment.

Paternal Rights:

Having already detailed the way the courts have officially rejected any attempts to restrict the activities of the mother on behalf of the foetus it may be obvious that any attempt to do so on behalf of the father will automatically fail. To say that the foetus can have no rights capable of overriding the mother's would be nonsensical if the courts were then to permit the rights of the father to do exactly that. It must be remembered that whilst the foetus' life is endangered by the actions of the mother the most that can be claimed by the father is that he will not have a child. Mason has argued that genetics alone cannot give the father rights equal to those of the mother due to the drastically disproportionate nature of the effort, both physical and mental, involved in the production of offspring.[442] Fortin states that many people would accept that the law should not enable a father to force his estranged wife or girlfriend to bear an unwanted child.[443] That being said though, there are frequent arguments in favour of paternal rights relating to the protection of the foetus. Such arguments usually attempt to establish that the father should have some right to prevent any abortion of the foetus.

Three cases are of importance in relation to the concept of paternal rights. The first of these is *Paton v. British Pregnancy Advisor Service Trustees*.[121] In this case a father attempted to obtain an injunction designed to prevent the mother from having an abortion. The court rejected the claim

[442] K. Mason, 'Abortion and the Law', p.59
[443] J.E.S. Fortin, 'Legal Protection for the Unborn Child', p.71 [121]
[1979] QB 276



and explained, without any qualifications that it was neither possible nor desirable for the court to use injunctions such as this to control behaviour within the matrimonial relationship.[444] The judge pointed out that the Abortion Act 1967 gave no right of consultation to the father and that he was possessed of no legal right, enforceable in either law or equity, by which he could prevent his wife's abortion.[445] He also stated that the law of England provides the father with no right to have a say in the destiny of a child he fathers.[446] The judgment focused clearly on the lack of any right supporting the father's claim compared with the mother's right to self-determination.

The second case involves the same parties and facts but was heard by the European Commission of Human Rights.[447] After losing his case in the English courts Paton attempted to claim that his rights under the European Convention of Human Rights were being infringed. The judgment stated that:

"*In the present case the Commission, having regard to the right of the pregnant woman, does not find that the husband's and potential father's right to respect for his private and family life can be interpreted so widely as to embrace such procedural rights as claimed by the applicant, i.e. a right to be consulted, or a right to make applications, about an abortion which his wife intends to have performed on her.*"[448]

The Commission refused to accept that the father's right to respect for family life, limited as it is by the need to respect the rights of others, could prevent the mother from having an abortion.[449] The father is dealt with in a similar way to the foetus. Whilst the court did not reject that he had a legitimate interest, they refused to acknowledge the existence of any rights capable of overriding

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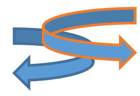
[444] ibid, at 280
[445] ibid, at 281
[446] ibid, at 282
[447] [1981] 3 EHRR 408
[448] ibid, at 417
[449] ibid, at 416



those of the mother. Some importance was placed upon the fact that the abortion was carried out to prevent harm to the mother's health, yet it has already been shown that this is quite a low threshold to overcome.

In ***C v. S***[450] the matter of whether or not a father could prevent his wife from having a legal abortion was not actually raised. However Heilbron J did state that the husband or father is not entitled to disclosure of information, consultation or a right of veto.[451] Further to that, Sir Donaldson MR, on appeal, stated if he had been called to decide on this matter then a great deal of weight would have had to be given to the decision of ***Paton v. British Pregnancy Advisory Service Trustees*.**

The legal position is accurately summarised by Douglas who states that there is no requirement to consult the father prior to an abortion let alone give him a right of veto. Douglas also states that "the mother, and only the mother, of the foetus has the right to decide whether or not to seek an abortion".[452] This appears to be a true description of the current position under the Abortion Act 1969. This would fit in well with the idea that the guiding principle of self-determination operates in a manner which places the autonomy of the mother above the interests of the foetus and denies the father any rights at all. The father in this instance must be distinguished from the assisted reproduction gamete donor who has a direct, physical, involvement in the treatment. Whilst it may be beneficial to the relationship between mother and father if the decision to abort is reached jointly, there is no legal requirement that this should be the case. It could be argued that whilst the child will benefit from being born it will experience what will probably be a permanent rift between

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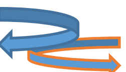
[450] [1988] QB 135

[451] ibid, at 139

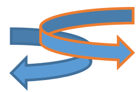
[452] G Douglas, *Law, Fertility and Reproduction*, p.82



the parents and will discover that its mother never wanted it to be born in the first place. It is hard to see how this could ever be in the best interests of the child.

Summary:

Just as the law relating to assisted reproduction represents the normal approach to competent adults combined with an application of the principle of best interests, the same is true of the approach to abortion, although best interests may not be as strong. The reduced importance of the best interests principle, when compared to assisted reproduction, can be explained due to the fact that the result would be to force the mother to endure a pregnancy she does not desire. In contrast, the application of the principle in relation to assisted reproduction only prevents the woman from becoming pregnant, which is an end that she desires but is not naturally capable of achieving. The same justification can be used to explain why the father has no rights in relation to abortion whilst a gamete donor retains control. In relation to abortion there must be a consent-refusal combination whereby the woman consents to the abortion whilst at the same time refusing to give consent to the continuation of her pregnancy. Whilst in relation to assisted reproduction incompetent adults are not likely to be encountered, it has been seen that in relation to abortion the essential principle applicable to such patients is that of best interests. By looking at abortion in this way it is possible to explain how the law can accept that foetuses have interests, albeit not rights as such, but still override them. When faced with a conflict of the mother's right to self-determination against the foetus' interests, the mother's autonomy will usually prevail.



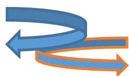
THE WAY FORWAD ON ABORTION

Right to Life protections do not apply before birth

Some opponents of abortion claim that right to life protections set forth in international and regional human rights treaties are accorded before birth, thereby prohibiting states from allowing abortions. The history of the development of UN human rights treaties, including the Convention on the Rights of the Child, and the subsequent interpretation of their right to life provisions by their treaty monitoring bodies, shows that the right to life treaty provisions only apply after birth. In fact, no human rights body has ever found allowing termination of pregnancy to be incompatible with human rights. UN bodies, however, have recognized that prenatal interests can be protected through promoting the health and well-being of pregnant women. Moreover, international human rights bodies have found restrictions on access to abortion in law or in practice to be a violation of state obligations, including obligations to protect pregnant women's and girls' rights to life and health.

Barriers to access must be identified and removed. Not only does the State have an obligation to make abortion services legal, but they have an obligation under international human rights law to ensure that where abortion is legal, it is also available and accessible to women. This requires States to establish a clear legal and policy framework on abortion that provides guidance on the circumstances in which abortion should be practiced.

Rhonda Copelon et. al. 'Human Rights Begin at Birth: International Law and the Claim of Fetal Rights', in Reproductive Health Matters Vol. 13, No. 26, November 2005, pp. 120-129. An argument to the contrary is erroneously built upon Paragraph 9 of the UN Convention on the Rights of the Child[22] Preamble, which provides: "Bearing in mind that, as indicated in the Declaration of the Rights of the Child, 'the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.' The history of negotiations by states on the treaty clarify that these safeguards "before birth," must not



affect a woman's choice to terminate an unwanted pregnancy. As originally drafted, the Preamble did not contain the reference to protection on the Rights of the Child.

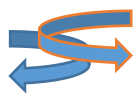
The Holy See led a proposal to add this phrase, at the same time as it "stated that the purpose of the amendment was not to preclude the possibility of an abortion" (UN Commission on Human Rights[453] , Question of a Convention on the Rights of a Child: Report of the Working Group, 36 th Session, UN Doc. E/CN.4/L/1542 (1980)). Although the words "before or after birth" were accepted, their limited purpose was reinforced by the statement that "the Working Group does not intend to prejudice the interpretation of Article 1 or any other provision of the Convention by States Parties." UN Commission on Human Rights, Report of the Working Group on a Draft Convention on the Rights of the Child, 45 th Session, UN Doc. E/CN.4/1989/48 (1989), p. 10.

The European Court of Human Rights, in A, B, and C v Ireland, left the issue of when life begins for the purposes of abortion for states to determine, invoking their margin of appreciation doctrine. (The margin of appreciation is a doctrine with a wide scope in international human rights law. It was developed by the European Court of Human Rights, which sets that States are in the best position to interpret the implementation of a human right set in the European Convention of Human Rights). Although the Court declined to address the explicit question of the extent to which Convention protection applies prenatally for the purposes of abortion, the Court has consistently found state failure to implement existing abortion laws and barriers to accessing abortion as violations of the Convention, including in the case of A, B, and C v Ireland[454] .

See for example, CEDAW Article 12; CEDAW General Recommendation 24 on Women and Health, UN Doc. A/54/38/Rev.l (1999), para. 31(c) be legally provided, and ensures timely remedy and redress for women and girls who are denied access to legal abortion services. In addition, states must also provide post-abortion care to women, regardless of whether abortion is legal.

Criminal laws against abortion create a "chilling effect" which may deter medical professionals from providing abortion even in cases when it is legal, and contribute to severe stigma against women, which can be a very real barrier to access in practice. Additional barriers stemming from the fact abortion is treated as a criminal law matter rather than a health service include mandatory

[453] UN Commission on Human Rights
[454] A, B, and C v Ireland



waiting periods, biased counselling, a requirement for authorization by multiple providers, criminalization of provision of abortion related information and stigma related to abortion.

Conclusion and Recommendations

Amnesty International Ireland has repeatedly called on the Government to repeal the Eighth Amendment to the Irish Constitution, so as to enable the provision of a human rights compliant framework for abortion and information, in law and in practice. We have also called on the Government to:

Decriminalize abortion in all circumstances (for women seeking services and health care workers providing abortion services), while still enabling incidents of malpractice to be handled through general criminal law, as is done with any other health service.

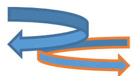
Repeal the Protection of Life during Pregnancy Act and replace it with a human rights compliant legislative framework that ensures access to abortion both in law and in practice, so women and girls can access ab01tion services in a timely manner and through processes that respect their autonomy.

Repeal the Regulation of Information Act 1995 and ensure full provision of information on abortion services

Regulate conscientious objection in a way that does not jeopardize women's and girls' human rights. Make clear that those who object to providing abortion services have a duty to make a timely referral to another health care provider who will offer the services, and to always provide care, regardless of their personal beliefs or objections, in emergency circumstances or where a referral or continuity of care is not possible.

Eliminate unnecessary barriers to accessing abortion services, which are unsupported by evidence, such as requirements that a provider consult with one or more other health care practitioners before performing an abortion or that abortions must always be per- formed in tertiary care facilities.

Eliminate specific access barriers impacting marginalized groups including young women, asylum-seekers, undocumented migrants, women or girls with limited financial means, and members of the Traveller community.



Amnesty International urges the Citizen's Assembly to consider suppolting these calls in its recommendations to the Oireachtas.

However Uganda should ensure that free or affordable public-sector family planning services reach all women, especially those who are poor and young, to reduce unmet need for contraception and lower the unintended pregnancy rate. Programs should offer comprehensive family planning services, including counseling, and a wide range of contraceptives methods, to enable women to choose the best methods for themselves, to use methods effectively and to switch methods when desired.

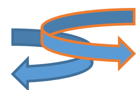
Expand and improve the quality of post abortion care services to treat the often serious health complications resulting from unsafe abortion. More providers, including midlevel ones, must be trained in comprehensive post abortion care (particularly provision of manual vacuum aspiration) to adequately address the need for services in all parts of the country. Sensitivity training of providers is also needed.

Improve health care providers' ability to offer abortion services within the confines of the law. It is critical to raise providers' awareness of the content and scope of Uganda's abortion Law and equip them with appropriate training to provide safe abortion services in legally permitted circumstances.

In a nutshell; The World Health Organization (WHO)[455] guidelines on abortion, developed on the basis of public health evidence, specify that despite the increased use of contraceptives, women's need for abortion cannot be eliminated. WHO also notes that restricting legal access to abortion does not decrease the need for abortion, but it is likely to increase the number of women seeking illegal and unsafe abortions which can lead to injuries or even death.

EUTHANASIA IN UGANDA

[455] The World Health Organization (WHO)



5.6 EUTHANASIA

Introduction.

Questions regarding death and dying have recently become popular topics for discussion by lawyers, physicians, theologians, philosophers, and the public. Is euthanasia murder? Should steps be taken towards legalization? Is private regulation an effective method for control? These questions are numerous and others are being asked with increasing frequency. These are urgent questions that require careful and thorough analysis and comprehensive answers. An opinion needs to be taken on whether abortion should be legalized or criminalized.

One of the main problems with euthanasia, as a concept, is that different people use it to refer to different things.[456] By looking at the involvement of the doctor and the patient's participation in the decision making process it is possible to identify a number of types of euthanasia:

- Passive Voluntary – Patient's refusal of treatment results in doctor not acting.
- Passive Non-Voluntary - Doctor does not act but does so without patient involvement.
- Passive Involuntary – Patient requests treatment but the doctor does not respond.
- Active Voluntary - Doctor acts in response to patient's request to die.
- Active Non-Voluntary - Doctor acts without either request or opposition.
- Active Involuntary - Doctor acts despite patient wanting to live.

For the purposes of this thesis the term euthanasia will be used to refer to active euthanasia designed to benefit the patient.[457] There will be no discussion of involuntary[458] forms of euthanasia

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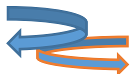
[456] Keown states that there is no universally agreed definition and that this is one of the main causes of confusion over the issues involved, see J. Keown, *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002), p.9

[457] This approach can be seen as gaining support from statements made by Lord Goff who has defined euthanasia as actively causing death to avoid or end the suffering of the patient, see *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 867

[458] Whilst some support the distinction between involuntary and non-voluntary euthanasia, for an example see J. Keown, *Euthanasia, Ethics and Public Policy*, p.9, others question this separation. Some academics even question that there is a distinction between voluntary and non-voluntary euthanasia, see J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p. 529.



which, it is submitted, are not really worthy of discussion as medical treatments, but are more adequately described as falling wholly within the remit of the criminal law of murder.

Background.

People ailing from serious illness that have stripped them off their health, livelihood, peace of mind and dignity have been consigned the footnotes of Uganda's socio-economic advancement and constitutional change. The constitution is silent on the rights and needs of these people. While advancement in medical research and treatment has offered hope to countless people grappling with complicated illnesses throughout the world, a great number still continue to endure a demeaning, undignified and intolerable life as a result of their A constitution is the source, the jurisprudential fountain head from which other laws must flow, succinctly and harmoniously[459]

A constitution is a living document; it goes beyond addressing the needs of the living, but the posterity as well. In order for the people of Uganda to recognize, respect, and appreciate the constitution, we must enjoy and feel protected by this supreme law[460] we must see its effects in our day to day life.

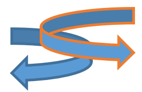
The constitution of Uganda 1995 thrust a robust and progressive bill of rights into the Ugandan system that provides for among other things the right to life and human dignity[461] . As a consequence and within the letter and spirit of those provisions, it will be examined if legalizing euthanasia would offer relief to persons enduring endless and incurable suffering, as a result of illness for them to end their life voluntarily subject to the approval of qualified medical practitioners and within the strict and explicit provisions of the law.

Our attitudes towards death have in recent years. In the past death was simply something that happened to us and had to be accepted. However with technology developments, it has become impossible to exercise greater control over our dying. Albeit the extent to which people should have control of their or another's death is highly controversia1[462].

Therefore owing to the controversial and maligned nature of the topic of euthanasia, and taking into account the pluralistic nature of the society we live in, I shall also look into and compare the implementation of the practice of euthanasia in countries that have legalized the same, and the lacunas that are likely to pop up if euthanasia is allowed in Uganda, and lastly the chances of success of such a practice within our borders.

Euthanasia and related issues have caused a great debate across the globe. Courts and legal scholars have faced a considerable challenge of determining whether euthanasia can truly fall within the scope of the fundamental human rights as recognized by a raft of international conventions, treaties and constitutions across the world. Euthanasia and related issues are topics that courts have

[459] S.N mwangi a history of constitutional making in Kenya 2012 page 1
[460] Article 2(2) Ugandan constitution 1995.
[461] Chapter 4 article 22 and 24 respectively of the 1995 constitution of Uganda
[462] J herring, medical law and ethics 4th edition page 473

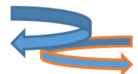


struggled to deal with. In Britain, the House of Lords called upon parliament to legislate on the area, Politicians, lawyers and judges have exhibited hands off approach[463] for many opponents of euthanasia.

At the heart of the issues surrounding euthanasia is the principle of sanctity of life,[464] they argue that the right to life is inviolable. For example, the House of Lords select committee on medical ethics concluded that the prohibition on intentional killing was "the cornerstone of law and of social relationships[465]

From a religious perspective, this vies is also largely upheld and respected. Pope John Paul Il said in one of his speeches that "euthanasia is a grave violation of the law of God. Man's life comes from God; it is his gift, his image and imprint, a sharing in his breath of life. God therefore is the sole hold of this life. More still, God has given to human kind the gift of life. As such, it is to be revered and cherished. Those who become vulnerable through illness or disability deserve special care and protection. We do not accept that the right to personal autonomy requires any change in the law in order to allow euthanasia.

[463] page 473 ibid. [7] Holy bible genesis 1:26, 1 Corinthians 2:16, Job 1:21, John 10:10, Matthew 22:39, psalms 139:13-16, john 13:34 [8]page 517 ibid.
[464] Church of England 1999
[465] Vitae gospel or life Paul john pope Il 1995.



AN OVERVIEW OF EUTHANASIA

Euthanasia is a term derived from a Greek word meaning happy or fortunate in death. It is commonly used now to denote the merciful infliction of death to avoid torment in fatal and incurable diseases, usually by the consent of the patient or family.

Accounts exist of tribes, ancient and modern who abandoned their aged and infirm, choked, starved or even stomped or clubbed them to death[466]

In some Eskimo cultures an old or sick Eskimo tells his family that he is ready to die and the family if it is a good one they will immediately comply by abandoning the aged person to the ravages of nature by killing him.[467]

Roman historian Plutarch, in his historical accounts of the city state of Sparta in Greece stated;

"The father had no authority to rear his child, when born but brought it to a place called the "lesche". Here the elders of the tribe sat and examined the infant but if it were feeble and ill shaped, they sent it to the so called place of casting out a chasm near Mt, taygetos considering that for a child ill- suited from birth for health and vigor to live was disadvantageous for itself and for the state."

This was albeit a more brutal and inhumane form of Euthanasia, an antithesis of the euthanasia allowed today by law.

From a philosophical perspective, both Plato and Aristotle were in favor of some sort of infanticide, similar to the practice in Sparta.

Plato in the republic wrote[468]

"The children of inferior parents, and any deformed offspring's of others, they

(guardians) will secretly put out of the way as is fitting. The city state of Athens also seemed to have a form of state assisted suicide. The roman writer Libanius reports:

"Whoever no longer wished to live shall state his reasons to the senate and after having received permission, shall abandon life. If your existence is hateful to you, die. If you are overwhelmed by fate, drink the hemlock, if you are bowed with grief, abandon life, let the magistrate apply him with the remedy, and his wretchedness will come to an end."

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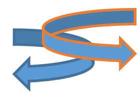
[466] History of euthanasia <http:www.christian life resources.com/article/historical look at euthanasia 280 > (30th June 2015)

[467] D Humphrey and A wictett, the right to die 1985 (DH)

[468] (380 BC).



The conclusion that can be drawn from these accounts is that among wise men of Greece ending one's life for reasons of pain, illness was considered rational though this was not unanimously upheld.

In Judaism and Christian Rome, the taking of life except when done by civil authorities in the interest of justice was never condoned. The suicide of the king Saul in the bible[469] The Talmund forbids suicide and does not even discuss mercy killing. It is written in the Talmund. And let not thy (evil) inclination assure thee that the grave is a place of refuge for thee."

Islam has held largely the same view. Several Ayat [16] in the Koran talk about death. The Koran states that it is God who gives life and he is the one who takes it away. The Koran [i7] confirms that it is Allah only who gives life and takes it away. It reads "we have decreed death among you.'›

Allah also says in[470] "he it is who gives life and causes death. And when he decides upon a thing he only says to it: bel and it is". "Verily we give life and cause death; and to us is the final return."

Later, renaissance Europe adopted a more relaxed approach to euthanasia, and was even amenable to the idea of voluntary euthanasia. Sir thorn more, in his utopia in 1516 stated "if besides being incurable the disease also causes constant excruciating pain some priests and government officials visit the person concerned and say...... since your life is a misery to you, why hesitate to die you are imprisoned in a torture chamber, why don't you break out and escape to a better world, well arrange for your release If the patient finds these arguments convincing, he either starves himself to death or is given a soporific and put painlessly out of his misery, but is strictly voluntary.

In the 18th century, this approach continued. French laws against suicide becoming more lenient with physicians such as parady's recommended an easy death for incurable and suffering patients.

German philosopher Arthur Schonenphauer[471] emphasized individualism and human autonomy by stating that a man has "unassailable title to his own life and person........It will be generally found as soon as the terrors of life reach the point at which they outweigh the terrors of death, a man will put an end to his life."

Nazi Germany[472] euthanasia was implicit and became a public issue in Germany after WW1, with the publication of the tract by Karl binding a lawyer, and Alfred Hoche psychiatrist the book talks about the perversion of euthanasia to justify the extermination of the countless mentally and physically sick adults and children.

The actions of easy death have been applied for hopeless patients who are suffering extreme pain since ancient ages. These actions are forbidden from time to time. In Mesopotamia, Assyrian physicians forbade euthanasia. Again in the old times incurable patients were drowned in the river

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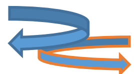
[469] 1st Samuel chapter 31 verse 4 is viewed in the context of his final alienation from the lord.

[470] Surat Ghafir

[471] 1788- 1860

[472] 1939-1945



Ganges in India. In ancient Israel, some books wrote that frankincense was given to kill incurable patients.

Jewish society, following the teaching of the bible and sixth commandment "*thou shall not kill*", had rejected centuries ago every theory shortening the life of handicapped or disadvantaged people. Judaism considered life to be sacred and equated suicide and euthanasia with murder. Dr Immanuel Jakobovitis, former chief rabbi of England explained, "cripples and idiots, however incapacitated, enjoy the same human rights (though not necessarily legal competence) as normal persons........One human life is as precious as a million lives, for each is infinite in value...."

In Sparta, it was the common practice for each newborn male child to be examined for signs of disability or sickness which if found, led to his death. This practice was regarded as a way to save the person from the burden of existence.

In ancient Greece, suicide of the patient who was suffering extreme pain and had an incurable terminal illness was made easy and for this reason the physician gave medicine (a poisoned drink) to him. Plato wrote "mentally and physically ill persons should be left to death; they do not have the right to live.

The first objection to euthanasia came from the Hippocratic oath which says " *I will not administer any poison to anyone when asked to do so, nor suggest such a course.',*

In ancient Rome, euthanasia was a crime and this action was regarded as murder. However history notes that sickly newborn babies were left outside overnight, exposed to the elements.
In middle ages in Europe, Christian teaching opposed euthanasia for the same reason as Judaism. Christianity brought more respect to human beings. Accordingly, every individual has the right to live since God creates human beings and they belong to him and not to themselves. Death is for God to decree not man.

In the 15th-17th centuries sir Thomas more [2473] is often quoted as being the first prominent Christian to recommend euthanasia in his book [23] where the utopian priests encouraged euthanasia when a patient was terminally ill and suffering pain(but this could only be done when the patient consented. The English philosopher, Francis bacon (1561-1621) was the first to discuss prolongation of life as a new medical task, the third of three offices preservation of health, cure of the disease, and prolongation of life. Bacon also asserted that "they ought to acquire the skill and bestow the attention whereby the dying may pass more easily and quietly out of life.

In the 18th century, Prussia on 1st June 1974 passed a law that reduced the punishment of a person who killed the patient with an incurable disease.

Until the 19th century, euthanasia was regarded as a peaceful death, and the art of its accomplishment. An often quoted nineteenth century document is [474] the inaugural professional

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[474] "de euthanasia medica prolusion"

lecture of Carl F.H.marx, medical graduate of Jena. "Its man's lot to die' ›states Marx. He argued that death either occurs as a sudden accident or in stages, with mental incapacity preceding the physical. Philosophy and religion may offer information and comfort, but the physician is the best judge of the patient's ailment, and administers alleviation of pain where cure is impossible.

In the 20th century the efforts of legalization of euthanasia began in the United States in the first years of the 20th century. The newyork state medical association recommended gentle and easy death. Even more active euthanasia proposals came to Ohio and Iowa state legislatures in 1906 and 1907 but these proposals were rejected.

In 1920 two German professors published a small book with the title[475] which recommended the killing of people whose lives were "devoid of value.". This book was the base of involuntary euthanasia in the third Reich.

The reduction in punishment for mercy killing was accepted in criminal law in Russia but this law was abolished after a short while.

A French physician called Dr.E. Forgue published an article named[476] in la revue de Paris, in 1925, and pointed out that killing an incurable patient was not a legal condition.

The laws that accept euthanasia as a legal condition are present in two countries of South America. According to the Uruguay penal code, a judge must not punish a person for mercy killing. A person must also be forgiven for this type of killing in Columbia.

Adolf Hitler admired Hoches writing and popularized and propagandized the idea. In 1935, the German Nazi party accepted euthanasia for crippled children and "useless and unrehabilitive" patients.

Before 1933 every German doctor took the Hippocratic Oath, with its famous "do no harm" clause. The oath required that the doctor's first duty is to his patient. The Nazis replaced the Hippocratic Oath with the "gesundheit", an oath to the health of the Nazi state.

Anyone in the state institution would be sent to the gas chambers if it was considered that he could not be rehabilitated for useful work. The mentally retarded, psychotics, epileptics, old people with chronic brain syndromes, people with Parkinson's disease, infantile paralysis, multiple sclerosis, brain tumors among others were those killed. The consent of the patient was absent in this type of euthanasia. This kind was applied by order.

Many people don't realize that prior to the extermination of the Jews by Nazi German, in the so called "final solution" as many as 350,000 Germans were sterilized because their gene pool was deemed to be unsuitable to the Aryan race, many because of mental disability, mental deficiency or homosexuality.

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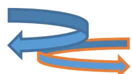
[475] releasing the destruction of worthless animals"

[476] 'easy death for incurable patients"



In 1936 the voluntary euthanasia association society was founded in England. The next year the English parliament (House of Lords) rejected a proposal to legalise euthanasia. In opinion polls of those years, euthanasia supporters had around 60% of their votes.

According to Amos Dakota [477] 53% of American physicians defended euthanasia. Approximately 2000 physicians and more than 50 religious ministers were among the members of American euthanasia society. At that time a majority of physicians in some American cities defended the subject.

In 1938, the euthanasia society of America was established in New York.

In October of 1939, amid the turmoil of outbreak of war, Hitler ordered widespread mercy killing of the sick and disabled [29] Code named "Aktion T4" Nazi euthanasia program to eliminate "life unworthy of life" at first focused on newborns and very young children. Midwives and doctors were required to register children up to age three who showed symptoms of mental retardation, physical deformity, or other symptoms included in a questionnaire from the Reich health ministry.

The Nazi euthanasia program quickly expanded to include older disabled children and adults. Hitler's decree of October 1939 typed on his personal stationery and back dated to September 1, enlarged the authority of certain physicians to be designated by name in such manner to persons who, according to judgment, are incurable, can upon a most careful diagnosis of their condition of sickness, be afforded a mercy death.

On August 3, 1941, the catholic bishop Clemens August of Galen openly condemned the Nazi euthanasia programme in a sermon and this brought a temporary end to the programme.

A law proposal that accepted euthanasia was offered to the government in Great Britain in 1939. According to the proposal, a patient had to write his consent as a living will which must be witnessed by two persons. The will of the patient had to be accepted in the reports of two physicians. One of these was the attending physician; the other was the physician of the ministry of health. The will of the patient had to be applied after 7 days and most of the relatives of the patient had to speak with him 3 days before the killing action. But this proposal wasn't accepted.

In 1973 Dr. Gertuida postma, who gave her dying mother a lethal injection, received a light sentence in the Netherlands. The case and its resulting controversy launched the euthanasia movement in that country.

The Dutch voluntary euthanasia society launched its member's aid service in 1975, to give advice to the dying. It received twenty five requests for aid in the first year.

In 1976 Dr tenrei Ota, upon formation of the Japan euthanasia society (now Japan society for dying with dignity), called for an international meeting of existing national right to die societies. Japan, Australia, the Netherlands, the united states were all represented. This first meeting enabled those

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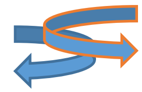
[477] Medical research student Birmingham university questionnaire 1937 [29] "History place" website.



in attendance to learn from the experience of each other and obtain a more international perspective on right to die issues.

In 1978, jeans way was published in England by Derek Humphrey, describing how he helped his terminally ill wife to die. The hemlock society was founded in 1980 in Santa Monica, California, by Derek Humphrey. It advocated legal change and distributed how to die information. This launched the campaign for assisted dying in America. Hemlocks national membership grew to 50,000 within a decade. Right to die also formed the same year in Germany and Canada.

The society of euthanasia assembled in oxford in the last months of 1980, hosted by the exit, the society for the right to die with dignity. It consisted of 200 members represented by 18 countries. Since its founding, the world federation has come to include 38 right to die organisations, from around the world and has held fifteen additional international conferences, each hosted by one of the member organisations.

On 5 th may 1980, the Catholic Church issued a declaration on euthanasia.

In 1984, the Netherlands Supreme Court approved voluntary euthanasia under certain conditions.

In 1994, Oregon voter approved measure 16, a death with dignity act ballot initiative that would permit the terminally ill patients, under proper safeguards, to obtain a physicians prescription to end human life in a humane and dignified manner. The vote was 51-49 percent.[478]

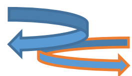
In 1995, Australia's northern territory approved an euthanasia bill. It went into effect in 1996 and was overturned by the Australian parliament in 1997. Only four deaths took place under this law, all performed by doctor nitschke.

On 13 may, 1997 the Oregon house of r3epresentatives voted 32 -26 to return measure 16 to the voters in November for repeal (H.B 2954). On 10 June the senate votes 20-10 to pass H.B 2954 and return measure 16 to the voters for repeal. On November 4 1997 the people of Oregon voted by a margin of 60-40 percent against measure 51, which would have repealed the Oregon death with dignity act 1994. The law officially took effect (ORS 127,800-897) on 27 October 1997.

In 1998, the Oregon health services commission decided that payment for physician assisted suicide could come from state funds under the Oregon health plan so that the poor would not be discriminated against.

In 1999, in the United States, Dr. jack Kevorkian was sentenced to 10-25 years imprisonment for the 2 nd degree murder of Thomas youk after showing a video of his death, by lethal injection, on national television. Kevorkian's first appeal was rejected in 2001. Kevorkian helped a number of people to die and even though he had been previously prosecuted, he remained free from criminal charges until 1999.

[478] www.life.org.nz/euthanasia.



In 2000, the Netherlands approved voluntary euthanasia. The Dutch law allowing voluntary euthanasia and physician assisted suicide took effect on the 1st of February, 2002 for 20 years previously; it had been permitted under guidelines.

Into the third millennium. In 2002 Belgium passed a similar law to the Dutch, allowing both voluntary euthanasia and physician assisted suicide.

In 2004 Lesley martin was convicted of attempted murder of her terminally ill mother. he served seven months of a fifteen month prison sentence, before being released on a good behavior bond, and subsequently failed, in two attempts to appeal against the conviction.

Switzerland, once known in the tourism business for its spectacular alpine landscape, the watches and chocolate has a new claim to fame as the world's death Mecca. Physically and mentally vulnerable patients have been lining up for a one way trip to Zurich.

In 2000 three foreigners committed suicide in Zurich. In 2001, the number of death of tourists increased to thirty eight, plus 20 more in Bern. Most of the death occurred in an apartment rented by dignitas, one of the four groups that have taken advantage of Switzerland's 1942 law on euthanasia to help the terminally ill die.

Dignitas has assisted the suicides of 164 people over the last four years. The Swiss parliament has been alarmed and there is a move to ban the 'suicide tourism' and to place tougher bans on assisted suicide.

When it was established in 1942, the Swiss euthanasia law was meant mainly to offer the opportunity for a dignified death for those with just two or 3 weeks to live.

Medical professionals had a pivotal role in this. In the trial of Adolf Eichmann [479] a heated exchange ensued between the judge and Eichmann's Defense counsel when the judge dismissed [480]the argument that killing by gas was a medical matter. To which the Defense counsel replied;

,'It was prepared by physicians a matter of killing and killing too is a medical matter" [32]

Over the years, the concept of euthanasia continued to gain worldwide attention. In 1980, the world federation of right to die societies was formed, with 27 groups from 18 countries.

Currently the federation consists of 45 right to die organisations from 25 countries. The federation provides an international link for organisations working to secure or protect the rights of individuals to self-determination at the end of their lives.

World right to die day is celebrated November 2 in countries such as France, Italy, Mexico, New Zealand, and Venezuela[481]

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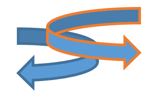
[479] A German Nazi s.s lieutenant colonel and one of the major organisers of the holocaust

[480] <http://journals.cambridge.org/download>(30 June 2021)

[481] htips.//en.m Wikipedia.org/wiki/world.



In 2011 the Dutch parliament debated whether a written request of euthanasia before the onset of dementia could still be used as grounds for termination later in the patient's life [482] they posed two requirements for the request of euthanasia. One, to establish hopeless and unbearable suffering and two ensure the patients consent is given freely and expressly.

J. Keown [483] in his book defines euthanasia as the intentional killing of a patient, by act or omission, as part of his medical care. But omission of treatment of a patient cannot be regarded as medical care. My understanding of medical care is the provision by a physician of services related to maintenance of health, prevention of illness, and treatment of illness or injury. This means that the medical practioner has to do everything within their means to save a life that is about to be lost, give palliative care to the sick which involves stopping pain that is severe rather than capitalizing on pain to end a patient's life. This undermines our trust in the medical profession. When we sanction euthanasia, the frail, elderly and the sick cannot be confident that the doctors will treat them rather than terminate them. Suffering and sick people need comfort and assurance not anxiety and fear as to what their doctors might do to them.

Michael Davies[484] in his book discusses the case of ***R v malcherk and stee1***[485] where the defendants were charged with murder for assaulting victims who were admitted and supported by a ventilator. Lord lane stated "where the medical practitioner, using generally accepted methods, came to the conclusion that the patient for all practical purposes was dead and that such vital functions as remained were maintained solely by mechanical means and accordingly discontinue treatment that did not break the chain of causation between initial injury and death.

The book does not cite the generally accepted methods that medical practitioners should use to end a person's life. Besides that doctors take the Hippocratic Oath to do everything within their means to save the life of a patients at all costs. This book does not address anything in relation to this oath as to how it would be contrary to allowing doctors or other medical practitioners perform euthanasia. It is thus my view that the doctor who withholds or withdraws treatment of a terminally ill patient is refusing to prolong the life of his patient at any cost and is only using active measures to bring human life to a premature end.

Secondly based on the fact that different doctors have different expertise what may appear as an end to life of a patient may not be the same to another medical doctor or physician. To him there could be a way out for the patient. So termination of life of a patient based on the judgment of one doctor as was stated by justice lane and supported by the author of the text would not be satisfactory enough to bring precious human life to an end.

L. Luke in his bool[486] defines medical ethics to connote the rules of etiquette adopted by the medical profession to regulate professional conduct with each other. But also towards their

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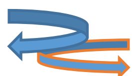
[482] Herring j protecting vulnerable adults oxford legal studies research paper no 10 2010.

[483] Euthanasia examined Cambridge university press 1995.

[484] Medical law 2'd edition oxford university press.

[485] 1981) 2 ALLER 422.

[486] Medical law 2nd edition oxford university press.



individual patients and towards the society. And includes considerations of the motives behind that conduct.

He lists some basic principles of medical ethics which include,

- Autonomy that is people have a right to control what happens to their bodies.
- Beneficence: all healthcare provides must strive to improve their patients' health.
- Nonmaleficence: do no harm to the patients is the bedrock of medical ethics.
- Justice. This principle demands that the medical practitioner should be as fair as . possible.

In his anti-euthanasia campaign he argues that doctors and other medical personnel should adhere to their professional standards in the practice of medicine and should not kill a patient regardless of the pain he is undergoing or even at the patient's request. He proposes that a patient should die a natural death.

I support his argument because viewing questions about death from the standpoint of medical ethics would therefore exclude legal, theological, and other implications which are indispensable to a comprehensive treatment of them, From this point of view euthanasia is murder within contemporary criminal law in Uganda because it includes the elements constituting the offence regardless what it may be called.

The Uganda penal code[487] provides as follows "any person who of malice aforethought causes the death of another person by an unlawful act or omission commits murder."

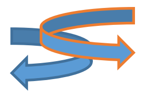
It is my view that the doctor or medical practitioner in this case forms the intention to kill when he believes that the person is suffering which he attributes to the fact that he cannot survive. It becomes unlawful in the sense that it is against the provision of the 1995 constitution of Uganda [41] which provides "no person shall be deprived of life intentionally except in the execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellant court.

The practice is also against medical ethics to end the life of another person. The Hippocratic Oath covers several important ethical issues between doctors and patients.

The oath first establishes that the practitioner of medicine gives deference to the creators, teachers, and learners of medicine. The oath also serves as a contract for doctors to work towards the benefit of the health of the public.

487 Section 188

'11Article 22



Other important tenants include maintaining the integrity of the doctor, ensuring the consent of the patients, preventing the exploitation of the patient, maintaining privacy and discretion, and forbidding deadly drugs and abortion.

One of the most important ideas codified in the Hippocratic oath is that the physician is accountable for his actions should problems arise.

After examining the above oath no provision for euthanasia is included, why then should the doctors go ahead and take the life of another under the belief that they are helping them to die peacefully and with dignity. Thus they should adhere to the medical standards or else the medical profession would turn out to be a threat for the terminally

Alfred Hocke professor of psychiatry at university of Freiburg and Karl binding, a professor of law at university of Leipzig in their book[488]

Argued that patients who ask for death should under very carefully controlled conditions be able to obtain it from a physician. The book does not labor to explain the very carefully controlled conditions that a physician can use to peacefully terminate the life of the patient and does not address what would follow if the patient did not provide consent however the doctor or physician so it relevant to terminate the life and he eventually terminates the life of the patient. So this still puts forward a question on whether this should be regarded as murder or not. Because the proponents of euthanasia say it is aimed at ending the suffering of the terminally ill patient and others say the doctor is the judge in this matter in this case in determining whether a patient is alive or dead my view is if it is left without any control it may be misused in that the doctors may look at the aspect of taking a person's life as normal and would even propose it where it is not necessary for example a person undergoing severe pain after losing a hand in a terrible accident and bleeding seriously, they could be a possibility that some malicious doctors mind will be corrupted into believing that they is nothing they could do to help out and hence would recommend that the patient be killed but peacefully this would eventually instigate fear into the public and would look at the medical profession as one that should not be fit for saving human life but rather one that takes human life.

Luis kutner[489] an attorney who practiced law in Chicago, Illinois, is credited with proposing that living will documents be used as a means of allowing people to express their wishes regarding end-of-life care. He published "Due Process of Euthanasia: The Living Will, a Proposal" in the Indiana Law Review in 1969. The paper was widely considered to be a milestone regarding the legal side of issues related to euthanasia and other matters dealing with the end of life. Kutner was motivated by his belief that people who wished to have assistance in committing suicide were denied legal rights and protections necessary to safeguard their wish to die. Those who agreed to assist them, he believed, should also be protected.

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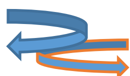
[488] 'releasing the destruction of worthless animals"

[489] Due process of euthanasia



He posited that his proposed living will document would enable adults who were mentally competent and healthy to put their wishes in writing so that there would be no question about what kind of care the person wanted at the end of life. Living wills are Now common.

I agree with kutner view because he goes ahead to show how exactly the will should be drafted, to whom it should be addressed and even shows that the will is the clear intention of the party seeking death which cannot even be subject to legal measures in case his life is terminated with his or her consent based on the fact that they are suffering extreme pain and cannot even get better. So for example if a cancer patient states it out in their living will that once I start suffering unbearable pain please terminate my life then why not? This is far much better than living it to the doctors and physicians to decide over a person's life or death even without their consent by assuming that it is what is best for them.

Rita marker[490]A practicing attorney, Rita Marker has served as director of the

International Task Force on Euthanasia and Assisted Suicide since the organization was founded in 1987. Marker previously served as an adjunct professor of Political Science and Ethics at the University of Steubenville, Ohio. She has written numerous

Articles and spoken on issues related to bioethics and human rights throughout the world. Marker's other advocacy efforts include offering testimony to the Subcommittee on the Constitution, Civil Rights, and Property Rights of the U.S. Senate Judiciary Committee. Marker wrote Deadly Compassion. In this book, she examined the topic of euthanasia in terms of the suicide of Ann Humphry and argued against the legalization of euthanasia.

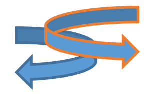
The author was against euthanasia but simply looking at one scenario which involved the way Ann Humphry was assisted to die against her will by her husband which she looks at as being improper but does not talk about what should happen in the event that consent is obtained from the terminally ill.

She suggests that it is actually more suffering to the person when their life is terminated but does not show how it amounts to more suffering. Because ordinarily a dead person would not feel the pain she is talking about. This leaves the readers to decide or predict or imagine the suffering that comes so the book still leaves many questions unanswered in regard to euthanasia. And as such would say it improperly addresses the issue of euthanasia by not handling some crucial elements.

Dr qui11 [491] Dr. Quill the physician referenced in quill v vacc0[46] co-edited a book with Margaret Pabst Battin, Ph.D. In the introduction to this book, Drs. Quill and Battin write that the central question in this issue is not whether people would prefer "access to palliative care and hospice or access to physician assisted death" (2004, 1). They pose the central question as "What would you prefer, access to excellent palliative care and hospice by themselves or access to excellent hospice

[490] Deadly compassion

[491] Physician assisted dying the case for palliative care and patient choice.



and palliative care plus legal access to a physician-assisted death as a last resort if your suffering becomes intolerable and you wish an earlier, easier death?" (Quill and Battin 2004, 1).

In this book they exhaust almost all the options available to a terminally ill patient before taking a final decision including the right to rescind in case they change their mind which I think is very fair to the patient because most times the state of mind in such severe pain makes them feel like they do not deserve to live however such pain may be short lived in the long run which I agree with.

Dr Edmund Pellegrino in his book[492] strongly advocates for the end of euthanasia. He argues that as a result of advancement in science and technology a disease that may appear incurable today may be curable the next day and so rushing into euthanasia may not be the best option for the terminally ill patient. He stresses that they should instead subject the patients to palliative care and try to relieve pain until a solution is found or else they live the patients to die a natural death amidst medication than help terminate their lives.

I agree with his argument Mercy killing is morally incorrect and should be forbidden by Law. It is a homicide and murdering another human cannot be rationalized under any circumstances. Human life deserves exceptional security and protection. Advanced medical technology has made it possible to enhance human life span and quality of life.

Palliative care and rehabilitation centers are better alternatives to help disabled or patients approaching death live a pain-free and better life. Family members influencing the patient's decision into euthanasia for personal gains like wealth inheritance is another issue.

There is no way you can be really sure if the decision towards assisted suicide is voluntary or forced by others. Even doctors cannot predict firmly about period of death and whether there is a possibility of remission or recovery with other advanced treatments.

So, implementing euthanasia would mean many unlawful deaths that could have well survived later. Legalizing euthanasia would be like empowering law abusers and increasing distrust of patients towards doctors. Mercy killing would cause decline in medical care and cause victimization of the most vulnerable society. Would mercy Killing transform itself from the "right to die" to "right to kill"? Apart from the above reasons, there are some aspects where there is a greater possibility of euthanasia being mishandled.

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How would one assess whether a disorder of mental nature qualifies mercy killing? What if the pain threshold is below optimum and the patient perceives the circumstances to be not worthy of living? How would one know whether the wish to die is the result of unbalanced thought process

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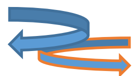
[492] Transcultural Dimensions in medical ethics



or a logical decision in mentally ill patients? What if the individual chooses assisted suicide as an option and the family wouldn't agree?

Wesley j smith in his book[493] in the introduction to the book argues that patients only choose the option of death because of the pain and depression. And if the pain can be dealt with then no one would request for euthanasia as this would rekindle their hopes of survival and free their minds from thinking about death.

He further argues that it is not a sane mind that makes people ask for euthanasia but the pain and agony they face from their terminal illness.

I vehemently agree with him on this position because,

- *Many pain killing drugs can now help a patient die with dignity.*
- *A dying patient may not be able to make a rational decision.*
- *A patient may have said they want euthanasia when they were nowhere near death; however, when faced with death they may change their mind but be incapable of telling anyone.*
- *Many people recover after being "written off" by doctors.*
- *Euthanasia makes life disposable — it could be the first step on a slippery slope.*
- *Hippocratic Oath: doctors must try to preserve life. If euthanasia was legalised, the relationship of trust between doctors and patients can be destroyed.*
- *If there were better facilities for caring for dying, there would be less need for euthanasia.*
- *People might be pushed into saying they want euthanasia by relatives who do not want to look after them.*

The Oregon Death with Dignity Act

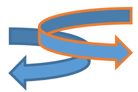
The Oregon Death with Dignity Act (ODDA) is a citizens.' initiative that was first passed by the voters of Oregon in November 1994 by a margin of 51 percent in favor and 49

Percent opposed.20 The Act was delayed due to a legal injunction and multiple legal proceedings, including a petition that was denied by the United States Supreme Court.

The Ninth Circuit Court of Appeals lifted the injunction in October 1997, and physician assisted Suicide (PAS) became a legal option for qualified terminally ill patients in Oregon.

In November 1997 the voters reaffirmed their support for the ODDA by Rejecting Measure 51, which asked them to repeal the Act on a general election ballot, by an increased margin of 60 percent in favor and 40 percent opposed. The Oregon Health Services (OHS) notes that the term physician-assisted suicide is used in the ODDA despite the fact that the Act explicitly states that ending one's life in accordance with the law does not legally constitute. "suicide.' • rather, the term

[493] Forced exit:euthanasia,assisted suicide, and the new duty to die



is used because it is so widely used by the public and scholars alike to describe the very act that the ODDA allows.

According to the Oregon Death with Dignity Act, an adult who is capable, who is a resident of Oregon, who has been determined by the attending physician and a consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die may make the informed decision to initiate a request for medication for the purpose of ending his or her life in a humane and dignified manner. On the Moral and Social Implications of Legalized Euthanasia This concise iteration of the ODDA requires some clarification in accordance with the specifications of the Act. The term adult designates an individual who is 18 years or older and the term resident of Oregon applies (but is not limited) to individuals who have a driver's license, are registered to vote, own or lease property, or filed their most recent tax return in Oregon.

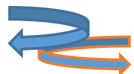
The term terminal disease designates an incurable and irreversible disease that has been medically confirmed by the attending and consulting physicians and is expected to, within reasonable medical judgment, produce death within six months. The term capable means that in the opinion of the court, attending physician, consulting physician, psychiatrist, or psychologist the patient has the ability to make and communicate informed health care decisions to health care providers (or can do so with the assistance of a person of their choosing).

The term informed decision is used to designate a decision made by a qualified patient based on an appreciation of the relevant facts and after being fully informed by the attending physician of the following:

- The medical diagnosis and prognosis;
- The potential risks and probable results of taking the prescription; and
- The feasible alternatives to using the prescription including (but not limited to) comfort care, hospice care, and aggressive pain control.

The term attending physician designates the physician who has primary responsibility for the care of the patient, while the term consulting physician designates a physician who is qualified by specialty or experience for consultation to confirm the diagnosis and prognosis regarding the illness of the patient.

The attending physician may sign the patient's death certificate, notwithstanding other legal restrictions. If either the attending or consulting physician suspects that the patient may be suffering from a psychiatric or psychological disorder or from depression that is causing impaired judgment, the patient must be referred for counseling. If the counselor determines that the patient is not suffering from impaired judgment, then (and only then) may the patient qualify for PAS. The Act specifies that the attending physician must:



- Make the initial determination of whether a patient has a terminal disease, is Capable, and has made the request voluntarily; On the Moral and Social Implications of Legalized Euthanasia
- Ensure that the patient is making an informed decision
- Refer the patient for counseling if appropriate

- Refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination as to whether or not the patient is capable of making an informed decision and is acting voluntarily;

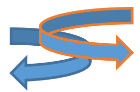
- Recommend (but not require) that the patient notify next of kin;

- Counsel the patient about the importance of having another person present when taking the medication and of not taking the medication in a public place (the presence of physician at the time of ingestion is recommended, but not required);
- Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner;
- Verify immediately. prior to writing the prescription that the patient is making an informed and voluntary decision;
- Fulfill the medical record documentation requirements of the Act;
- Ensure that all appropriate steps are carried out in accordance with the Act prior to writing the prescription; and
- Dispense the prescription directly, provided he or she is qualified to do so; or, with the patient's written consent, contact and inform a pharmacist of the nature of the prescription and then deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to the patient, the attending physician, or an expressly identified agent of the patient.

(The Act was modified from its original form in this regard, and now specifically allows pharmacists to refuse to participate in the ODDA who morally object to PAS). Once a qualified patient has made the first oral request to the attending physician, he or she must then make a written request followed by a second oral request in order to remain eligible to receive the prescription. The second oral request must take place after the written request has been completed, and there is a mandatory 15 day waiting period between the two oral requests. The attending physician cannot write the prescription until 48 hours after the written request has been completed, and must remind patients of their right to rescind their request at any time upon receiving the second oral request.

The prescription generally consists of a lethal amount of barbiturates and other medications to help alleviate the nausea or vomiting that can sometimes occur when the barbiturates are ingested.

The primary medication used has changed from secobarbital to pentobarbital because the manufacturer of secobarbital (Eli Lilly) stopped producing the drug because of a lack of



profitability and difficulty in producing the drug due to a shortage of supplies, not for ethical or publicity reasons.

On the Moral and Social Implications of Legalized Euthanasia the ODDA allows qualified individuals to obtain prescriptions for the purposes of ending their lives, but specifically prohibits physicians from directly administering medication for the purposes of ending the life of the patient (active euthanasia). No professional organization or association, or health care provider, or physician may be punished either for participating or for refusing to participate in the ODDA. Furthermore, participation in the ODDA does not have an effect upon a life insurance, health Insurance, accident insurance, annuity policy, will, contract, or statute.

The Annual Report

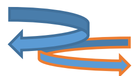
The Oregon Health Services (OHS) is required to annually review a sample of records maintained with regard to the ODDA and to ensure that all health care providers file a copy of the dispensing record with the OHS upon writing a prescription in accordance with the ODDA. Reporting is not required if a patient begins the process but never receives a prescription, and the number of individuals who begin the process but never receive the prescription is unknown.

However, one physician who has participated in the ODDA reported that she has begun and not finished the legislative process nearly twice as often as she provided prescriptions, suggesting the possibility that at least twice the number of patients who have participated in the ODDA make an initial inquiry or verbal request for medication which is left undocumented and unreported.

The OHS is authorized to make rules to facilitate the collection of information regarding the ODDA and (except as otherwise required by law) the information collected Shall not be a public record and may not be made available for inspection by the public.

The OHS is then required to generate and make available to the public an annual Statistical report of information collected in a neutral manner in order that informed Ethical, legal, and medical decisions can be made based on interpretation of the data. The Statistics The Annual Reports provided by the OHS contain all of the statistical information regarding the ODDA that is made available to the public.

The Reports were obtained On the Moral and Social Implications of Legalized Euthanasia from physician and pharmacy reporting, physician interviews, and death certificates. The Fourth Annual Report was made available on February 6, 2002, and the other three Reports (plus a preliminary Report issued after the first 10 deaths under the ODDA were reported) can be found on the OHS website.30 According to the Reports, a total of 140 prescriptions have been written under the ODDA since physician-assisted suicide became legal in Oregon (24 in 1998, 33 in 1999, 39 in 2000, and 44 in 2001). Nineteen of the 33 patients who were prescribed medication under the Act in 2001 died after ingesting the medication; 14 died from their underlying disease; and 11 were alive as of December 31, 2001, Two patients chose not to use prescriptions received in 2000 until



2001, bringing the total number of patients who died after ingesting the medication to 21 in 2001, 27 in 2000, and 27 in 1999, and 16 in 1998. Thus, the total number of patients who have died after ingesting lethal medication prescribed in accordance with the ODDA regulations comes to 91 out of the 140 who have received a lethal prescription.

The 21 patients who died as a result of ingesting lethal medications in 2001 were comparable in many ways to the other 6,265 Oregon residents who died from similar diseases during the year, although they were slightly more likely to be women, to have graduated from college, and to have been divorced. Trends such as these do not seem to have a particular pattern, but have varied from year to year.

The most commonly mentioned end of life concerns were losing autonomy, decreasing ability to participate in activities that make life enjoyable, losing control of bodily functions, becoming a burden on family and friends, and suffering from inadequate pain control. Typically, the median age of participants is around 70, they are likely to have a high school diploma, and they tend to be white. One of the most important findings over the four year period is that it has not been the case in any year that PAS was disproportionately chosen by terminally Ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking end of life care.

The majority of patients who have chosen to participate in the ODDA suffer from some form of cancer (86 percent in 2001). It should be stressed that most of the patients utilized hospice care at some point during their illness (76 percent in 2001), while all of the patients who did not utilize hospice care were offered it and declined. Approximately half of the attending physicians were present at the time of ingestion, while other health On the Moral and Social Implications of Legalized Euthanasia. Care providers were present in almost all of the remaining cases. Approximately one-half of patients become unconscious within 3 minutes and die within 25 minutes, and complications are rare. A small number of patients have lived for longer than 24 hours after ingesting the medication and a small number have vomited shortly after ingestion.

Two physicians have been questioned in regard to submitting incomplete written consent forms, but formal charges have not been filed against them. Finally, Oregon physicians have consistently reported increased efforts to improve their knowledge of the use of pain medications, to improve their ability to recognize psychiatric disorders (such as depression), and have been referring more patients to hospice care since the passage of the ODDA. Political Controversy In November 2001, U.S. Attorney General John Ashcroft issued a directive specifying a new interpretation of the Controlled Substances Act (CSA) that was specifically aimed at prohibiting physicians from prescribing medication for use in PAS on a federal level, but not intended to increase scrutiny on physicians who prescribe pain controlling medications.

According to Ashcroft's interpretation of the federal law, the dispensing of controlled substances to assist in suicide does not constitute a legitimate medical purpose and, therefore, the ODDA violates federal regulations. This reverses the policy of former U.S. Attorney General Janet Reno,

who deferred to state law in the determination of what constitutes a legitimate medical practice. In response to these actions, Oregon Attorney General Hardy Myers filed a federal lawsuit claiming that the directive is inconsistent with the intended use of the CSA as created by Congress, and that it is unconstitutional on both Commerce Clause and Tenth Amendment grounds.

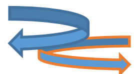
U.S. District Judge Robert Jones issued a temporary restraining order against Ashcroft's directive in response to the suit, thereby allowing physicians to continue participating in the ODDA pending legal proceedings which were to be held within the year. Timothy Quill, a leading advocate for the ODDA, charged Ashcroft with unjustly attempting to usurp the rights of the state of Oregon and its voters by attempting to circumvent the democratic process. He maintains that the ODDA has On the Moral and Social Implications of Legalized Euthanasia been a success, and that the continuation of the Act will provide important information that is vital in making the decision as to whether or not PAS can be regulated without undermining the quality of end of life care.

The legality surrounding the ability of states to govern their practice of medicine is somewhat unclear in this regard, but will likely be clarified to some extent as a result of these recent events. It has been suggested that the increase in support for the ODDA that occurred when the voters were (unsuccessfully) asked to repeal the Act in Measure 51 may have been due to the disapproval of voters who perceived Measure 51 as an attack on the democratic process.

It is not unlikely that a similar effect is occurring in Oregon now, caused by the feeling that Oregon's right to pass legislation regarding the practice of medicine within the state is being challenged. Some recent studies conducted by non advocacy organizations have demonstrated a strong support throughout the U.S. for legislation based on the ODDA to be passed in additional states (61 percent of those surveyed) and a public disapproval of Ashcroft's directive (58 percent).

In April 2002, U.S. District Judge Robert Jones ruled that Ashcroft lacks the authority to overturn the ODDA, noting that the legislation was passed after two votes in Its favor. According to the Washington Post, Jones. "Scolded." Ashcroft by saying that he was attempting to . "Stifle an ongoing, earnest, and profound debate in the various states concerning physician-assisted suicide." and concluded that the Controlled Substance Act did not support Ashcroft's directive.

In closing, Jones remarked that his. "Task is not to criticize those who oppose the concept of assisted suicide for any reason. Many of our citizens, including the highest respected leaders of this country, oppose assisted suicide. But the fact that opposition to assisted suicide may be fully justified, morally, ethically, religiously or otherwise, does not permit a federal statute to be manipulated from its true meaning to satisfy even a worthy goal." Despite this ruling, an appeal is expected to be filed and the end result of Ashcroft's directive is unlikely to be known for some time. As I mentioned above, the Annual Reports issued by the OHS have suggested that many requests for assistance in dying are motivated by one or more of a limited number of Concerns.



The identification of these concerns offers a rare and valuable insight into some of the more common hopes and fears expressed by persons engaged in the dying process.

On the Moral and Social Implications of Legalized Euthanasia 16 In the following section, I expand upon this issue and attempt to better explain the motivating factors which commonly prompt requests for assistance in dying.

The Leading Motivations for Requesting Physician-Assisted Suicide

The Fourth Annual Report on Oregon's Death with Dignity Act found that the most commonly mentioned end of life concerns for those who requested assistance in dying in accordance with the ODDA were: losing autonomy, decreasing ability to participate in activities that make life enjoyable, losing control of bodily functions, becoming a burden on family and friends, and suffering from inadequate pain control.41 Discussing the typical factors which have motivated such patients to request assistance in dying is one way in which we can better understand what the notion of a {Death with dignity." Might really mean to an individual patient nearing the end of life.

The Legal Definition Of Death.

The legal definition of death has been the source of much academic commentary medical technology with its potential to refine the boundaries of life has forced radical reconsideration of what is meant by death. Jean (McHale and Marie fox in health care law text and materia1[494] establish that ascertaining the point at which death occurs may be of considerable practical and importance.

The assignment of the point of death is a crucial matter considering whether to withdraw life support i.e. passive euthanasia and determining criminal culpability of doctors while performing this procedure.

Michael Davies in the textbook on medical law[495] offers an insight into the idea of death from a purely medical perspective. He writes that "the idea of death combines the absence of cognition and respiration, combined with these two is the unifying matter of the brain stem". He describes how the system works in the following manner.

"The heart and lungs as a team supply oxygen to the brain, therefore the brain cannot function without the operation of the heart and lungs in turn, respiration itself is controlled by the brain stem, and it performs the 'vegetative' functions.'

He goes further to state that according to current medical practices, the functions of the heart and lungs can be artificially maintained, but the not the functions of the brain stem. As far as technology stands at the moment, when the brain stem has irreversibly ceased to function, there

[494] 2nd edition Thomson sweet and Maxwell limited chapter 15 page 1089.

[495] See Michael Davies textbook on medical law 2 nd edition oxford university press chapter 16 page 376-377

can no longer be spontaneous heartbeat or respiration. This now leads to the popular conception that death has occurred.

Definition of death.

Broadly speaking, a number of options exist of what could amount to a definition in addition to the medical position such as human features of biological, religious or philosophical nature.

From a biological perspective, cessation of respiration and heart beat can amount to death. However there may be difficulty in maintaining that a person is dead if technology were available to produce mechanically the activities of the heart and lung.

From a religious perspective it has been argued that human life begins when the soul enters the body, so it ends when the soul departs. This notion is however vague and prone to being construed differently among the existing strands of religious conviction.

From a philosophical perspective, the human body is the sum of its parts and loss of that capacity for bodily integration is tantamount to death.

Michael Davies, in relation to the philosopher's aspect of death writes,

"Humans are more than the flowing, of fluids. They are complex integrated organisms with capacities for internal regulation, with and only with these integrating mechanisms is homosapiens"[496]

Currently, the brain stem death is recognized, by the medical profession and by the courts, as the point of death.[497]

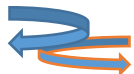
In 1968, the ad hoc committee of the Harvard medical school to examine the definition of brain stem death published its report and the brain death achieved worldwide recognition. The committee established the following fourfold criteria for brain death.

- Absence of cerebral responsiveness
- Absence of induced or spontaneous movement e Absence of spontaneous respiration e Absence of brain stem and deep tendon responses.

It is documented that no patient meeting the Harvard criteria has ever recovered despite the most heroic management. It is clear that the medical profession has reached a consensus as to the point of death.

[496] [51] M Davies textbook on medical law 2nd edition Oxford University press chapter 16 page 378,

[497] J MC hale and M fox health care law text and materials 2nd edition Thomson sweet and Maxwell limited chapter 15 page 1089.



Death at common law.

A locus classicus case on the judicial interpretation of brain stem death is the case of R v malcherk and stee1.[498]

The defendants were charged with murder the Defence claimed that the chain of causation was broken because after the assault, the victims had been supported on a ventilator and death occurred as a result of removal of the ventilator. Lord lane in his judgment stated;

"Where the medical practitioner, using generally acceptable methods, came to the conclusion that the patient was for all practical purposes dead , and that such vital functions as remained were being maintained solely by mechanical means and accordingly discontinued treatment, that did not break the chain of causation between the initial injury and death."

The case confirmed the judicial acceptance of recognition of brain stem death as death [499]

The stance was also upheld in the case of ***RE A***[500]In this case a baby was taken to a hospital suffering from injuries apparently as a result of a fall at home. The child was found not to be having a heartbeat on arrival to the hospital. The child was transferred to another hospital where a number of attempts were made to resuscitate. The child was placed in a ventilator. Court considered whether the child had died thus could be removed from the ventilator. Johnson J in his judgment declared the child dead for legal and medical purposes and held that the doctor was not acting unlawfully because the child was already dead. This case showed the need to seek judicial approval in withdrawing treatment and the ethical requirements of passive euthanasia.

On the other hand cases of patients in a persistent vegetative state, [56] who had no prospect of recovery, supported via artificial nutrition and hydration are a different matter, especially when it comes to withdrawal of treatment for such patients [57]

A PVS case was at the centre of the legal question regarding withdrawal of treatment. In the case of ***Aire dale NHS Trust v Bland*** [501]

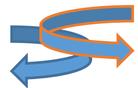
Bland a football spectator was injured in a football ground in April 1989 at Hillsborough. He remained in this state and showed no signs of recovery. The hospital sought a declaration authorizing the discontinuation of all life sustaining treatment and medical support mechanisms. The court of appeal declared bland to be alive, though his condition may be described as a living death. The court stated that a doctor has a duty of care over his patient that includes acting in the

[498] (1981) 2 ALLER 422

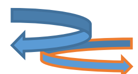
[499] Davies textbook on medical law 2 nd edition Oxford University press chapter 16 page 382-83.

[500] J MC Hale and Marie fox health care text materials 2nd edition Thomson sweet and Maxwell limited chapter 14 page 1021.

[501] (1993) ALLER 521 (1993) A.c 879.



patient's best interest and wishes. The court thus held that the act of withdrawing treatment is no longer of criminal law if done in the patient's best interest.



A COMPARATIVE ANALYSIS WITH OTHER JURISDICTIONS

As already defined, is the intentional killing of a patient, by act or omission, as part of his or her medical care.[502] ***Black law dictionary***[503] defines euthanasia as the act or practice of causing or hastening the death of a person who suffers from an incurable disease or terminal disease or condition especially a painful one, for reasons of mercy.

There are in addition various classifications of euthanasia such as voluntary euthanasia, non-voluntary euthanasia, passive euthanasia and active euthanasia.
Black law dictionary defines all the classifications as follows.

a. *Voluntary euthanasia is euthanasia performed with the terminally ill persons consent.*

b. *Non voluntary euthanasia is euthanasia of a competent, non-consenting person.*

c. *Passive euthanasia is the act of allowing a terminally ill person to die, by either withholding or withdrawing life sustaining support respirator or feeding tube.*

d. *Active euthanasia is euthanasia performed by a facilitator, such as a healthcare practitioner who not only provides the means of death, but also carries out the final death causing act.*

The position of the Uganda constitution. The Ugandan constitution does not support or guarantee the right to euthanasia. [6] 'no person shall be deprived of life intentionally except in the execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellant court".

This particular article however gives latitude to deprive life where a sentence has been passed by a competent court. Therefore there exist certain provisions under the constitution that could provide an argument for proponents of euthanasia.

The constitution further provides that "no person has the right to terminate the life of an unborn child except as may be authorised by law" [504] from this provision an argument may be put forth that it seems contradictory of the state to permit abortion under specific circumstances and refuse euthanasia. To this end one may ruminate on the following question;

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[502] J Keown, euthanasia examined Cambridge university press 1995.

[503] Bryan A Garner – Black's Law Dictionary -9th Ed.

[504] Article 22(2)

If upon the opinion of a qualified medical professional, the condition of a terminally ill patient is deemed as so hopeless and death seems evident, why then should such a person not be allowed the freedom of choosing an earlier death to end his suffering?

In addition, the constitution provides that every person has a right to belong to, enjoy, practice, profess, maintain and promote any culture, cultural institution, language, tradition, creed or religion in community with others.

Thus, based on the understanding of this provision, those whose values and belief allow their conscience to support euthanasia should not be denied the right to undergo it, if they desire and freely consent. Equally those who do not support euthanasia should not be compelled to undergo the same.

The principle of double effect. Shawn D. pattisson writes in his book that the principle has its origin in the moral theology of t6he Roman Catholic Church. It holds that an act has two predicted consequences, one good and the other one bad, can morally be permissible where the intention is to achieve good, and the bad is unavoidable. [505]

Shawn affirms that it is permissible to produce a bad consequence only if,

- The act engaged in is not itself bad.
- The bad consequence is not a means to the good consequence.
- The bad consequence is foreseen but not intended.
- There is a sufficiently serious reason for allowing the bad consequence to occur.

The principle can apply to end of life decisions in two ways

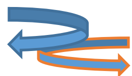
1) Applied to patient reasons for refusing life sustaining treatment. Here the intentions of the patient are paramount. Refusing treatment with the primary intention of committing suicide violates the sanity of life. On the other hand, refusing treatment with the primary the knowledge that death will result, but without the intention to die, does not violate the sanctity of life[506]

2) Apply to doctor's reasons for administering life shortening treatment or otherwise accelerating the patient's death.

Administering life shortening treatment with intention of killing the patient is viewed as morally unacceptable. On the other hand, administering life shorteni9ng treatment with the intention of relieving the patients pain and distress is considered morally permissible, the case of air dale NHS trust v bland sufficiently predicates this statement, where it was held that a doctor has a duty to act in the best interest of the patient, a duty that may require the doctor to shorten the patient's life by withdrawing treatment to relieve the patients treatment to relieve the patients suffering.

[505] SD pattisson medical law and ethics 4th edition sweet and Maxwell chapter 15-002 page 534.

[506] (1757) crim IR 365



The principle of double effect has been applied in determining a number of cases revolving around the circumstances mentioned above. F04r instance in the case of R v Adams64

Where it alleged that Dr Adams injected an incurably but terminally ill patient with increasing doses of opiates. In summing up to the jury, Delvin j brought up the principle of double effect.

Delvin j stated If the first principle f medicine, the restoration of health, can no longer be achieved there is still much for a Doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measure he takes may incidentally shorten life."

Dr Adams was subsequently acquitted of murder on the grounds that ending of life was incidental to relieve pain. [507]

Michael Davies in his textbook on medical law states that according to the double effect principle, when doctors give pain relieving drugs in the knowledge that in addition to relieving pain, the same drugs will shorten life, then that is not seen as legal cause of death, since the "good effect" is desired while the "bad one" is not intended [66]

The double effect principle lays a plausible legal and ethical justification for severely ill patients with no chance of recovery, to end their lives voluntarily. For such patients, the good intention is to alleviate their suffering at the hands of an incurable illness and the bad consequence, that is unavoidable, is inflicting death on themselves.

This was the scenario in the case of ***R v COX***[508]

Where Mrs. Boyes was suffering friom8 an incurable and increasing distressing form of arthritis, which made her hypersensitive to touch and this could not be eased by painkillers in its latter stages.

As the hypersensitivity to pain increased at the end of her life, Mrs. Boyes and her sons repeatedly requested that doctors in attendance end her life. Dr Cox administered a lethal dose of potassium chloride and Mrs. Boyes died. Ognall J stated, "It was plainly Dr Cox's duty to do all that was medically possible to alleviate her pain and suffering, even if the course adopted carried with it an obvious risk that as a side-effect... of that her death would be rendered likely or even certain. " Here, the principle of double effect is manifested in the judgment set out. Death was an unavoidable and an unwanted consequence of the doctor carrying out his duty to alleviate his patient's pain and suffering. In addition, the court however held that "...what can never be lawful is the use of drugs with the primary of hastening the moment of death."

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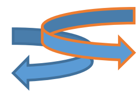
7 [507] M Davies textbook on medical law 2nd edition Oxford University press chapter 15 page 346-47.

[508] (1992) 12 BMLR



EMERGING JURISPRUDENCE ON EUTHANASIA

Carter v Canada[509]

Facts: It was a crime in Canada to assist another person in ending their own life. The Canadian Criminal Code prohibited the provision of assistance in dying in Canada. The Canadian Criminal Code provided as follows, "No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.[510] The Code further provided, "Everyone who counsels a person to commit suicide, or aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years[71] After T was diagnosed with a fatal neurodegenerative disease in 2009, she challenged the constitutionality of the Criminal Code provisions prohibiting assistance in dying. She was joined in her claim by C and J, who had assisted C's mother in achieving her goal of dying with dignity by taking her to Switzerland to use the services of an assisted suicide clinic; a physician who would be willing to participate in physician-assisted dying if it were no longer prohibited; and the British Columbia Civil Liberties Association. The Attorney General of British Columbia participated in the constitutional litigation as of right.

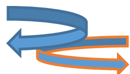
The issue whether the criminal prohibition that gave a terminally ill person the choice of violently ending their life or suffering until they died violated their Charter rights to life, liberty and security of the person and to equal treatment by and under the law.

Held: The Criminal Code unjustifiably infringed on the Charter and was of no force or effect to the extent that they prohibited physician-assisted death for a competent adult person who;

(i) Clearly consented to the termination of life
(ii) Had a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that was intolerable to the individual in the circumstances of his or her condition.

The prohibition on assisted suicide was, in general, a valid exercise of the federal criminal law power and it did not impair the protected core of the provincial jurisdiction over health. Health was an area of concurrent jurisdiction, which suggested that aspects of physician-assisted dying had to be the subject of valid legislation by both levels of government, depending on the circumstances and the focus of the legislation. Insofar as they prohibited physician assisted dying for competent adults, who sought such assistance as a result of a grievous and irremediable medical condition that caused enduring and intolerable suffering, section 241 and 14 of the Criminal Code deprived these adults of their right to life, liberty and security of the person under section 7 of the Charter, that provided, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. " Here, the prohibition deprived some individuals of life, as it had the effect of forcing some

[509] (attorney general), 2015 SCC 5 supreme court of Canada
[510] Section 14



individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. The rights to liberty and security of the person, which dealt with concerns about autonomy and quality of life, were also engaged. An individual's response to a grievous and irremediable medical condition was a matter critical to their dignity and autonomy.

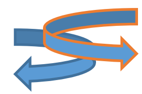
The prohibition denied people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenched on their liberty. And by leaving them to endure intolerable suffering, it impinged on their security of the person. The prohibition on physician-assisted dying infringed the right to life, liberty and security of the person in a manner that was not in accordance with the principles of fundamental justice. The object of the prohibition was not, broadly, to preserve life whatever the circumstances, but more specifically to protect vulnerable persons from being induced to commit suicide at a time of weakness. Since a total ban on assisted suicide clearly helped achieve this object, individuals' rights were not deprived arbitrarily. However, the prohibition caught people outside the class of protected persons. It followed that the limitation on their rights was in at least some cases not connected to the objective and that the prohibition was thus over-broad. The case had to involve matters of public interest that were truly exceptional. It was not enough that the issues raised had not been previously resolved or that they transcend individual interests of the successful litigant; they also had to have a significant and widespread societal impact.

The appropriate remedy was not to grant a free-standing constitutional exemption, but rather to issue a declaration of invalidity and to suspend it for 12 months. Nothing in this declaration would compel physicians to provide assistance in dying. The Charter rights of patients and physicians would need to be reconciled in any legislative and regulatory response to this judgment.

Tony Nicklinson v Ministry of justice [511] In this case, Mr. Nicklinson suffered a catastrophic stroke when he was aged 51. As a result, he was completely paralysed, save that he could move his head and his eyes. He was able to communicate, but only laboriously, by blinking to spell out words, letter by letter, initially via a Perspex board, and subsequently via an eye blink computer. Despite loving and devoted attention from his family, his evidence was that he had for the past seven years consistently regarded his life as "dull, miserable, demeaning, undignified and intolerable", and had wished to end it. Because of his paralysed state, Mr. Nicklinson was unable to fulfill his wish of ending his life without assistance, other than by self-starvation. His preference was for someone to Mr. Nicklinson applied to the High Court for:

- A declaration that it would be lawful for a doctor to kill him or to assist him in terminating his life, or, if that was refused
- A declaration that the current state of the law in that connection was incompatible with his rights

[511] (2012) EWHC 2381



The High Court refused him both reliefs and he embarked on the very difficult and painful course of self-starvation, refusing all nutrition, fluids, and medical treatment, and he died of pneumonia. Mr. Nicklinson's wife was then added, because she contended that she had a claim in her own right and substituted, in her capacity as administratrix of Mr. Nicklinson's estate, as a party to the proceedings, and pursued an appeal to the Court of Appeal.

The Court of Appeal gave Mrs. Nicklinson and another permission to appeal to the Supreme Court.The Supreme court found that Mercy killing is a term which means killing another person for motives which appear, at least to the perpetrator, to be well-intentioned, namely for the benefit of that person, very often at that person's request. Nonetheless, mercy killing involves the perpetrator intentionally killing another person, and therefore, even where that person wished to die, or the killing was purely out of compassion and love, the current state of the law is that the killing will amount to murder or manslaughter.

The Court concluded that only parliament had the power to change the law relating to murder, which would allow someone to assist another person to die.

The court stated, "To do as Tony wants, the courts would be making a major change in the law... These are not things which the court should do It is not for the court to decide whether the law about assisted dying should be changed and, if so, what safeguards should be put in place. '

Re Quinlan

Facts:

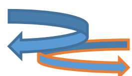
In 1975, 21-year-old Karen Ann Quinlan suffered cardiopulmonary arrest after ingesting a combination of alcohol and drugs.

She subsequently went into a persistent vegetative state.56 Dr. Fred Plum, a neurologist, described her as no longer having any cognitive function but retaining the capacity to maintain the vegetative parts of neurological function. She grimaced, made chewing movements, uttered sounds, and maintained a normal blood pressure, but was entirely unaware of anyone or anything. The medical opinion was that Quinlan had some brain-stem function, but that in her case, it could not support breathing. She had been on a respirator since her admission to the hospital.

Quinlan's parents asked that her respirator be removed and that she be allowed to die. Quinlan's doctor refused, claiming that his patient did not meet the Harvard Criteria [512]for brain death.

Based on the existing medical standards and practices, a doctor could not terminate a patient's life support, if that patient did not meet the legal definitions for brain death. Quinlan's father, Joseph Quinlan, went to court to seek appointment as his daughter's guardian, since she was of legal age, and to gain the power to authorize "the discontinuance of all extraordinary procedures for

[512] Discussed earlier under the title the legal definition of death.



sustaining Quinlan 's vital processes. The court denied his petition to have Quinlan's respirator turned off and also refused to grant him guardianship over his daughter. Joseph Quinlan subsequently appealed to the Supreme Court of New Jersey. He requested, as a parent, to have Quinlan's life support removed based on the U.S. Constitution's First Amendment.[513]

Held: The New Jersey Supreme Court stated that an individual [1]s right to privacy was most relevant to the case.Although the U.S. Constitution does not expressly indicate a right to privacy, U.S. Supreme Court rulings in past cases had not only recognized this right but had also determined that some areas of the right to privacy are guaranteed by the Constitution.

The Court ruled that, "Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present" It was further noted as follows:

"We have no doubt that if Karen were herself miraculously lucid for an interval and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus even if it meant the prospect of natural death.'ı

Balanced against Quinlan's constitutional right to privacy was the state's interest in preserving life. The court, in light of this stated, "...we think that the State's interest ... weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. " Ultimately there comes a point at which the individual's rights overcome the State's interest.

The court also observed that life-prolonging advances had rendered the existing medical standards ambiguous, leaving doctors in a quandary. Moreover, modern devices used for prolonging life, such as respirators, had confused the issue of "ordinary" and "extraordinary" measures. Therefore, the court suggested that respirators could be considered "ordinary" care for a curable patient, but "extraordinary (care for irreversibly unconscious patients.

The court suggested that hospitals form ethics committees to assist physicians with difficult cases like Quinlan's. The committees would not only diffuse professional responsibility, but also eliminate any possibly unscrupulous motives of physicians or families. The New Jersey Supreme Court also ruled that, if the hospital ethics committee agreed that Quinlan would not recover from irreversible coma, her respirator could be removed [514]

The above cases show that euthanasia has acquired a widespread recognition and approval. But whilst some countries such as England are reluctant to legalise euthanasia, their courts do envision the law making bodies of those countries soon putting in place a legal framework to allow seriously ill patients to end their life.

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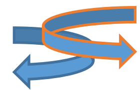
[513] The right to religious freedom.

[514] http:(/www.libraryindex.com/pages/„582/court-end-life„right-privacv-karen-ann-quinlan.html(29 July 2021)



Euthanasia in Netherlands

Since 2002, the Netherlands has been one of the few countries where Euthanasia and physician-assisted suicide are under strict conditions regulated by law.

However, initially, the Dutch Penal code [515] made both Euthanasia and assisted suicide

The Dutch Penal code [516] provides as follows whoever causes death by doing an act with the intention of causing death, or with the intention of causing bodily injury as is likely to cause death, commits an offence of culpable homicide.

The code[517] further expounds on culpable homicide as murder when -

a) The act by which death is caused is done with the intention of causing death
b) If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused
c) If it is done with the intention of causing bodily injury to any person, and the bodily injury to any person, and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death; or
d) If the person committing the act knows it is so imminently dangerous that it must in all probability cause death, or such bodily injury is likely to cause death and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid.

Albeit, as a result of various court cases and legislation which will be discussed later, doctors who directly kill patients or help patients kill themselves would not be prosecuted as long as they follow certain guidelines. [518]

In the Netherlands, Euthanasia is an option for those patients who suffer unbearably and without any prospect of improvement, and who express the explicit wish to die by means of euthanasia. The decriminalization of Euthanasia made the Netherlands the first country to formally sanction mercy killing. The first glimpse of the Netherlands gradual acquiescence of euthanasia and PAS[519] began with the case of Alkmaar[520]

Where Article 293 and 294 of the Dutch penal code were interpreted by the Dutch

Supreme Court as susceptible to the defence of necessity contained in the penal code.[521] The Penal Code provides, any person who commits an offence under the compulsion of an irresistible force

[515] Article 293 and article 294

[516] Article 293

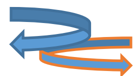
[517] Article 294

[518] The royal Dutch medical association <http://knmg.artesennet.nl/dossier-9/dossier

[519] Physician assisted suicide

[520] Nederland jurisprudence 1985 No. 106

[521] Article 40



shall not be criminally liable. It was held that the defence of necessity would apply where the doctor acted according to 'reasonable' medical opinion. [522]

Legal framework & Practice

Euthanasia in the Netherlands is regulated by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act as from 2002. The Act[523] amended Article 293 of the Dutch Penal Code as follows —

offence of assisted suicide shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and who informs the municipal autopsist of this jn accordance with Article 7 second paragraph of the Burial and Cremation Act.

The Act provides that euthanasia and physician-assisted suicide are not punishable if the attending physician acts in accordance with criteria of due care. [524]

The Act elucidates due care will be established when the physician —

a) Holds the conviction that the request by the patient was voluntary and wellconsidered,
b) Holds the conviction that the patient's suffering was lasting and unbearable,
c) Has informed the patient about the situation he was in and about his prospects, and the patient hold the conviction that there was no other reasonable solution for the situation he was in
d) The Act further provides, in relation to minors, that if the minor patient has attained an age between sixteen and eighteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request for termination of life or assisted suicide, after the parent or the parents exercising parental authority and/or his guardian have been involved in the decision process.

The physician and Patient do not arrive at the decision to terminate life on their own, A regional review committee[525] established under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, reviews notifications made by physicians of cases of termination of life on request and assistance in a suicide, on whether a case of termination of life on request or assisted suicide complies with the due care criteria.

The committee is composed of an uneven number of members, including at any rate one legal specialist also chairman, one physician and one expert on ethical or philosophical issues. The committee also contains deputy members of each of the categories mentioned.[526]

[522] M Davies textbook on medical law chapter 15.3.2 page 353
[523] Article 20
[524] Article 2
[525] Chapter Ill article 3

[526] ibid

The committee has the following powers —

l. Assess whether the physician who has terminated a life on request or assisted in a suicide has acted in accordance with the requirements of due care, referred to in of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act. [527]

ll. The committee may request the physician to supplement his report in writing or verbally, where this is necessary for a proper assessment of the physician's actions.

Ill. The committee may make enquiries at the municipal autopsist, the consultant or the providers of care involved where this is necessary for a proper assessment of the physician's actions. [528]

The committee informs the physician within six weeks of the receipt of the report.

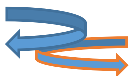
Further, The committee informs the Board of Procurators General and the regional health care inspector of its opinion if the committee is of the opinion that the physician has failed to act in accordance with the requirements of due care, [529] thus making the concerned physician Criminally liable. The committee also informs the concerned physician of any provision of information to the public prosecutor.[530] The committee also ensures the registration of the cases of termination of life or assisted suicide reported for assessment. Further rules on this may be laid down by a ministerial regulation. [531]

Euthanasia In India

In India, attempt to suicide is an offense punishable under the Indian Penal Code. The Penal code provides under attempts to commit suicide Whoever attempts to commit suicide and does any act towards the commission of such offense shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both[532]

A Division Bench of the Supreme Court of India in ***P. Rathinam v Union of India*** [96] Held: The right to live which Article 21 of the Constitution of India speaks of can be said to bring in its trail the right not to live a forced life, and therefore, section 309 violates Article 21. This decision was, however, subsequently overruled by a Constitution Bench of the Supreme Court in — Gian Kaurv

[527] Article 2
[528] Article 8
[529] Article 9(2)
[530] Article 10
[531] Article 11
[532] section 309,indian penal code AIR 1994 SC 144



State of Punjab[533] Held: Article 21 could not be construed to include within it the right to die'as a part of the fundamental right guaranteed therein; therefore, it was ruled that; It could not be validly stated that section 309 is violative of Article 2.

In 2008 the Law Commission of India[534] submitted a review to the government to repeal section 309. The Law Commission said "The Supreme Court in Gian Kaurfocused on constitutionality of section 309. It did not go into the wisdom of retaining or continuing the same in the statute. The Commission has resolved to recommend to the Government to initiate steps for repeal of the anachronistic law contained in section 309 of the IPC[535] which would relieve the distressed of his suffering. The suicide rate in India is above the average world suicide rate.[536] However, later in 2011, a landmark case delivered by the supreme court of India turned the tides and established a new status quo as far as euthanasia in India is concerned. In ***Aruna Shanbaug v Union of India***[537] Where Shanbaug, 60, a former nurse, was beaten and sexually assaulted in 1973 by a co-worker, a hospital janitor at Mumbai's King Edward Memorial Hospital. She suffered severe brain damage and paralysis after her attacker, Sohanlal Bhartha Valmiki, reportedly choked her with a chain. Valmiki was convicted of robbery and assault in 1974 and imprisoned for seven years. After his release, he reportedly moved, changed his name and found another hospital job.

The petition asking that Shanbaug be allowed to die was brought by Pinki Virani, an author and right-to-die activist, after Shanbaug's family abandoned her. Virani argued that with the patient unable to see or speak properly, keeping her alive violated her basic dignity. Virani expressed regret that the court didn't put an end to Shanbaug's force-feeding. He stated, "She still does not, after more than three and a half decades receive justice, the bizarre postscript to Aruna's story is that those who claim to 'love' her and 'look after her' are the ones who want her not to rest in peace.

Held: A two-judge bench of Supreme Court comprising of justices Markandey Katju and Gyan Sudha Mishra, in a landmark judgement on 7th March 2011, allowed passive euthanasia of withdrawing life support to patients in P VS but rejected outright active euthanasia of ending life through administration of lethal substances. The apex court while framing the guidelines for passive euthanasia asserted that it would now become the law of the land until Parliament enacts a suitable legislation to deal with the issue.

Katju J stated, "A person attempts suicide in a depression, and hence he needs help, rather than punishment. The Apex Court further noted that though there is no statutory provision for withdrawing life support system from a person in PVS, it was of the view that passive euthanasia

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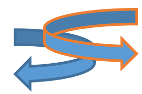
[533] report of the law commission of India-humanization and decriminalization of attempt to suicide

[534] 210'' report of the law commission of India-humanization and decriminalization of attempt to suicide

[535] Indian penal code

[536] A shaha legalizing euthanasia-issues and challenges(LLM thesis savitribai phule pune university 2014-2015 (2011) 4 scc 454

[537] (2011) 4 sec 454



could be permissible in certain cases for which it laid down guidelines and cast the responsibility on high courts to take decisions on pleas for mercy killings. [538]

The Following guidelines were laid down:

a) A decision to discontinue life support has to be taken by the parents or spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient.
b) Even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned.

c) When such an application is filled the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. A committee of three reputed doctors to be nominated by the Bench, who will give report regarding the condition of the patient. Before giving the verdict a notice regarding the report should be given to the close relatives and the State. After hearing the parties, the High Court can give its verdict.

The matter of Euthanasia in India continues to be debated on from a jurisprudential perspective.

On 25 February 2014, a three judge bench of the Supreme court of India in ***A Regd. Society v Union of India*** observed that the judgement in the *Aruna Shanbaug v Union of India* was inconsistent in itself, since the judgement claimed Euthanasia could only be allowed by legislation yet it went ahead to lay down guidelines on the same.

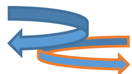
The matter was referred to a five judge Constitutional bench that is yet to deliver its verdict on the issue.

Euthanasia In The USA

It is increasingly likely for Americans to die in institutions from chronic illnesses and public concern has become increasingly focused on how society can best protect the dignity and independence of individuals as they reach the end of life. There is a broad movement within the medical community to improve the quality of end of life care, and this trend is most aptly illustrated by the freedom granted to physicians in providing adequate pain control at the end of life; a goal which can be pursued even to the point of hastening death.

Yet the process of dying has been extended by the proliferation of medical technologies available to us and many of us will die while experiencing unnecessary pain. Furthermore, studies show that an overwhelming majority of Americans express a desire to die at home, and yet the vast majority

[538] shaha legalizing euthanasia-issues and challenges(LLM thesis savitribai phule pune university 2014-2015 1 (2014) 5 scc 338



of us will die in health care facilities. The current trend in public debate favors the discussion of death and the current level of care provided at the end of life with an emphasis on honesty and openness and this increasing level of discussion is being matched with broad social movements to improve the care provided for the dying.

However, too many, dying. "well." involves having a certain amount of control over the place and manner of our deaths. Patients nearing the end of their lives often express concerns about receiving inadequate pain control, receiving too much care, or receiving too little care. To a large extent, these and similar issues can be adequately addressed within the current ethical and legal framework governing medical care.Yet, there are many patients who express a desire to obtain assistance in dying at the place and time of their choosing. The recent passage of the Oregon Death with Dignity Act, which legalizes physician-assisted suicide and regulates the practice, has encouraged both public and Scholarly debate on the topic of legalized euthanasia.

It this concern, whether or not patients who request assistance in dying ought to be able to legally obtain euthanasia, which I will primarily address. I argue that individual acts of euthanasia can be morally justified and that euthanasia ought to be a legitimate medical option for those patients On the Moral and Social Implications of Legalized Euthanasia who request assistance in dying.

Individuals ought to be free to determine for themselves the manner in which they wish to die. A physician willing to provide euthanasia for a patient who competently makes a voluntary and informed request for assistance in dying ought to be legally permitted to provide the kind of care that the patient desires.

Furthermore, legalizing and regulating the practice of euthanasia will serve to increase the quality of care provided at the end of life. The leading objections against the moral permissibility of euthanasia fail to adequately demonstrate that individual acts of physician-assisted death cannot be morally justified and are incompatible with currently accepted medical practices. While some patients and physicians might understandably wish to avoid hastening death as much as possible, patients experiencing irremediable suffering can legitimately request euthanasia; this is a point on which even those staunchly opposed to legalized euthanasia agree. However, some critics have argued that the potential abuses of poor or otherwise vulnerable patients would outweigh the benefits of legalizing and regulating the practice, regardless of whether or not individual cases of euthanasia can be morally justified.

Furthermore, some critics worry that pressing for the legalization of euthanasia will ultimately result in decreasing the level of care provided at the end of life. I argue that an Honest and open-minded evaluation of the leading concerns regarding the moral and Social implications of legalized euthanasia reveal that these fears are largely unfounded Or misguided and do not adequately justify a blanket prohibition against euthanasia.

In Oregon, the legitimate medical option of physician-assisted suicide has not been disproportionately chosen by terminally ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking in end of life care. Furthermore, Oregon

physicians have consistently reported increased efforts to improve their knowledge of the use of pain medications to alleviate physical suffering, to improve their ability to recognize psychiatric disorders, and have been referring more patients to hospice care since the passage of the Act.

The results of this Death with Dignity initiative in Oregon have thus far demonstrated that the feared abuses are not occurring and that the goals of better health care and legalized euthanasia are not mutually exclusive; rather, they can be pursed in harmony. I argue that Oregon should be allowed to proceed with its self-proclaimed bold experiment, and I support the continuation of Death with Dignity initiatives as a legitimate movement likely to improve the quality of care provided to patients at the end of life.

Euthanasia is illegal in majority of the states in the USA. However, the States of Washington, Oregon and New Mexico have legalised Physician assisted dying. For one to understand physician assisted dying in the U.S one must look in to the U.S legal system. In the United States, the Constitution is the highest law of the land. Federal law enacted by the U.S congress follows next. The U.S Congress can adopt laws that control every state, however, this is subject to the circumstances of each state, the U.S Constitution and court decisions permit.

State legislation comes last. These are laws passed by a legislature of each state. [539] In the state of Washington, Euthanasia is regulated by the Washington death with dignity Act.[540] It is a state legislation. The Act[541] provides for who may make a request to end life.

It provides, an adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her desire to die... Such an expression is made in writing requesting for medication that the patient may self-administer in accordance with the Act.[542] The Patient can rescind request at any time and in any manner without regard to his mental state. [543]

The Act[544] provides that the written request shall be in a prescribed form set out in the following manner —

RERQUEST FOR MEDICATION TO END MY LIFE IN A HUMAN AND DIGNIFIED MANNER

[539] <HTTP:system.uslegal.com/> (18th august 2015) 2(1)

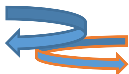
[540] An act relating to death with dignity. Section

[541] Section 2 (1)

[542] Ibid

[543] Section 10

[544] Section 22



……………. am an adult of sound mind. I am suffering from ………………………………,which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that I may self administer to end my life in a humane and dignified manner and to contact any pharmacist to fill the prescription.

INITIAL ONE:

………………………………I have informed my family of my decision and taken their opinions into consideration.

……………………………I have decided not to inform my family of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full impact of this request and I expect to die when I take the medication to be prescribed. I further understand that although most death occurs within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed ... ...……………………………………………………

Dated... ....……………………………………………….

DECLARATION OF WITNESSES

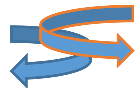
By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request has done it voluntarily.

The Act also provides for safeguards to ensure credibility of the life ending process. The Act provides for the following responsibilities for the attending physician.[545] They include among others;

- Make an initial determination whether the patient has a terminal disease, is competent and has acted voluntarily
  - To ensure the patient makes an informed decision by informing the patient

- His or her medical diagnosis

[545] Section 4



- His or her prognosis
- The risk of taking the life ending medication
- The feasible alternatives to ending life

- Ensure all appropriate steps as provided under the Act are followed before writing a prescription for medication to end life
- Deliver the prescription either personally or by mail to the pharmacist who in turn delivers it to the concerned patient

A consulting physician on the other hand examines the patient and his or her relevant medical records and confirms, in writing, that the attending physician's diagnosis that the patient is suffering from a terminal disease is correct, and verifies that the patient is capable, is acting voluntarily and has made an informed decision.[546]

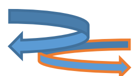
The Act also provides for liabilities for malpractices. The Act provides that a person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing death is guilty of a Class A felony.[547]

Coercion or exerting undue influence on a patient s also prohibited and is also a Class A felony.[548] In the state of Oregon, Euthanasia is regulated by The Oregon Death with Dignity Act. Just like in Washington, The Act allows physicians to prescribe patients lethal drugs in certain circumstances. The Act provides:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner...[549]

The Act also provides for the prescribed form through which a patient makes a request to end his or her life, safeguards and liability for malpractices identical to the Washington death with dignity Act.[550]The euthanasia debate in the United States began, in a sense, with the legal proceedings

[546] Section 5
[547] Section 20(1)
[548] Section 20(2)
[549] Section 2
[550] Cambridge University press online books.



Surrounding the right to withhold or withdraw of life sustaining treatment. The courts have consistently rejected a distinction between withholding and withdrawing life

Sustaining treatments, as well as a distinction between ordinary and extraordinary Treatment.[551]Thus, artificial nutrition and hydration are considered to be medical treatment that competent patients or proxies may refuse, based on the constitutionally protected and deeply personal right of the individual to refuse to consent to invasive bodily intrusion or to refuse to continue life sustaining treatment. However, if there is a constitutionally protected right to assistance in active euthanasia or physician-assisted suicide, it has yet to be recognized and upheld in the United States legal system. Karen Quinlan[552]

The first landmark case of this sort involved Karen Quinlan, a 21 year old woman who Suffered irreparable brain damage after she ceased breathing for unknown reasons during A birthday party. Karen was treated aggressively, placed on a respirator, and given Artificial nutrition and hydration even though she was eventually diagnosed as being Permanently comatose.

The cost of maintaining Karen, which was nearly $450 per day, was being covered by the state.

As more and more possible causes of her coma were ruled out, it became clear to her adoptive parents and physicians alike that she was unlikely to recover. However, when her parents requested that the life sustaining treatment be stopped, they met with resistance and were forced to seek legal assistance to allow her to die.[553]

In 1976, the New Jersey Supreme Court ruled that Karen's right to privacy could be extended to her family, allowing them to make decisions regarding her medical care even if those decisions Would result in her death. After 10 years, the life sustaining treatments were ceased and Karen was allowed to die. The court found that the right to refuse treatment is based on the doctrine of informed consent and holds that physicians have a duty of care that requires disclosure of benefits, risks, and adverse effects of medical treatment. The court has also recognized a. "Liberty interest." of competent patients to refuse unwanted medical treatment that can be extended to the. "Dramatic consequences.' of refusing life sustaining treatments. Furthermore, a durable power of attorney allows a patient to designate an agent or proxy who may make health care decisions on his or her behalf.

***Nancy Cruzan*[554]**

[551] Lawrence gostin deciding life and death in the court room: from quinlan to Cruzan, glucksberg and vacco. A brief history and analysis of constitutional protection of the right to die.

[552] Supreme court of new jersey 70 NJ 10,355 A.d 647,(1976)

[553] Ronald munson,intervention and reflection : basic issues in medical ethics 6th edition

[554] 497 261 (1990)

The second highly influential case involves a patient named Nancy Cruzan. When she Was 25, Nancy was involved in a serious automobile accident that left her in a persistent Vegetative state. The cost of providing care for Nancy was $130,000 per year, which Karen Quinlan) was covered by the state. Although her parents initially hoped that she would come out of her coma, after eight years of waiting they became convinced that she was unlikely to recover and made the decision to request that treatments keeping her alive be ceased. This decision was not supported by the hospital, and her parents were forced to go to court.

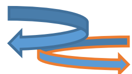
Many of her family and friends testified that Nancy would not want to be kept alive in such a condition, and in 1988 the local County Circuit Court ruled in favor of allowing the removal of life sustaining treatments. However, the Missouri Supreme Court overruled this decision on an appeal, claiming that there was no. "Clear and convincing." evidence that Nancy would not have wanted to be maintained in a persistent vegetative state; The case was then appealed to the United States Supreme Court, which ruled that the Missouri Supreme Court was right in requiring. "Clear and convincing." evidence for the decision to be made, but also found a constitutional. 'Liberty interest.' that grants proxies the power to make medical decisions on the behalf of others and that there is no rational basis for distinguishing between artificial nutrition and hydration and other forms of medical treatment.8 the case was Then presented to the County Circuit Court, which ruled that the testimony provided by Nancy's family and friends did constitute. "Clear and convincing." evidence of her wishes, and she was allowed to die in December of 1990.

Vacco v. Quill[555]

In 1997, the United States Supreme Court ruled that New York's prohibition on assisting Suicide does not violate the Equal Protection Clause of the Fourteenth Amendment by Denying the ability to hasten death to those who cannot do so by refusing life sustaining Treatments. The Supreme Court found that the Second Circuit Court judgment which was overturned was based on a faulty interpretation of New York law as creating a . "Right to hasten death.." Instead, they found that only a right to refuse treatment was supported. The Supreme Court maintained that the distinction between assisting suicide and withdrawing life sustaining treatment is. "Widely recognized and endorsed in the medical profession and in our legal traditions." and is rational, important, and logical.

In their decision, the Supreme Court held that the distinction between refusing treatment and assisting in suicide rests in the principles of causation and intent. When a patient refuses life sustaining treatment, they are killed by the underlying disease; a physician who withdraws treatment. "Purposefully intends, or may so intend, only to respect his patient's wishes.." The same is said to be true with the provision of palliative care that may hasten the time of the patient's death. On the other hand, they maintained that a physician who assists in suicide must. "Necessarily and indubitably intend primarily that the patient be made dead.

[555] 521 U.S 793



Furthermore, every competent individual is, regardless of their medical condition, entitled to refuse unwanted life sustaining medical treatment, while no one is permitted to assist in suicide. Thus, they ruled that a law which applies so. "evenhandedly." to all individuals cannot be thought to lack compliance with the Equal Protection Clause of the Fourteenth Amendment.

Washington v. Glucksberg[556]

On the Moral and Social Implications of Legalized Euthanasia In conjunction with the ruling in . "***Vacco v. Quill,"*** the Supreme Court upheld a law in Washington specifically prohibiting physician assistance in suicide and stated that there was no need to address the more narrow questions as to whether or not: A mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death.... There is no need to reach that question in the context of the facial challenges to the New York and Washington laws as issue here.... The parties and amici agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.... In this light, even assuming that we would recognize such an interest.... the State's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide. The Supreme Court found that the constitutionally protected. "Liberty interest.' in refusing

Medical care cannot be. "Somehow transmuted.' into a right to assistance in committing Suicide. they also hold that there are a number of legitimate interests that may prompt the State in prohibiting assistance in suicide. First, the State has an interest in the preservation of human life and a prohibition against assisted suicide, like homicide laws, would promote this interest. Second, the State has an interest in protecting the integrity and ethics of the medical profession that may involve a prohibition against assisted suicide.

Third, the State has an interest in protecting vulnerable groups (which includes the poor, elderly, and disabled persons) from abuse, neglect, and mistakes. Finally, the State may fear that permitting assisted suicide will . "Start it down the path to voluntary and perhaps even involuntary euthanasia.." However, despite these fears, the federal government recognizes that it would be problematic to formulate legislation explicitly regulating or prohibiting the practice of euthahasia because it is unclear what effects such legislation might have,The position which the government has taken, then, is to allow individual states to form their own legislation regarding euthanasia pending information that suggests creating a federal stance.

This opinion has been expressed by Supreme Court Justices who maintain that the. "Challenging task of crafting appropriate procedures for safeguarding Liberty interests is entrusted to the. 'laboratory.' of the states.." Thus, states are free to form legislation on either side of the euthanasia debate. Indeed, the rulings of the Supreme Court leave open ."Room for vigorous debate."

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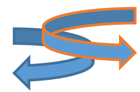
[556] 521 U.S 702 (1997)



regarding physician-assisted suicide and voluntary active euthanasia and this is precisely what has been occurring in the last few years. Recently, the citizens of Oregon voted to approve an Act that legalizes and regulates the Practice of physician-assisted suicide. This legislation has been the subject of substantial Political controversy and has served to advance the level of public and scholarly debate on the timely and important topic of legalized euthanasia. In the state of New Mexico, a court decision established the legality of Euthanasia as a right in the case of -
Katherine Morris & Aja Riggs v Attorney General of the State of New Mexico[557]

The Plaintiff Aja Riggs was diagnosed with uterine cancer in August 2011. She wanted the "peace of mind" of knowing that aid in dying would be an option available to her if she found her suffering in the terminal stage of her cancer unbearable. Held: "Medical practices, medical treatment and medical ethics have changed radically over the past fifty years. Certainly the medical and legal ethical considerations regarding end of life care have changed over the past fifty years... This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and

happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying... The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution. "

Recommendations

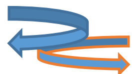
For legalization of euthanasia to be effected in Uganda, I suggest that the following measures be incorporated;

(i) A well formulated and laid down legal framework. This should include a legislation stipulating the manner which patients could voluntarily chose to end their lives, the act of parliament would expressly define euthanasia and PAS, provide for procedures to be followed when soliciting and carrying out mercy killing and the role of all parties involved. A model similar to the Washington death with dignity Act in the U.S.A should be adopted. this act provides the following key regulations.

(a) Who exactly may make a request to end life?
(b) A prescribed form within which a patient may make a request to end life with a witness declaration of approval.
(c) Rules to be followed by physicians when conducting mercy killing and a mandatory requirement for consultation to eliminate malpractices.

Further, Netherlands also offers a good example on how to lay the procedural groundwork for such a law. The Netherlands termination of life in request Act provides for regional review committees charged with a responsibility to review notifications made by physicians of cases of termination of life on request and register cases of mercy killing. The committee also reports cases of medical

[557] No.D-202-CV 2012-02909



malpractices making the physician(s) involved criminally liable. In Uganda, such a committee would be formed to further make the procedure of mercy killing credible and within the acceptable ethical, moral and legal parameters. As is the case in the Netherlands. These committees would operate independently in a manner akin to Constitutional commissions.

ii) All stakeholders such as doctors, nurses, consultants, lawyers and the general public would have to participate in the law making process and its subsequent implementation. Given the controversial nature of mercy killing, all these aforementioned parties would have to ensure that the noble purpose of the practice is achieved consistently.
Civic education would go a long way in achieving these objectives.

iii) The law would also have to raise the level of criminal culpability for anyone who flouts the procedures for mercy killing put in place. This would however require amendments to our current laws. For instance, Section 196(d) of the Penal Code of Uganda outlaws aiding death of another. The Section provides that if by any act or omission a person hastens the death of another person suffering under any disease or injury which apart from that act or omission would have caused death has caused death of another and will be liable to death as stated under section 189 of the penal code act. Section 209 of the penal code outlaws aiding suicide it provides: "Any person who;

- Procures another to kill himself or herself
- Counsels another to kill himself or herself and thereby induces him to do so, or
- Aids another in killing himself or herself Commits a felony and is liable to imprisonment for life.'

Regarding culpability for malpractices relating to mercy killing procedures, and in the interests of justice and integrity, the proposed legislation would also encompass offences such as altering or forging requests to end life, inconsistent and reckless modus operandi. Most importantly, the legislation would also impose punishment for each of the offences pursuant to the Latin maxims *nullum crimen sine lege* and *nulla poena sine lege.*

iv) The proposed legislation would also necessitate an amendment of the 1995 constitution. The constitution under article 22(1) provides that " no person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction shall be confirmed by the highest appellate court." This provision would need to provide for the option of euthanasia as well. As another ground for which ones life can be terminated.The constitution being the supreme law of the land as it expressly states in article 2 requires any amendment providing for the option of euthanasia to start from the supreme law itself. Such a radical and for reaching addition to our body of laws would inevitably come bundled with challenges and potential pitfalls. In order to be as objective and pragmatic as possible in my study, I have identified the most pertinent challenges as follows;

- *Given the pluralistic nature of the Ugandan society today, this change of law would likely generate endless political, moral and religious debates in Uganda.*

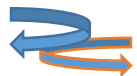
- *The constitution of Uganda has created a justice system and a democratic space that paves the way for any concerned citizen or lawful group to challenge legislations in Court and subject them to the test of constitutionality. An Act of parliament Legalising mercy killing would be no exception.*
- *The proposed legislation would also demand a substantial pecuniary investment. The creation of bodies to oversee its implementation, notwithstanding the state machinery needed to enforce some of its provisions would be great.*

I would therefore submit that Uganda currently is not ready for such a Law, but nonetheless it is a law that would require much consideration and assessment in future.

DOUBLE EFFECT & MERCY KILLINGS:

The first issue to be looked at is the doctrine of double effect. This doctrine justifies the provision of treatment that will have a positive medical impact upon the patient, usually by way of pain relief, but will also have the consequential side effect of shortening the patient's life.[558] On the acceptability of such forms of medical treatment Lord Donaldson said:

[558] Keown states that the requirements for double effect are; the act is not bad in itself, the bad consequence is not a means of achieving the good consequence, the bad consequence is not intended but may be foreseen, there is a sufficiently serious reason for allowing the bad consequence, see J. Keown, *Euthanasia, Ethics and Public Policy*, p.20. There is some doubt, however, as to whether or not it is possible to distinguish between intention and foresight in the way proponents of double effect claim, see J. Griffiths, A. Bood & H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998), p.161



"The use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so."[559]

Lord Goff, in ***Airedale NHS Trust v. Bland***, also supported the acceptability of such treatments.[560] In the criminal case of *R v. Adams*[561] a doctor was charged with administering large doses of heroin and morphine to a patient prior to her death. In his summing up to the jury Devlin J stated that:

"If the first purpose of medicine… could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve the pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps even longer."[562]

It is submitted that there are two important distinctions between lawful and unlawful treatment. The first of these is the effect of the treatment in question. If the treatment carries with it the possibility of benefit then it may be lawful. This raises the question of what type of outcomes will be classified as being of benefit to the patient? Lord Keith has stated that:

"The object of medical treatment and care is to benefit the patient. It may do so by taking steps to prevent the occurrence of illness, or, if an illness does occur, by taking steps towards curing it. Where an illness or the effects of an injury cannot be cured, then efforts are directed towards preventing deterioration or relieving pain and suffering."[563]

Lord Brandon has stated that treatment can only be in the interests of the patient, and therefore seen as beneficial to the patient, if it achieves one of three ends, namely; saving life, ensuring improvement or preventing deterioration.[564] It would be wrong to argue that causing death could be seen as falling within the notion of reducing suffering[565] as this would almost certainly be a case of instigating deterioration rather than preventing it. To hold otherwise would be to distort the doctrine and the result would be the legalisation of euthanasia.

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[559] *Re J (A Minor)(Wardship: Medical Treatment)* [1990] 3 All ER 930, at 938

[560] [1993] 1 All ER 821, at 868

[561] [1957] Crim LR 365

[562] ibid, at 375

[563] *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 860

[564] *F v. West Berkshire Health Authority* [1989] 2 All ER 545, at 551

[565] Pabst Battin argues that in some instances the only way to reduce pain is to render the patient unconscious and that, for the patient, this is the same as death and, therefore, mercy killing in such circumstances ought to be allowed, see M. Pabst Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (Oxford: OUP, 1994), p.105. If, however, there is no difference between death and unconsciousness then maintaining the patient in an unconscious state cannot harm them.

It has already been suggested that the principle of allowing treatment is limited according to the definition of treatment. Lord Keith and Lord Brandon's definitions of treatment focus upon the need for treatment to provide some benefit to the patient. They also make it clear that this benefit can only be provided through saving the patient's life, reducing their pain or preventing the deterioration of the condition. It is suggested that the same approach applies in relation to the principle of allowing treatment. In order for the principle to support treatment it is necessary for it to offer a benefit in one of the ways identified by Lord Keith and Lord Brandon. The potential that any particular treatment has to offer a benefit to the patient is determined on a blanket basis. This means that the interests of the individual patient are not considered when determining whether or not the treatment is, prima facie, beneficial. Those interests will be important, however, when the principle of best interests is applied in order to determine whether or not the principle of allowing treatment ought to be set aside. If the beneficial effect is present then a concurrent disadvantage will not necessarily make the treatment unlawful. It is submitted that the doctrine of double effect supports this limitation upon the definition of treatment as it only permits treatment that has a positive impact upon the continued, albeit shortened, life of the patient.

The second important distinction relating to double effect is based upon the intention of the doctor providing treatment. Any treatment administered with the intent of causing the patient's death will be unlawful. However, should the intention be to alleviate the pain and suffering of the patient, then the fact that life may be shortened will not prevent treatment being lawful. If the intention of the doctor is to cause the death of the patient then the doctrine of double effect no longer applies. In such instances the term of mercy killing is frequently adopted, yet it must not be forgotten that such events constitute both active euthanasia and murder. Lord Goff has stated that it will never be lawful for a doctor to administer treatment which is designed to end the patient's life. This remains true regardless of the extent of the suffering and pain which may give rise to the decision to administer such treatment.[566] Ognall J stated that if the primary purpose of treatment is to end life then the doctor is guilty of murder regardless of the motivation which drove him to that act.[567] It is clear that the law does not permit doctors to act in a manner which is designed to end the patient's life.

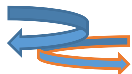
It has been argued that whilst the concept of 'mercy killing' has not been adopted into legislation, the courts have shown a reluctance to convict doctors of a crime which carries a mandatory sentence of life imprisonment.[568] This can be seen in the way that doctors are charged with assisted murder rather than murder itself. This allows the courts to exercise sentencing discretion rather than having to impose the mandatory life sentence. In *R v. Cox*[569] the doctor was found guilty of attempted murder but was not sent to jail, rather he was given a suspended sentence. Further to this, Dr Cox was never stuck off by the General Medical Council but was allowed to continue to

[566] *Airedale NHS Trust v. Bland* [1993] 1 All ER 821, at 867

[567] *R v. Cox* (1992) 12 BMLR 38

[568] J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.531

[569] (1992) 12 BMLR 38



practice medicine. It would appear, therefore, that Dr Cox managed to escape without any real punishment whatsoever.

It is submitted that the leniency that is offered to doctors who engage in mercy killing is not demonstrative of its acceptability. As has already been shown, the courts have constantly reasserted the fact that deliberate killing or shortening of life is unacceptable. Rather it is an admission that the motives and pressures that drive the doctor's decision may be noble. Whilst motive will not affect the legality of the act[570] it may be of import when considering the sentencing should the verdict be guilty. It should not be thought that this is an indication of a desire to legalise euthanasia. Whilst the arguments for the decriminalization of euthanasia are abundant and highly emotive,[571] the courts have made it clear that it is currently seen as murder and if that is to change it must come through parliament[572] rather than through the courts as it did in the Netherlands[573.] As the leniency shown to doctors does not effect the legality of their actions it is submitted that it does not impact upon the application of the guiding principles. It would be different if the courts were saying that the act was wrong but then attempting to find ways around the doctors' guilt[574], but that is not the case here.

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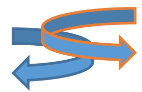
[570] ibid

[571] Hendin criticises many pro-euthanasia writers for using extreme cases, which are claimed to be typical, to sway public opinion. Yet he uses exactly the same technique to oppose the decriminalisation of euthanasia, see H. Hendin, Seduced by Death (London: WW Norton, 1998). Hendin's work has also been criticised for a number of other flaws including the misrepresentation of opinions expressed in interviews, see J. Griffiths, A. Bood & H. Weyers, Euthanasia and Law in the Netherlands, p.23

[572] It has been suggested that euthanasia occurs in practice and that the law should be used to regulate it, as is the case in the Netherlands, rather than simply prohibit it. Keown opposes this though by arguing that it is wrong to say that something should be legalised simply because the law is broken and points out that if doctors are

[573] Keown argues that there is little sense in which euthanasia can be said to be controlled in the Netherlands though, and that all it demonstrates is the validity of the slippery slope argument, see J. Keown, 'The Law and Practice of Euthanasia in the Netherlands' (1992) 108 LQR 51, pp.77-78. It has been argued, however, that there is no evidence that the number of non-voluntary terminations is increasing in the Netherlands, see J. Griffiths, A. Bood & H. Weyers, Euthanasia and Law in the Netherlands, p.26. Frey criticises the slippery slope argument for failing to look at the risks involved in not legalising euthanasia, see R.G. Frey, 'The Fear of a Slippery Slope' in G. Dworkin, R.G. Frey & S. Bok, Euthanasia and Physician Assisted Suicide, p.57

[574] An example of this was seen in relation to pregnant women desiring to refuse treatment. Whilst the courts accept that women retain the right to refuse treatment, they are continually found to be lacking in the competence required to make that refusal binding.



THE UNIQUE SCENARIO OF CONJOINED TWINS:

Re A (Children)(Conjoined Twins: Surgical Separation)[575] involved conjoined twins, Jodie and Mary, who were born to parents who did not feel capable of authorising a separation. Jodie could survive independent of Mary, but if they were not separated she would die within a few weeks. For Mary, on the other hand, separation could only hasten an inevitable death. The result of this was that in order to save Jodie the doctors had to act in a manner which could constitute the murder of Mary through euthanasia. The case is interesting because it combines a treatment with a positive outcome and one with a negative result in not only the same case, but also the same procedure. The court was faced with having to use the law to find a solution to an extremely difficult issue that had never been envisaged. Not only that, but due to the combination of positive and negative effects it could impact upon the principles applied to all other areas of medical law.

When deciding what treatment children should receive the courts constantly refer to the need to look at what the child's interests require. Ward LJ pointed out that this is only the first stage in the process and it will always be subject to a second question as to the legality of the procedure.[576] In relation to the first question, the court held that whilst the separation procedure was in the interests of Jodie, it was not in the interests of Mary. The only gain for Mary would be the acquiring of the bodily integrity and dignity which is natural for all humans.[577] It was accepted that this was purely illusory though, as Mary would be dead before she could enjoy this gain.[578] It is certainly hard to see how a person can benefit from increased integrity and dignity if they will never have the opportunity to experience it. Having decided that the interests of the two children were in conflict the question was how to resolve that conflict. Ward LJ stated that:

"*Given the conflict of duty I can see no other way of dealing with it than by choosing the lesser of the two evils and so finding the least detrimental alternative. A balance has to be struck somehow.*"[579]

In carrying out this balancing act it was made clear that it was not possible to balance one right to life against the other, as both were equal.[580] The child's quality of life, both current and potential, could be taken into account when looking at the value of the treatment.[581] It was held that this fell

[575] [2000] 4 All ER 961

[576] ibid, at 994

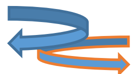
[577] ibid, at 998

[578] ibid

[579] ibid, at 1006

[580] ibid, at 1010

[581] ibid. The court also accepted Keown's distinction between 'quality of life' and 'Quality of life' and the fact that only the former was acceptable.



in favour of Jodie, as Mary would die with or without treatment.[582] The final factor to be balanced was the ability to exercise the right to life. The court stated that the doctors were the only people who could help Jodie, but that nobody could help Mary.[583] The result of this balancing exercise indicated that the separation should be carried out. The consequence of this is that it was possible to say that, on the whole, the treatment was beneficial to those involved despite the fact that it would have a negative impact upon Mary. Bainham has argued that the balancing exercise represents a more respectable and convincing approach than that which was adopted in previous cases,[584] where the courts have simply denied that the problem arose.[585] If Bainham's accusation that the courts have previously ignored the problems caused by conflicting interests is accurate then his praise for the approach adopted in *Re A* appears to be justified, as any attempt to deal with these problems will be better than simply ignoring their existence. It is submitted that the same principles apply here as in relation to other children. The starting point remains the principle of allowing treatment and an analysis of best interests is undertaken in order to see whether or not this should be rebutted. The only difference here is that more than one child was involved and the interests had to be balanced.

The next question was whether or not the treatment would be lawful in the sense that it might be seen as murder.[586] The court rightly rejected the suggestion that the operation could be seen as an omission similar to the withdrawal of treatment. Ward LJ thought that such a classification would be utterly fanciful.[587] Brooke LJ pointed out that the separation would involve numerous invasions of Mary's body, that these could only be classed as positive acts and that it would bear no resemblance to the discontinuance of artificial feeding.[588] To say that the separation was an omission would have been to stretch an already artificial distinction beyond the bounds of all logic. Any suggestion that the doctors would not intend to kill Mary was also dismissed, Brooke LJ stated that the death of Mary must be intended as the doctors were aware of its virtual certainty.[589] Too frequently intention is confused with desire, it is possible to intend a consequence without desiring it.[590] Whilst the doctors did not desire to kill Mary it was one of their intended consequences as its certainty, combined with their awareness of it, meant that they must have considered it and it would be unrealistic to say that they did not intend it, although unhappily so. Robert Walker LJ

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[582] ibid

[583] ibid

[584] The cases referred to by Bainham are *Birmingham City Council v. H (A Minor)* [1994] 2 AC 212 and *Re T and E (Proceedings: Conflicting Interests)* [1995] 1 FLR 581. Whilst neither of these cases involved conjoined twin they did involve the conflicting interests of multiple children.

[585] A. Bainham, 'Resolving the Unresolvable: The Case of the Conjoined Twins' (2001) 6 CLJ 49, p.52

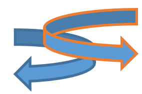
[586] Normally this question never has to be considered and the question of best interests will determine whether or not the treatment will be lawful.

[587] [2000] 4 All ER 961, at 1003

[588] ibid, at 1027

[589] ibid, at 1029

[590] An example of this is a person who attacks somebody because he is under threat of force. Whilst that person intends to inflict the injury he does not desire to do so.



rejected the suggestion that the doctrine of double effect could apply as that required that all the consequences, both positive and negative, be aimed at the same person.[591]

The consequence of this was that the separation would be seen as murder unless there was a defence available. Ward J considered the idea that private defence could apply and described Mary as inflicting a fatal harm upon Jodie which the doctors could act to prevent.[592] The court though, preferred a defence of necessity.[593] Brooke LJ stated that the requirements for the defence were that: the act was needed to avoid inevitable and irreparable damage, no more should be done than is reasonably necessary, the evil inflicted should not be disproportionate to the evil avoided.[594] Ward LJ stated that there is no reason the doctors could not use a similar balancing act to that used in relation to best interests to decide what treatment would be justified by necessity.[595] The outcome of this was that the separation would be justified as the evil of two twins dying was greater than the evil of one dying earlier and one living a long and healthy life.[596] This is yet another example of how the principle of allowing treatment is limited to those treatments which have a positive effect. The balancing exercise of necessity helps to determine whether or not a positive effect is possessed by the procedure in question and, therefore, whether treatment will be permissible.

ASSISTED SUICIDE:

Whilst it has been shown that doctors are not permitted to actively end or shorten a patient's life, the question remains as to whether they can take the halfway step of helping a patient end their own life. Montgomery argues that it is possible to assert that English law recognizes a limited right to die.[597] He bases this argument upon the fact that the law no longer punishes suicide or attempted suicide. The reason for the decriminalization of suicide and attempted suicide was not an acceptance of any right to die however, rather it was due to the futility and harshness of

[591] ibid, at 1063

[592] ibid, at 1017. This idea is supported by Rogers, see J. Rogers, 'Necessity, Private Defence and the Killing of Mary' (2001) Crim LR 515, p.524

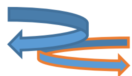
[593] The problem with the use of necessity is that it risks confusion with the doctrine of necessity which serves to authorise treatment which is in the best interests of an incompetent patient. The two terms are not the same and should not be confused and this is a real danger following *Re A*.

[594] [2000] 4 All ER 961, at 1052

[595] ibid, at 1016

[596] The judges were keen to make it clear that the procedure was only valid because of the unique combination of facts involved in the case. Ward LJ stated that it could only be an authority in the following situation: "It must be impossible to preserve the life of X without bringing about the death of Y, that Y by his… very continued existence will inevitably bring about the death of X… that X is capable of living an independent life but Y is incapable… of viable independent existence", see ibid, at 1018.

[597] J. Montgomery, 'Power Over Death, The Final Sting', p.37



punishing people who had attempted to take their own lives.[598] This is evidenced by the fact that whilst suicide is no longer a criminal offence, the Suicide Act 1961, s.2(1), preserves the offences of aiding, abetting, counselling or procuring a suicide or attempted suicide.[599] Due to this Montgomery accepts that it may be more appropriate to argue that the law recognizes the right to be allowed to die rather than a right to die.[600]

In ***R (Pretty) v. DPP***[601] the claimant suffered from a progressive and degenerative terminal illness that would result in a distressing and humiliating death. The DPP had been asked to provide a guarantee that Mr Pretty would not be punished should he assist his wife in taking her own life.[602] When the DPP refused to provide such a guarantee it was argued that the claimant's rights, under the ECHR, were being violated, primarily because the right to life[603] involves a right to die. Lord Steyn stated that the existence off such a right had to be approached with scepticism due to the varied attitudes of the states subject to the ECHR.[604] Lord Bingham provided a stronger argument by relying upon the language of the Convention rather than its cultural background and held that it reflected the sanctity which western society attaches to life and that because of this it was not possible to see it as providing a right to die or enlist assistance in dying.[605] He stated that:

"*It is not enough for Mrs Pretty to show that the United Kingdom would not be acting inconsistently with the Convention if it were to permit assisted suicide; she must go further and establish that the United Kingdom is in breach of the Convention by failing to permit it.*"[606]

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[598] *R (Pretty) v. DPP* [2002] 1 AC 800, at 825. Kasimar states that: "The fact that we no longer punish suicide or attempted suicide does not mean that we *approve* of the acts or that we *recognise* that an individual's right to *self-determination* or *personal autonomy* extends this far", see Y. Kasimar, 'Physician Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia' in J. Keown (ed), *Euthanasia Examined*, p.229

[599] *Attorney General v. Able* [1984] 1 All ER 276, at 288, provides a definition for the offence. Under s.2(4) of the Act a prosecution can only be brought with the express permission of the DPP.

[600] J. Montgomery, 'Power Over Death, The Final Sting', p.40

[601] [2002] 1 AC 800. This case has now been affirmed by the European Court of Human Rights in *Pretty v. United Kingdom* (2002) 35 EHRR 1

[602] In actuality the court held that the DPP did not possess the power to provide this guarantee. Lord Steyn held that whilst s.2(4) of the Suicide Act 1961 enabled the DPP to exercise his discretion in deciding whether or not to prosecute this could only be done in relation to past events, see [2002] 1 AC 800, at 867.

[603] European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), Article 2, which states: "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

[604] [2002] 1 AC 800, at 833

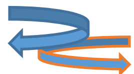
[605] ibid, at 810

[606] ibid, at 814

Whilst Lord Bingham accepted that a patient's condition may mean that the positive obligation to preserve life may be weakened, this was not the same as accepting that there exists a right to be assisted in taking ones own life.[607]
The court also made it clear that the right to respect for family and private life[608] could not apply as this protected how people choose to live, not how they choose to die.[609] The court held that even if this was not the case the protection of life was a sufficient justification for any breach. Lord Steyn held that the right to freedom of belief[610] was never intended to give anyone the unfettered right to do anything they wished in pursuance of their beliefs.[611] Whilst this appears perfectly true it leaves unaddressed the issue of who decides which belief motivated actions are worthy of protection. Another argument that was suggested was that, by refusing to guarantee that the husband would not be prosecuted, the DPP was inflicting inhumane and degrading treatment.[612] The court found it impossible to accept this and said that Mrs Pretty's suffering was a result of her condition not the inability of her husband to assist her in dying.[613] It may be possible, in certain circumstances, for a failure or refusal to act to constitute inhumane or degrading treatment, but it is hard, however, to see how that could be the case here and saying that it is the medical condition which causes the suffering is accurate. By rejecting all of these rights based arguments the court placed great importance upon preserving the patient's life. In this case the preservation of life could not be achieved by providing treatment, rather it had to be through withholding treatment. As has already been stated, the principle of allowing treatment is limited according to the definition of treatment. As a result of this it can be seen as prohibiting any procedure, like assisted suicide as was the case here, which may not be properly classed as medical treatment designed to benefit the patient.

This case illustrates a great reluctance to accept that assisted suicide should be seen as acceptable. It could be suggested that the result was reached prior to the reasoning being carried out rather than the reasoning leading to the conclusion. This reluctance was reinforced by the court's view that there was no real difference between a right to assisted suicide and a right to euthanasia.[614] Keown supports this view and argues that it can be extremely difficult to decide where assisted

[607] ibid, at 813. Dworkin, however, argues that as the law accepts that there is a right to refuse life saving treatment it ought to permit patients to request either euthanasia or physician assisted suicide, see G. Dworkin, 'The Nature of Medicine' in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide*, p.4.
[608] ECHR (1950), Article 8
[609] [2002] 1 AC 800, at 822
[610] ECHR (1950), Article 9
[611] [2002] 1 AC 800, at 836. The example he gives is a person who believes that animal testing is wrong and then decides to attack an animal testing centre or its staff.
[612] ECHR (1950), Article 3
[613] [2002] 1 AC 800, at 815
[614] ibid, at 811



suicide ends and euthanasia begins.[615] Griffiths argues that psychiatrists are already carrying out assisted suicide and that it cannot be controlled if it is kept secret. He argues that whilst the Dutch system has flaws it is at least attempting to confront the problem.[616] Keown, however, doubts the extent to which assisted suicide is practised[617] and Hendin criticises attempts to legalise either assisted suicide or euthanasia before the public have a proper understanding of the implications.[618] He also argues that a doctor who suggests suicide as an option, or accepts a request for assistance too readily, gives a clear signal that he believes the patient should not continue to live.[619] Whilst Dworkin accepts such a risk, he argues that it can be just as harmful to keep patients alive when they genuinely want their life to end.[620]

SUMMARY:

It is submitted that when a patient is approaching death in a natural manner, meaning that the time of that death is not being advanced by medical intervention, the guiding principles that are applied to determine whether treatment should be provided are primarily the same as those which would be applied to the availability of general treatments throughout his or her life. Hence for children and incompetent adults the principles are those of allowing treatment as counteracted by a negative application of best interests. For competent adults it is the principle of self-determination which will be determinative.

The guiding principle which seems to apply in relation to double effect, mercy killing and assisted suicide is that of allowing treatment. Whilst this may seem strange when the law actually prohibits treatment, it is argued that the principle operates as a two edged sword. Whilst it provides justification for treatments which provide a benefit to the patient it also serves the purpose, through defining what will be classed as medical treatment, of prohibiting treatments which provide no benefit and could be seen as falling outside the realm of medicine. The Hippocratic Oath supports the idea that euthanasia and assisted suicide are not ethically acceptable and states: "To please no-

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[615] J. Keown, *Euthanasia, Ethics and Public Policy*, p.33. Keown refers to the giving of medicine for the purpose of suicide and asks when it becomes euthanasia. Is it when the drugs are passed to the patient, when the doctor places them in the patient's mouth, or when he forces them down her throat?

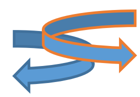
[616] J. Griffiths, 'Assisted Suicide in the Netherlands: The *Chabot* Case' (1995) 58 MLR 232, p.249. One argument is that such behaviour occurs in all modern medical systems and that simply saying that it is morally and legally wrong does nothing to control it, see J. Griffiths, A. Bood & H. Weyers, *Euthanasia and Law in the Netherlands*, p. 21

[617] J. Keown, *Euthanasia, Ethics and Public Policy*, pp.61-62

[618] H. Hendin, *Seduced by Death*, p.24

[619] ibid, p.185. Dworkin, on the other hand, points out that if a doctor can manipulate a patient into requesting assisted suicide the same influence could be used to manipulate a patient into refusing life-saving treatment, see G. Dworkin, 'Public Policy and Physician Assisted Suicide' in G. Dworkin, R.G. Frey & S. Bok, *Euthanasia and Physician Assisted Suicide*, p.67.

[620] R. Dworkin, *Life's Dominion: An Argument About Abortion and Euthanasia* (London: HarperCollins, 1995), p.197. It has also been argued that it would be an insufficient excuse to say, to a patient wishing to die, that no assistance could be offered because of the risk of another patient, in an unrelated instance, being exposed to abuse, see G. Dworkin, 'Public Policy and Physician Assisted Suicide', p.70.



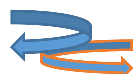
one will I prescribe a deadly drug, nor give advice which may cause his death".[621] The definition attached to treatment seems to greatly favour the preservation of life. Whilst the doctrine of double effect authorises treatments that shorten life it does so only where the reduction of suffering is the primary aim. The courts view the role of doctors as concerned with improving life. Whilst this can be done by reducing pain or lengthening life it cannot be done by deliberately shortening that life. It is for this reason that the administration of a lethal injection would be unlawful, as would other euthanasia techniques. Hence, when the patient is approaching death, through either a medical condition or personal choice, it is the principle of allowing treatment which determines when a doctor will be free to offer assistance in the form of medical intervention aimed at ending life. When an application of the principle of allowing treatment indicates that a course of action will not be medical treatment then it becomes an issue of the criminal law, usually murder or assault.[622]

Final Summary

Finally, it is submitted that, far from being an ad-hoc collection of unrelated decisions, the law in relation to when it will be possible for doctors to provide treatment to a patient, does adhere to a logical structure. It is argued that the theory of Graduated Guiding Principle Identification can be used to both explain how and why the law approaches certain issues and to accurately work out how future cases are likely to be decided. For the majority of people though there is certainly some point during their lives when one or more of the other guiding principles will apply. Even for the competent adult there is the prohibitive aspect of the principle of allowing treatment, thereby placing limits upon what can be consented to. Whilst the principles which apply will vary depending upon the exact circumstances of the case they do so in a manner which, contrary to many academics, is both logical and consistent.

[621] Whilst it could be argued that the Hippocratic Oath is outdated, for example it rejects payment for a physician's work and for teaching others the profession, similar statements can be found in the Declaration of Geneva and the International Code of Medical Ethics.

[622] Figure 5 in Appendix A provides a visual representation of how the guiding principles apply when life comes to an end.



LIABILITY OF MEDICAL PRACTITIONERS

5.7 LIABILITY OF MEDICAL PRACTITIONERS

Medical practitioners include but is not limited to doctors, nurses, midwives and surgeons. When people are sick they always perform their job in line with the highest professional standards. However, not every doctor does a reasonably good job and their patients or clients decide to sue.

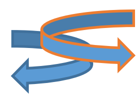
Medical malpractice involves a situation in which a medical professional such as a doctor, fails to act according to the Professional such as a doctor who fails to act according to the proper standard of care towards a patient when providing medical care or treatment there by injuring the patient thereby causing harm or injury and violating the right to health. There are certain serious acts and commissions by a medical practitioner which in essence, have a potential to cause permanent injury to a patient or their loved ones. Efforts to prevent and punish these are what is entailed in this chapter.

The first step in determining one's success in a matter of professional misconduct is first of all, proving the existence of a right, that this right violated and the defendant is the one who violated this right. It is a known principle of law that "*where there is a right, there is a remedy.*" This is written in the Latin Maxim "***Ubi ius, ibi remedium***"

In Uganda, the right to health remains under great contestation as it is not expressly provided for in the constitution. This means that court rulings are the stronger basis that we rely in claiming this particular right, specifically, the judgment of *Justice Mugambe* in the ***E.D of Mulago Case.***

The World Health Organisation (WHO) was the first international instrument to explicitly recognize the right to health? Its Constitution affirms that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[623]The Uganda government has ratified a significant number of international instruments which recognize the right to health, such as the Universal Declaration of Human Rights (UDHR), International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on Elimination of Discrimination Against Women (CEDAW), and Convention on the Rights of the Child (CRC) among others.

[623] Preamble of the WHO Constitution



Uganda is a member state of the **World Health Organization**, which defines health as the state of complete physical and mental wellbeing, not merely the absence of infirmity or disease. In the international policy framework before 2015, the Millennium Development Goal (MDG) aimed at reducing maternal mortality. Currently, the Sustainable Development Goals (SDGs) provide a policy regime aimed at transforming the world for sustainable development by 2030, and SDG 3 caters for good health and well-being, and in overcoming inequalities within and between countries globally. In the absence of an express stipulation of the right to health in Uganda's constitution, this chapter examines key sources of law applicable to the right to health, with a specific focus on international, regional and national laws. Uganda is a party to some of these human rights instruments that provide for the right to health. The Ugandan Constitution also contains provisions that have a bearing on this right. There are also health related policy frameworks aimed at ensuring that citizens enjoy good health.[624]

PROFESSIONAL MALPRACTICE IN THE MEDICAL SECTOR.

Professional malpractice is an everyday occurrence in Uganda. It takes different forms such as carrying out operations without consent, medical negligence, discrimination, giving improper prescriptions, abandonment of patients, revealing patient's information to third parties with their consent, sexual harassment and injecting patients with already used syringes among others.

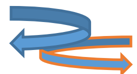
Medical personnel's using one syringe / needle on more than one person.

The medical personnel have adopted a bad habit of spreading diseases to the patients by using one needle for more than one person. This is unethical and unprofessional and it leads to spread of diseases including HIV/ AIDS.

There are other instances in which medical practitioners maliciously inject themselves with one needle and yet they are well aware that they are sick and inject the same needle on other patients.

In ***Uganda V Namubiru Rosemary***[625]**,** the accused was a senior nurse who pricked herself with a needle and then injected with the same needle yet she was HIV Positive. She was sentenced to three years imprisonment.

[624] For example Ministry of Health, Health sector strategic plan, 2010/11-14 (2010)
[625] Uganda V Namubiru Rosemary. [HCT-00-CR-0050-2014]



The Concept of Medical Negligence as professional malpractice.

The concept of negligence developed from the English Common Law of Tort which aims at compensating a claimant who has suffered pain and or financial loss by suing the wrongdoer. The tort of Negligence was developed by the House of Lords in Donoghue vs. Stevenson where court affirmed the neighbor principle. Lord Atkin stated the principle to be that;

"The rule that you are to love your neighbor becomes in law you must not injure your neighbor; and the lawyer's question "Who is my neighbor?" receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbor. Who then in law is my neighbor? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."

Case law has defined medical negligence as, the omission to do something which a reasonable man would do, or doing something which a reasonable man would not do.[626] Medical Negligence therefore relates to the failure or deviation from medical professional duty of care or the failure to exercise an accepted standard of care in medical professional skills or knowledge, resulting in injury, damage or loss. [627] Medical negligence is built and premised on this principle of the tort of negligence generally, save that the standards of proof is higher than in other ordinary cases of negligence.

Medical negligence occurs where a medical professional owes a duty of care to a patient, that duty of care is breached the breach caused injury, damage or death, and that injury, damage or death is as a result of the breach of that duty. The patient has a duty to prove fault on the part of the medical professional throughout the case for a claim in medical negligence.

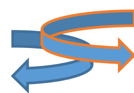
As already noted, certain actions or omissions by a medical practitioner which appear minor in the eyes of a reasonable man may have a lifetime effect upon a patient and their loved ones. A typical example of a minor mistake causing long life effect is the following; a most recent Kenyan television broadcast read as follows;

"KNH management says that the hospital has suspended the admission rights of a neurosurgery registrar and issued him with a shown cause letter for apparently operating on a wrong patient. The said patient that required nursing and medication to treat a swelling on the head got an open brain surgery meant for another patient after there was a mix-up in their identification tags[628]. The doctors did not realize their mistake until "hours into the surgery", They then realized "there was no blood clot". This is one of the extreme cases of medical professional negligence ever recorded in East Africa.

[626] Blyth Vs. Birmingham Water Works Co. (1856) 11 Ex 781; 156 ER 1047

[627] **Indian case**

[628] https://www.bbc.com/news/world-africa-43255648 accessed on 31st December 2021



Legal regime governing Professional medical negligence.

The legal framework relating to medical negligence is scattered in different laws and policies. Uganda has ratified a number of international and regional treaties and declarations as per ***Article 123 and 287 of the 1995 constitution of Uganda,*** and some of them address issues relating to human rights to which the right to health care and medical negligence is imbedded.

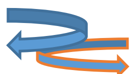
These include ***the International Covenant on Economic, Social and Cultural Right*** ; ***Article 12(1) of the International Covenant on Economic, Social and Cultural Rights*** provides for the right to the highest attainable standard of physical and mental health. It entered into force 3 January 1976 and Uganda is a signatory.

The ***Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) ; Article 12*** of the Convention provides that state parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

The ***Convention on the Rights of the Child (CRC) ; Article 24 (1)*** of the Convention provides that State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

The ***Convention on the Rights of Person with Disability (CRPD); Article 25*** of the Convention provides for the rights of persons with disabilities to health, including access to gender -sensitive health services.

African Charter on Human and Peoples' Rights (ACHPR); Article 16 (1) and (2) provides for the right to enjoyment of the best attainable state of physical and mental health and puts an obligation and duty on State parties to the Charter to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick respectively.



Treaty for the establishment of the ***East African Community; Article 118 (b)*** of the Treaty enjoins partner states to cooperate in the area of health, in the management of health systems, drug policies, harmonization of national health policies and exchange of information and promotion of research. ***United Nation Declaration on Human Rights (UNDHR) ; Article 25 (1)*** states that everyone has the right to a standard of living adequate for the health and well - being of himself or herself and of his or her family, including ....and medical care and necessary social services.

The ***Abuja Declaration*** ; The Declaration 31 reaffirms the commitment undertaken by the member states to reallocate 15 % of the national revenues toward progressive achievement of access to health care in their respective countries. The ratification of these international conventions and declarations creates an obligation upon Uganda and her development partners to ensure that legal and institutional frameworks are in place to provide healthcare within the minimum standards so as to protect its citizens against any acts that may infringe their enjoyment of the right to health including incidence of medical negligence.

Historically, it is universally recognized that the Constitution of any country is the supreme law of the land. ***Article 2*** of the constitution, provides that the constitution in the supreme law of Uganda and shall have binding force on all authorities and persons throughout Uganda, and that if any other law or any custom is inconsistent with any of the provisions of the constitution, the constitution shall prevail, and that law or custom shall be void. Uganda domestically drives from the national policies of the Constitution.

Therefore **Objective XX** is to the effect that the State shall take all practical measures to ensure the provision of basic medical services to the population. And ***Objective XXIII*** provides that the State shall institute effective machinery for dealing with any hazard or disaster arising out of natural calamities or any situation resulting in general displacement of people or serious disruption of their normal life.

The Constitution simply provides that the NODPSP shall guide all organs and agencies of the State, all citizens, organizations and other bodies and persons in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions for the establishment of a just, free and democratic society under NODPSP I. Thus in ***Zachary Olum & Another v Attorney-General Constitutional Petition 6/1999,*** the court observed that although the NODPSP form an important part of the Constitution and are crucial canons in

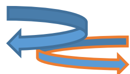
the interpretation of the Constitution, they are not justiciable. More so in ***Tinyefuza v Attorney-General Constitutional Petition 1/1996,*** although Egonda Ntende J observed that the NODPSP should guide all organs of the state including the judiciary in the interpretation of the Constitution, he fell short of saying that these objectives and directives are by themselves legally binding.

Principally ***Article 20(2) of the Constitution*** provides for the right and freedom of the individual and groups enshrined in this chapter shall be respected, upheld and promoted by all organs and agencies of the government and by all persons. Thus in ***Christopher Mtikila V the Attorney General [Tanzania] HCCS NO.5/1993*** Lugakingira J, stated that fundamental rights and freedoms of the individuals are inherent by born and not granted by the state.

Thus the Constitution contains a number of human rights and freedoms, which are critical for the protection of the right to health, given the interdependence, indivisibility and interrelationship of human rights.

The legal framework relating to medical negligence is scattered in different laws and policies. These include the 1995 Constitution of the Republic of Uganda as above;

The Penal Code Act, Cap 120, Section 224 provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case. ***Sections 227 –229*** provide for criminal recklessness and negligence; that is to say, that any person who by rash or negligent act not amounting to manslaughter, causes the death of another person is liable to imprisonment for a term not less than seven years or a fine not exceeding seventy thousand shillings or both such imprisonment and fine; that any person who, in a manner so rash or negligent as to endanger human life or to be likely to cause harm to another person gives medicine or surgical treatment to any person whom he or she has undertaken to treat or dispenses, supplies, sells, administers or gives away any medicine or poisonous or dangerous matter commits a misdemeanor.



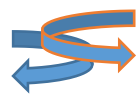
The Allied Health Professionals Act, Cap 268; Section 38 (1) provides that where the council receives an allegation which, if proved, would constitute a professional misconduct on the part of a person registered under this Act, it may refer the matter to the disciplinary committee to hold an inquiry into the alleged misconduct.

The Uganda Medical and Dental Practitioners Act, Cap 272; Section 33 of the provides that the council shall hold an inquiry where it receives an allegation which, if proved, would constitute professional misconduct on the part of the registered practitioner and ***Section 47 (f)*** provides that on conviction, a medical professional is liable to a fine of not less than three hundred thousand shillings and not more than three million shillings or to imprisonment for not less than three months and not more than one year or to both.

The Nurses and Midwives Act Cap 274; Section 1 (i) defines a midwife to mean a person who is trained and qualified in the care of women in relation to childbirth and in the care of infants and who is registered or enrolled under the Act. ***Section 1 (k)*** further defines a ***Section 28 (1) (c) t***he Act provides for the removal from the register or roll, after an inquiry, the name of any person, who is found guilty of professional misconduct by the council19 or who is suspended from practice.

The Pharmacy and Drugs Act Cap 280; Section 15 provides for a disciplinary committee empowered to take disciplinary measure with regards to the conduct of pharmacists. ***Section 16 (1) (b)*** of the Pharmacy and Drug Act specifically provides for disciplinary proceedings where a registered complaint, is made against a pharmacist has been guilty of professional misconduct specified in the second schedule of the Act which among many include knowingly supplying of addictive drugs contrary to ***Schedule 2 (10) and*** supply of substance ordinarily requiring a prescription of a medical professional contrary to ***Schedule 2(13).*** In addition to the existing legal framework, the government of Uganda has put in place national strategies to guide policies and legislation formations on health care to include ***National Development Plan (NDP) 2015/16 –2019/20*** which emphasizes the importance of a human rights - based approach to health. It states that the right of everyone to enjoy the highest attainable standard of physical and mental health is recognized in Uganda.

The Second National Health Policy (NHP II) and it is aligned with the 2030 Agenda for Sustainable Development. Sustainable Development Goal 3 on Health calls upon the



government to ensure healthy lives and promote well - being for all at all ages with a specific target on promotion of mental health and well - being. This reiterated in the Common African Position of the African Union 2014 which highlights mental health a key priority area.

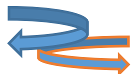
The Second National Development Plan (UNDP II) sets four key objectives to be attained during the five year period of 2015/2020 of which enhancing human capital development and strengthening mechanisms for quality, effective and efficient service delivery are mentioned. The UNDP has set interventions upon which quality of care and patient safety can be achieved. Among these are: - establishing dynamic interactions and feedback mechanisms between health care providers and consumers; strengthen national and sub national capacity to implement quality improvement interventions.

Recommendations

Reforming some of the medical negligence laws ; in reforming current Rules of Courts, it is essential that the Ugandan Government closely consults with and actively involves people with cases of medical negligence themselves. This not only makes good policy sense but is required by the constitution itself under **Article 28** which provides fair hearing. Given the lack of official statistics of people with medical negligence accessing justice and the limited awareness of judicial officers at present, their direct involvement in judicial reform efforts are essential. Effective involvement and consultation will also ensure that the Rules of Courts avoid derogatory terms, and will result in increased accessibility, and understanding of procedural, and reasonable accommodations.

Secondly to create accountability for actions; Research indicates that a patient's prime decision to sue is largely based on patient dissatisfaction and medical professional communication and interpersonal skills. Theoretically, lawsuits deter medical professional from negligent acts and omissions in the performance of their tasks by serving as a reminder to those who wish to avoid the emotional and financial costs of litigation that they must take care.

To create accountability for actions. The patient's prime decision to sue is largely based on patient dissatisfaction and medical professional communication .in a situation where a medical personnel



performs his or her work negligently should be held liable for their acts and omissions. the laws put in place should be enforced and strictly adhered too by the medical personnel in order not to be held accountable for their actions .

However, there has been less empirical scrutiny of the performance of the malpractice system as a means of deterring substandard care than there has been of its record as a mechanism for proving compensation. Legal deterrence is a notoriously difficult phenomenon to measure and as such, legislative measure alone may not necessarily deter medical negligence. There is a need therefore to reform medical negligence strict laws in Uganda.

Thirdly to provide compensations for injuries; The principle of compensation is underlined by reasons of fairness and efficiency which dictates that the party at fault for an injury should bear the associated costs, including lost earnings, medical bills and pain and suffering caused. Health facilities are well placed to bear the costs of injury due to their ability to pool risks and resources through insurance indemnity.

The law should be amended and reformed because the Claim for damages is based on the principle that if a person has committed a civil wrong, he must pay compensation by way of damages to the person wronged. More specifically, the assessment process is said to aim firstly at restitution, punitive and deterrent respectively. Thus the law on medical negligence should be reformed and provide adequate compensation.

Fourthly to foster patient safety and quality services; Specific medical negligence legislation should ensure that medical professional take the necessary precautions to provide safety and quality services for the patients. Medical litigation should also reveal that malpractice suits have contributed to improving clinical practice, as the health workers become more attentive to the quality of care offered; this will improve the quality of healthcare by making the providers more careful.

Therefore, having a law in Uganda which will separate meritorious from unpromising medical negligence claims, where the courts of law step in to provide compensation and deterrence in cases in which self - regulation has failed to prevent a breach of accepted standards of care and a liability coverage to ensure that healthcare providers are not bankrupted by a single large pay - out and thus resources will be available to compensate patients/victims is merited.

Further in terms of implementing the law, there are opportunities for improved interaction across institutions, such as: strengthening interaction between health and education services and stimulating shared mandates, such as in promotion of Primary Health Care;

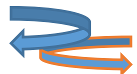
- strengthening coordination between central and local government and other institutions, including private sector and non - governmental entities working in health;
- strengthening the capacity of regulatory agencies and professional regulatory bodies established under the law in terms of their operations, technical knowledge and expertise, reporting and accountability, infrastructure and equipment, financial resources, number and skills of staff;
- Providing public information on existing policies and laws and strengthening access to courts by vulnerable groups by creating more awareness of the existence of the rights and the available avenues for redress in case of breach; and legal training in public health to increase competencies in the courts to manage public health cases.

Relevant Case law

Hellen Kimosho v Wakapita and 2 others HCCS No. 385 0f 2014[2018 UG HCCD 71], the plaintiff sued case medical center in tort of professional negligence the defendant negligently dispersed medical advice to the plaintiff but subsequently put her life and of her unborn child at risk. On suing they prayed for general damages and they were awarded.

Kabito v AG CS 26 of 2012 [2019 UG HCCD 197], where the defendant founded in action in negligence. Proper medical attention was not given to the deceased and he bled and died while in labour. Failure by defendant workers to provide life saving blood and equipments leaving the deceased to bleed without rescue resulted into her death. The plaintiff sued and they were awarded special damages, general damages and costs.The purpose is that medical negligence legislation would promote professionalism within the medical profession which would in turn improve medical standards, patient to-doctor relationship and health service delivery system thus meeting the patients expectations with the medical expectations in Uganda.

In addition to the existing legal framework, the government of Uganda has put in place national strategies to guide policies and legislation formations on health care to include National



Development Plan (NDP),[629] from which the Second National Health Policy (NHP II) [630] was informed. The process of reviewing policies and legislation has been slow due to inadequate and limited financial and human resources allocated towards these processes.[631] Structures mandated to enforce the health regulatory framework such as the Health Professional Councils and the National Drug Authority have limited capacity leaving enforcement of both legislation and policies at a cross road of serious challenge and thus contributing to major gaps that lead to medical negligence.

This study intends to identify and establish the lacuna in the existing legislative and non-legislative framework that contributes to medical negligence with a view of formulating proposals and recommendations to address and reduce them.

International And Regional Instruments.

In addition to national legislation and policies, Uganda has ratified a number of international and regional treaties and declarations addressing issues relating to human rights to which the right to health care is imbedded. These include the International Covenant on Economic, Social and Cultural Right[632]; The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW); The Convention on the Rights of the Child (CRC)[633]; The Convention on the Rights of Person with Disability (CRPD)[634]; African Charter on Human and Peoples' Rights

[629] 2010/11-2014/15

[630] The Second National Health Policy, 2010, will provide direction for the Health Sector in the next medium to long term period.

[631] THE SECOND NATIONAL HEALTH POLICY; Promoting People's Health to Enhance Socio-economic Development 2010,

[632] *Article 12(1) of the International Covenant on Economic, Social and Cultural Rights provides for the right to the highest attainable standard of physical and mental health. UN DOC A/6316, 993 UNTS 3, entered into force 3 January 1976 and Uganda is a signatory.* [25] *Article 12 of the Convention provides that state parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.*

[633] *Article 24 (1) of the Convention provides that State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.*

[634] *Article 25 of the Convention provides for the rights of persons with disabilities to health, including access to gender-sensitive health services.*

(ACHPR)[635]; Treaty for the establishment of the East African Community[636]; United Nation Declaration on Human Rights (UNDHR) [637] and the Abuja Declaration.[638]

These covenants and declarations list down the steps to be taken by the state parties to the maximum of available resources and with financial and technical assistance from development partners, with a view of progressively achieving the full realization of the right to health. The ratification of these international conventions and declarations creates an obligation upon Uganda and her development partners to ensure that legal and institutional frameworks are in place to provide healthcare within the minimum standards so as to protect its citizens against any acts that may infringe their enjoyment of the right to health including incidence of medical negligence.

Factors That Determine Medical Negligence.

Cases of medical negligence have become a common occurrence in Uganda causing damages, injury and death.

In ***Centre for Health Human Rights and Development (CEHURD) & 4 Others Vs. Nakaseke District Local Government HCCS No. 111 of 2012***; court noted that the Government of Uganda should be committed to promoting and providing medical care and services at the same time ensuring the protection of patient's safety with regard to health care procedures and facilities. Principally Medical Negligence therefore relates to the failure or deviation from medical professional duty of care or the failure to exercise an accepted standard of care in medical professional skills or knowledge, resulting in injury, damage or loss. Medical negligence is built and premised on this principle of the tort of negligence generally, save that the standards of proof is higher than in other ordinary cases of negligence. Medical negligence occurs where a medical professional (1) owes a duty of care to a patient, (2) that duty of care is

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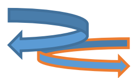
[635] *Article 16 (1) and (2) provides for the right to enjoyment of the best attainable state of physical and mental health and puts an obligation and duty on State parties to the Charter to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick respectively*.

[636] *Article 118 (b) of the Treaty enjoins partner states to cooperate in the area of health, in the management of health systems, drug policies, harmonization of national health policies and exchange of information and promotion of research.*

[637] *Article 25 (1) states that everyone has the right to a standard of living adequate for the health and well-being of himself or herself and of his or her family, including ….and medical care and necessary social services.*

[638] *The Declaration[31] reaffirms the commitment undertaken by the member states to reallocate 15 % of the national revenues toward progressive achievement of access to health care in their respective countries. Adopted from the* 11th *Annual Report of The Uganda Human Rights Commission Report of Parliament the Republic of Uganda Pg. 96*



breached (3) the breach caused injury, damage or death, and (4) that injury, damage or death is as a result of the breach of that duty. The patient has a duty to prove fault on the part of the medical professional throughout the case for a claim in medical negligence.

Duty Of Care.

The relationship between a doctor and a patient is a special one, when a patient is admitted to any health facility; a relationship based on the duty of care principles is created. Duty refers to the standard of behaviour which imposes restrictions on ones' conduct[639]. In the medical professional-patient relationship, a duty is imposed on the medical professional to use the same level of care that any reasonable competent medical professional would use to treat a condition under the same circumstances.[640] Therefore any patient that a medical professional comes across in a professional environment is owed a duty of care.

A patient generally approaches a doctor or health facility with *expectations*; that a doctor or the health facility is expected to provide medical treatment with all the *knowledge and skill* at their command and that they will not do anything to harm the patient in any manner either because of their negligence, carelessness or reckless attitude to either them or their staff. Through a doctor may not be in position to save a patient's life at all times, he is expected to use his special knowledge and skill in the most appropriate manner keeping in mind the interest of the patient who has been entrusted to him.[641]

Therefore once a doctor voluntarily decided to treat a person or come to their aid, he or she becomes liable for any damage, injury or loss that results from any negligence during that assistance. Once the medical professional-patient relationship is established, the doctor owes the patients a duty of care and treatment with that degree of skill, care and diligence as possessed by or expected of a reasonably competent doctor under similar circumstances.

Standard Of Duty Of Care.

The standard of duty of care expected of a reasonably skillful doctor (medical professional) has been discussed in case law going back as far as 1838 where Tindall CJ in the case of **Lanphier V Phipos**[642] states that *"every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of skill and care. He does not undertake, if he is an attorney that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure nor does he undertake to use the highest possible degree of skill. Hence if a person holds*

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[639] Flores Vs. Pineda, G.R. No. 158996, 571SCRA 83, Republic of the Philippines SUPREME COURT, 2008

[640] Cayao-Lasam, 574 SCRA 439, 454, December 18, 2008

[641] Medical Negligence: Coverage of the profession, duties, ethics, case law and enlightened defence: Legal Perspective. M.S.Pandit and Shobla Pandit- Indiana Journal 2009 July-Sep

[642] (1838) 8 C&P 475 AT 478

himself out as possessing special skill and knowledge, by and on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment.[643]*"*

A medical professional is not expected to be a miracle-performer guaranteeing a cure or a man of high skill in his calling. McNair J discussed the standard of duty of care

In the case of **Bolam Vs Friern Management Committee**[644] stating that *"the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possesses the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary man exercising that particular art."* Hence in the case of a medical professional, *negligence means the failure to act in accordance with the standards of reasonably competent medical professional at the time*.

Therefore a doctor can only be held guilty of medical negligence only when he falls short of the standard of reasonable care.[645]

Thus a medical professional having that degree of competence expected of the ordinary skillful medical professional sets the standard. He or she is a practitioner who follows the standard practice of his or her profession or at least follows practices that would not be disapproved of by responsible opinion within the profession.[646]

On the other hand, not every error of judgment made by medical professionals constitutes negligence (see *Sarah Watsemwa Goseltine and another v. Attorney General)*[647] The test of professional negligence is the standard of the ordinary skilled man exercising and professing to have that special skill as visible in ***Maynard v. West Midlands Regional Health Authority***[648]**.**

Breach Of Duty Of Care.

For a breach of duty to occur, it must have been the direct or proximate cause (which is a natural and continuous sequence, unbroken by any intervening event) of the loss, injury or damage. To show deviation from duty of care, one must prove the following; that there was a usual and normal practice, that the medical professional has not adopted that practice, that the medical professional instead adopted a practice that no professional or ordinary skilled person would have taken[649] and as a result, has led to the loss, injury or damage complained about.

In the case of ***Haribhua Khodawa V State of Maharshtra***, the supreme court of India on determining breach of duty in the medical field held that the skill of medical practitioners differs

[643] (1925) 94 LJKB 791 at 794,CCA

[644] (1957) 2 ALL ER 118 at 121

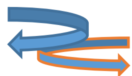
[645] Dr. Subramanyam and Anor Vs. Dr. B.Krishna Rao and Anor II (1996) 233 (NC)

[646] Law and Medical Ethics, Mason &McCall Smith Fourth Edition Butterworths pg.199

[647] H.C.C.S. No. 675 of 2006).

[648] [1985] 1 WLR 685, [1985] 1 All ER 635).

[649] Supra at FN. 44



from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable in treating a patient. The court emphasized that courts would be slow in attributing negligence on part of the doctor if it is proved that he performed his duties to the best of his abilities and with due care and caution.

Nature of Duty Of Care.

In the Indian case of **Dr. Laxman Balkrishnajoshi vs. Dr Trimbark Babu Godbole & Another** [650] court laid down three medical legal principles on duties that govern doctor patient relationships; stating that when a doctor is consulted by a patient, the duty of care includes: duty of care in deciding whether to take the case, a duty of care in deciding what treatment to give, duty of care in the administration of that treatment. The breach of any of these duties may give rise to a cause of action for medical negligence.

However, a medical professional is not negligent if he or she has acted in accordance with the practice accepted as proper by a responsible body of medical men and women skilled in that particular art and neither can he or she be held negligent if he or she is acting in accordance with such a practice merely because there is a body of opinion who would take a contrary view[651].

Doctors and other medical professionals have a duty to their patients, to provide treatment that is in line with the "medical standard of care," defined as the level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would have provided under the circumstances that led to the alleged malpractice. A doctor who professes to exercise a special skill must exercise the ordinary skill of his specialty. The true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care.

It is well settled that medical professionals have a duty to conduct their practice in accordance with the conduct of a prudent and diligent medical professional in the same circumstances. In the case of a specialist, such as a surgeon, the surgeon's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in that field. While conformity with common practice will generally exonerate medical professionals of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be so where the standard practice is fraught with obvious risks such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise.

In ***Freda Kasaira 5 Ors v. Registered Trustees of Nebbi Diocese***[652] it was stated that "for the plaintiffs to succeed in an action of this nature, they must therefore prove that; (a) a doctor-patient relationship existed, (b) the medical professionals were negligent, (c) the medical professionals' negligence caused the death. It would be necessary for the court to be satisfied that the defendants vicariously failed to have or to exercise the knowledge, skill and understanding expected in

[650] AIR 1969 SC 128 and AIR 1989 SC 1570

[651] Bolam Vs. Friern Hospital Management Committee [1957] 1 WLR 582

[652] (2016)

accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances." in that case, the plaintiffs sued he defendants vicariously as administrators of St. Luke Hospital where a parent of the plaintiffs had died following an unsuccessful operation to cure appendicitis. It was also held that; For the defendant's to be found vicariously liable, it must be established that the medical professionals at the hospital failed to have or to exercise the knowledge, skill and understanding expected in accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances.

As in ***Inman v. Binghamton Housing Authority, 1957,*** harmful consequences must be foreseeable by the professional (or, better by a reasonable professional) but also unforeseeable by the injured party in order for the responsibility to be ascribed to the professional.

According to the decision in ***Muwonge v. Attorney General***[653] an act may be done in the course of employment so as to make the master liable even though it is done contrary to the orders of the master, and even if the servant is acting deliberately, wantonly, negligently, or criminally, or for his own behalf, nevertheless if what he did is merely a manner of carrying out what he was employed to carry out, then his master is liable.

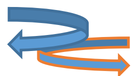
Causation.

Common law has always recognized that there are two fundamental questions involved in the determination of causation in tort: the first relates to the factual aspect of causation, namely, the aspect that is concerned with whether the negligent conduct in question played a part in bringing about the harm, the subject of the claim. The second aspect concerns the appropriate scope of liability for the consequences of tortious conduct. In other words, the ultimate question to be answered when addressing the second aspect is a normative one, namely, whether the defendant ought to be held liable to pay damages for that harm. Causation will be established if, on the balance of probabilities, the harm would not have occurred "but for" the defendant's breach of his or her duty of care.

Causation is the relationship that must be found to exist between the acts of the doctor and the damage, injury or loss to the patient in order to justify a cause of action for negligence and meriting compensation. The breach of the duty of care must have materially contributed to the injury, damage or loss and or it is more likely that the damage, injury or loss was due to the negligence than any other cause.

The patient therefore must prove that the breach of duty on part of the doctor caused the patient to suffer damage injury or loss which he or she otherwise could not have suffered. In other words the patients could not have suffered the damage, injury or loss if the doctor had provided the correct

[653] [1967] EA 17,



standard of care based on the skills of that profession. It will do the patient no good to establish negligence on the part of a doctor unless he is able to prove that the damage, injury or loss he or she has suffered was caused by that negligence.[654]

Courts have consistently reaffirmed that the general test for causation is that, which requires the injured party to show that the damage, injury or loss would not have occurred "but for" the negligence of the doctor. Court in the case of ***McGhee vs National Coal Board***[655] stated that liability will be imposed if it can be established that the negligence of the defendant materially increased the risk of the plaintiff being damaged in the way in question.

To be successful under this test, the plaintiff is required to establish on a balance of probabilities that the defendants act was a necessary cause of his or her damage, injuries or loss and the onus of proof lies on the plaintiff or one who claims to be injured.[656]

However sometimes in the absence of any reasonable explanation for a phenomenon, the principle of *"res ipsa loquitor"* a Latin phrase which means *"the facts speak for itself"*, applies. Such a situation would apply to procedures performed on the wrong limb or side and if damage occurs from that, then causation is assumed to have been established unless the defendant can show that there is another reasonable explanation.

The 'but for' test is generally an important guide in determining causation. The test assumes that there was at the moment of question, a single set of conditions sufficient to cause the harm or injury. The principle is important especially in situations where the injury did not result from one set of events.

In ***Mc Ghee v National Coal Board***, the plaintiff, a worker in a brick kiln contracted industrial dermatitis through exposure to brick dust. Since the risk of dermatitis was part of the job due to exposure to brick dust. However the employers had negligently increased the period of exposure by failing to provide showering facilities at the workplace. It was not clear where he contracted the disease from; whether it was due to his cumulative exposure to the brick dust or as a result of single abrasion caused by the dust.

The House of Lords ruled in favor of the plaintiff on the basis that an increase in the risk of dermatitis could be treated as having made a substantial contribution in the injury.

At common law, if it is an established fact that conduct of a particular kind creates a risk that injury will be caused to another or increases an existing risk that injury will ensue; and if the two parties stand in such a relationship that the one party owes a duty not to conduct himself or herself in that way; and if the first party does conduct himself or herself in that way; and if the other party does suffer injury of the kind to which the risk related; then the first party is taken to have caused the

[654] Ibid page 210
[655] (1972) 3 ALL ER 1008 At 1011
[656] Wilshire Vs. Essex Area Health Authority (1988) 2 WLR 557

injury by his or her breach of duty, even though the existence and extent of the contribution made by the breach cannot be ascertained[657]. The precise and particular character of the injury or the precise sequence of events leading to the injury need not be foreseeable. It is sufficient if the kind or type of injury was foreseeable, even if the extent of the injury was greater than expected.

According to ***R v. Smith***[658] If at the time of death, effects of the original act or omission are still an operating and substantial cause, then the death can properly be said to be the result of the act or omission, albeit that some other cause of death is also operating. Only if it can be said that the original act or omission is merely the setting in which another cause operates, can it be said that the death does not result from the act or omission. In other words, only if the second cause is so overwhelming as to make the original act or omission merely part of the history can it be said that the death does not flow from the act or omission

In ***Fairland V. Glenhaven Funeral Services***[659], the House of Lords confirmed the McGhee case concerning the but for test and held that the but for principle strictly works in cases of scientific or medical nature.

Failure to provide the appropriate medicine/ giving wrong prescription.

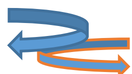
Providing appropriate medicine means giving the right prescription for the disease or disorder the patient is suffering from. In order for patients to heal very well, they need the right medicine prescription. However, in most cases medicines are made inaccessible. The patients end up failing to get the appropriate drugs to cure their diseases either because of scarcity of the drugs on the market or because the doctors have put those drugs in the private hospitals and clinics or pharmacies where they charge exorbitant fees.

The effect is that the patients are given under doze which means giving few medicines than what the patient ought to get. The patients who insist on full dozes are obliged to pay exorbitant fees.

Access to Medicines and Human Rights.

Advances in scientific and technological innovation over the past several decades have changed the current picture of the world's access to medicines. Innovation has motivated the development of new vaccines, reduced the prevalence of infectious diseases (for instance, polio and human papillomavirus), and significantly decreased the global disease burden of HIV/AIDS. The invention of molecularly targeted therapies has even showed early promise for treating cancer, and

[657] (see McGhee v. National Coal Board [1973] 1 WLR 1).
[658] [1959] 2 QB 35; Cheshire v R. [1991] 3 All ER 670 and People v. Lewis 57 Pac 470 (1899) (Cal SC).
[659] (2002) UKHL 22.



the biomedical industry has made strides in strengthening the prevention, treatment, and control of transmissible and non-transmissible diseases. Tuberculosis is illustrative of this progress: Between 1990 and 2013, the tuberculosis mortality rate fell by 45 percent, and the prevalence rate fell by 41 percent.

In **2015**, the international community adopted the Sustainable Development Goals (SDGs), a set of 17 goals to be achieved by 2030. **Goal 3** is committed to "ensure healthy lives and promote well-being for all at all ages"—proposed a range of targets from addressing non-communicable diseases to substance abuse to environmental health. Imbedded in the fulfilment of **Goal 3** was the target to end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and to combat hepatitis, water-borne diseases, and other communicable diseases. **Goal 3** also called for the achievement of universal health coverage, greater investment in research and development of medicines for communicable and non-communicable diseases.

Essential medicines.

Essential medicines are those medicines that satisfy the priority healthcare needs of the population.

According to the **World Health Organization (WHO)**, essential medicines are selected on the basis of their estimated current and future public health relevance, evidence of efficacy and safety, and comparative cost-effectiveness. Medicines that meet these principles are published in the World Health Organization's model list of essential medicines, an inventory updated every two years and tailored to national or regional health needs in a national essential medicines list.

It also should be noted that now more than ever, the high pricing of essential medicines is increasingly understood as a global problem affecting all countries, not just developing ones.

An overview of the international human rights framework on access to medicine.

Access to essential medicines, nested in the right to the highest attainable standard of health, is well founded in international law. **The 1946 Constitution of the World Health Organization and the 1948 Universal Declaration of Human Rights (UDHR)** both expressly recognize the right to health. The **1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR),** elaborates that the right to health includes "access to health facilities, *goods*, and services."

In **General Comment 14 (2000) on the right to health, the Committee on Economic, Social and Cultural Rights (CESCR)** interprets the normative content of **article 12 of the ICESCR.** Although the ICESCR only requires the *progressive* realization of the right to health in the context of limited resources, there is a core set of *minimum obligations* which are not subject to progressive realization, including access to essential medicines. The **World Health Organization, numerous national court cases and resolutions of the Human Rights Council,**

and the Doha Declaration on TRIPS and Public Health reaffirm access to essential medicines as a human right that must be available for all people.

While government of Uganda and its agencies as according to **article 20(2) of the constitution**[660] is obliged to promote, protect and uphold all rights and freedoms including a right to health and in particular holding the core responsibility for provision of essential medicines provision, these responsibilities are shared with other non-state actors. For example, pharmaceutical companies have human rights responsibilities described by the former **United Nations Special Rapporteur on the Right to Health**, including the duty to take all reasonable measures to make new medicines "as available as possible" for those in need.

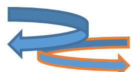
Additionally, the **UN Guiding Principles on Business and Human Rights, which were unanimously endorsed by the United Nations Human Rights Council in 2011**, obliges the private sector to take responsibility for violations of human rights related to access to medicines. The international community also has human rights obligations to assist governments lacking resources to achieve their minimum core duties through international cooperation and assistance. In the face of disaster, the international community bears the duty to contribute to relief and humanitarian assistance by providing medical supplies as a matter of priority.

Human rights-based approach (HRBA) contribute to access to medicines.

A Human Rights Based Approach identifies all human beings as having indivisible, interrelated rights, and in this case, to health and to access essential medicines. In addition to duties and entitlements, and as articulated by the World Health Organization and Convention on Economic Social Cultural Rights, a Human Rights Based Approach applies the principles of non-discrimination and equality; participation and inclusion; accountability; and the rule of law to universal access policies. These principles are conceived to inform all stages of programming and advocacy work, including monitoring and evaluation. A Human Rights Based Approach to access to medicines draws special attention to marginalized, disadvantaged, and excluded populations and endows all populations with the ability to achieve outcomes through an inclusive, transparent, and responsive process.

A human rights-based approach can also be applied to improve access to medicines at the policy level. The right to health offers a framework from which national health policies and laws can be shaped for universal and equitable access. The result can manifest as positive health outcomes and the individual realization of health rights and access to medicines. For instance, domestic constitutions that recognize access to medicines as part of the right to health can support individual claims for essential medicines in national courts.

[660] 1995 as amended.



For individuals and communities living in relative poverty, recasting their lack of access to health care and essential medicines not as a failure of government policy, but as a denial of their rights, is tremendously empowering. When the needs essential to a life lived in dignity are elevated to the rank of legal entitlements, they have the power to change political discourse and the horizon of social expectations. Reframing health as a human right is not simply to appear in court; it is to expand the bounds of what is possible, to mobilize neglected communities, to raise public awareness and trigger activism and education.

Importantly, application of the human rights framework also provides a clear delineation of the spheres of responsibility of different stakeholder, as circumscribed by human rights treaties, guiding principles, and general comments. States are obliged under international human rights law to respect, protect, and fulfill the right to health, which includes an obligation to adopt legislative, administrative, and budgetary measures to facilitate access to medicines that are affordable, accessible, culturally acceptable, and of good quality. This obligation for a state to "use all available resources at its disposal to satisfy its obligations with respect to health will often require a state to make full use of the public health flexibilities available under international law.

Meanwhile, pharmaceutical companies bear a responsibility to respect human rights vis-à-vis the Ruggie trinity of *protect*, *respect,* and *remedy*. Within this framework, corporations have a duty to avoid causing or contributing to adverse human rights impacts through their own activities, and address such impacts when they occur; and prevent or mitigate adverse human rights impacts that are directly linked to their operations, products, or services by their business relationships, even if they have not contributed to those impacts. Essentially, pharmaceutical firms bear a responsibility to act with due diligence to avoid infringing on the right to health. These responsibilities come into stark relief when pharmaceutical firms prioritize the enforcement of their intellectual property rights at the expense of their right-to-health obligations.

Human rights elements for access to medicines.

According to **General Comment 14,** realizing the right to access medicines is contingent upon the realization of four interrelated elements. Medicines must be available, accessible (with accessibility implying affordability, physical accessibility, and accessibility of information), (3) acceptable, and of good quality.In complement to the "AAAQ" framework described above, WHO has outlined the following four key building blocks as essential toward ensuring access to medicines in national health systems.

-Rational selection and use of essential medicines, based on national lists of essential medicines and treatment guidelines;

-Affordable prices for governments, health care providers and individuals;

-Fair and sustainable financing of essential medicines as part of the national health care system through adequate funding levels and equitable prepayments systems, to ensure that the poor are not disproportionately affected by medicine prices; and

-Reliable health and supply systems to ensure sufficient and a locally appropriate combination of public and private service providers.

Article 2 (1) of the ICESCR also calls for the "progressive realization" of economic and social rights. In other words, the ICESCR recognizes that some states are burdened by resource constraints, and therefore, allows obligations to be realized over time. Therefore, in theory, a lack of resources can justify non-compliance. However, as it was just mentioned and as the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights have elaborated, the progressive realization of rights also suggests that states, regardless of their level of economic development, are obligated to take measures immediately and "move as expeditiously as possible" towards the realization of those rights. Within the context of medicines, states must create and implement a reasonable action program to continuously improve access to essential medicines.

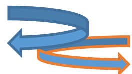
Regional instruments and documents agreed upon by the health community also clearly recognize the right to health. **Article 16 of the African Charter on Human and Peoples' Rights article 11 European Social Charter, article 10 of the Protocol of San Salvador**, the World Health Organization Constitution, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalized World all consider health a fundamental human right. These agreements can support access to medicines claims in domestic courts. In addition, the **1978 Declaration of Alma-Ata** establishes a clear and important link between the provision of primary health care and the provision of essential drugs.

Human Rights-based interventions and practices with regard to access to medicines.

Operationalizing a human rights framework is an essential approach toward advancing access to medicines. This multi-pronged approach should involve participation and coordination between governments, philanthropic organizations, international entities, civil society groups, and the private sector.

To start, programmatic reforms to increase access must be incorporated in national policies and programs, with special consideration for populations that routinely face access barriers, such as incarcerated persons, women, children, and those affected by diseases that can only be treated with high priced medicines.

Equally, the prioritization of access to essential medicines must be reflected in new rights-based laws and licensing the products of medical research. In addition, states, especially in the Global South, should fully utilize the public health flexibilities available under TRIPS to address their country's specific domestic health needs. A number of other mechanisms are available to help make medicines more affordable. Some of these methods include promoting generic competition, local production, and voluntary licensing by innovator to generic companies. Pharmaceutical



companies should respect the right of states to use TRIPS flexibilities and refrain from pursuing stronger intellectual property protection than that is required by TRIPS.

Initiatives to increase access to medicines must also bear in mind the principle of transparency, so that accountability frameworks can hold all stakeholders to account and better address the misalignment between the right to health, trade, intellectual property, and public health objectives.

A human rights approach must also be supported by robust international assistance and cooperation, especially where public health objectives cannot be fulfilled immediately by the state. As part of the tripartite classification of obligations for all human rights, experts increasingly contend that the duty to fulfill rights suggests that developed countries have positive duties beyond borders.

Official and Non-Governmental Initiatives and International Assistance

The right to health obliges states to advance access to medicines through international assistance and cooperation. To help meet these commitments, the Global Fund to Fight AIDS, Tuberculosis and Malaria, an independent, multilateral financing entity, was conceived in 2002. The Global Fund directs resources to countries to support their response to HIV/AIDS, tuberculosis, and malaria and is the largest multilateral funder program that provides access to treatments those diseases. UNITAID, an international drug purchasing financing facility, has been another pioneering initiative.

Discrimination as an underlying professional malpractice.

Access to medicines remains an illusory goal for traditionally marginalized groups. However, non-discrimination and equality – two of the most fundamental principles under human rights law – is central to the right to health. Under the ICESCR, access to medicines should be realized without distinction on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, disability, birth or other status. The International Convention on the Elimination of All Forms of Racial Discrimination also emphasizes that states must prohibit and eliminate racial discrimination in the enjoyment of public health and medical care. Failure to comply with these standards amounts to a violation of international law.

In relation to Covid-19 situation, there have been reported cases of clinicians discriminating against patients with liked symptoms to Covid-19 for fear of the likelihood of being quarantined for the 14 mandatory days through contact tracing or may be the risk of infection with SARS-CoV-2. This has been reported about in one of the daily newspapers in Uganda where a one Ms. Natalie Asiimwe and her 72-year-old father Ambrose who has a pneumonia health record were turned away by two private hospitals in Kampala on basis that the patient had to first present COVID-19 results This has further set a very dangerous trend in the already weakened health systems in Uganda and service delivery owing to the situation that the Ministry of Health in Uganda has designated treatment centers and has put in place strict adherence rules to all private hospitals not

to treat patients with COVID-19 likely symptoms thus portraying the ineffectiveness of the current laws in regards to Public Health.

However, non-discrimination and equality do not always imply equal treatment. In some cases, states must assume positive obligations to prioritize underrepresented individuals.

Instituting a cause of Action for medical malpractice.

In malpractice litigation, the plaintiff can sue the medical personnel individually or under the principle of vicarious liability. An individual medical practitioner may be sued to obtain relief for his malpractice instead of the hospital.

A part time medical personnel is also sued individually for medical malpractice because he is under a contract for services and not a contract of services. A contract of services and contract for services is defined under **section 2 of the Employment Act[661].** A contract of services is where an employee enters into a contractual relationship with an employee for performance of work at an agreed remuneration. A contract for services is where an independent contractor enters into a contract to perform some activities using his expertise, tools and skills.

Vicarious liability is the liability that falls on another person. Vicarious liability attributes the actions of a worker – doctor to the hospital where he is employed. Since the aim of litigation is to obtain compensation, patients may be reluctant to sue an individual doctor but rather sue the entire hospital to obtain damages.

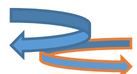
In ***Cassidy V Ministry of Health***[662], the plaintiff underwent an operation in the hospital which was performed by the full time medical personnel. However after the operation, the patients hand and forearm got bandaged for two weeks. The patient was simply given sedatives. When the bandages were removed, the hand became stiff and useless making him unable to work. The plaintiff sought damages.

Lord Denning, held that when hospital authorities undertake to treat a patient and select professionals to do that work, they are responsible for the negligent acts and omissions done by those people.

For the concept of vicarious liability to apply, there must be a relationship between the employer and employee. The medical personnel's negligence must have committed an injury, or harm to the patient in the course of his employment in the hospital. According to the case of ***Sheik Kateregga and another V UEB, (1995) 111 KALR 143,*** the burden of proving that the employee – the health practitioner was acting in the course of his employment lies on the plaintiff.

[661] Section 2 of the Employment Act

[662] Cassindy V ministry of Health (1951)I ALLER 574



Institutional framework for enforcing medical malpractice.

The role of courts.

There has been limited legal study to verify the efforts mad e to constitutionally implement the medical professional malpractice, which is the focus of this section. It is important to go beyond the foregoing collection of provisions in order to access how they translate themselves into actions closer to the daily lives of Ugandans. Each provision is applied and interpreted differently by the politicians, judiciary and population, which will each be considered below.

Article 129 of the Ugandan Constitution establishes the hierarchy of Ugandan courts. The Supreme Court is the highest and final appellate court, implying that its decision is final. Subordinate to the Supreme Court is the Court of Appeal and the Constitutional Court. The former handles appeals and the latter determines matters of constitutional interpretation in virtue of **Article 137 of the Constitution**. Subordinate to both these courts is the High Court where cases are heard by High Court Judges. It is divided in several divisions, including the Commercial division, the Land division and Anti-Corruption division. Some cases regarding crimes are qualified as capital offences (e.g., murder, rape, aggravated defilement) are heard before the High Court without going through a trial at the subordinate court, the Chief Magistrates Court, whose mandate does not cover such offences (Article 139 of the Constitution) (Republic of Uganda, 1995.

Claim medical Professional Malpractice Rights Before Domestic or Regional Courts.

The courts can also play a role in promoting health rights, including addressing the affordability and accessibility of medicines. This intervention in particular shows, in very practical terms, how human rights can be used as a tool to force the government to act.

The claims of individuals or groups have been particularly efficacious when access to medicines is linked to a country's constitutional right to health or human rights treaties (including the right to health) ratified by the government. Human rights are conceived as tools that allow people to live lives of dignity, to be free and equal citizens, to exercise meaningful choices, and to pursue their life plans.

A human rights-based approach (HRBA) is a conceptual framework that can be applied to advocacy, litigation, and programming and is explicitly shaped by international human rights law. This approach can be integrated into a broad range of program areas, including health, education, law, governance, employment, and social and economic security. While there is no one definition or model of a HRBA, the United Nations has articulated several common principles to guide the mainstreaming of human rights into program and advocacy work:

- The integration of human rights law and principles should be visible in all work, and the aim of all programs and activities should be to contribute directly to the realization of one or more human rights.
- Human rights principles include: "universality and inalienability; indivisibility; interdependence and interrelatedness; non-discrimination and equality; participation and inclusion; accountability and the rule of law."[175] They should inform all stages of programming and advocacy work, including assessment, design and planning, implementation, monitoring and evaluation.
- Human rights principles should also be embodied in the processes of work to strengthen rights-related outcomes. Participation and transparency should be incorporated at all stages and all actors must be accountable for their participation.

A Human rights based approach specifically calls for human rights to guide relationships between rights-holders (individuals and groups with rights) and the duty-bearers (actors with an obligation to fulfill those rights, such as States). With respect to programming, this requires assessment and analysis in order to identify the human rights claims of rights-holders and the corresponding human rights obligations of duty-bearers as well as the immediate, underlying, and structural causes of the non-realization of rights.

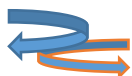
A Human rights based approach is intended to strengthen the capacities of rights-holders to claims their entitlements and to enable duty-bearers to meet their obligations, as defined by international human rights law. A Human Rights Based Approach also draws attention to marginalized, disadvantaged and excluded populations, ensuring that they are considered both rights-holders and

The Government of Uganda is committed to promoting and providing medical care and services[663] at the same time ensuring the protection of patient's safety with regard to health care procedures and facilities. Uganda has taken a number of steps towards the fulfilment of this commitment including the ratification of international treaties, conventions and declarations; and the establishment of legal and institutional frameworks that govern and protect peoples' rights to health.

The Uganda's health care system, aims at achieving and sustaining good health and health services for its growing population. The health care system has been evolving over the past 3 to 4 decades to handle emerging concerns and challenges within the health sector countrywide. Uganda's health care delivery is predominately through modern and traditional[664] practices. Modern health care delivery is done through a decentralized framework comprising of Health Centre II; III; IV; regional referral hospitals, national referral hospital, faith based health facilities and of late the

[663] HEALTH SECTOR STRATEGIC & INVESTMENT PLAN 2010, Promoting People's Health to Enhance Socio-economic Development 2010/11 – 2014/15

[664] This study will not make reference to traditional medical practitioners since they are not medical professional.



emerging private health facilities. The District health structure is responsible for all government structures in the district with the exception of Regional Referral Hospitals.

Despite the above initiatives, cases involving medical negligence are a frequent occurrence in the health care system of Uganda leading to a number of undesirable consequences such as death, injury and damage. For example, cases like ***Watsemwa & Anor. vs. Attorney General***[665], ***Kayamugule & Anor. Vs. Attorney General & 3 Others***[666], ***Centre for Health Human Rights and Development (CEHURD) & 4 Others vs. Nakaseke District Local Government*** [667] , the media reported case involving the famous Dr. Ssali, the director of the Women's Hospital and Fertility Centre with regards to the death of one ***Mercy Ayiru***[668] and the death of Cecilia Nambozo at Mbale Hospital[14] among others.

a. The Supreme Court.

The Supreme Court has had few opportunities to intervene in the enforcement of health rights and has produced mixed judgments on the topic in the case of **Charles Onyango-Obbo & Another v Attorney General) (Uganda Constitutional Court, 2014)**. When presented with the opportunity to pronounce itself on matters of health, the Supreme Court has often referred to legal and hierarchy issues to send the cases back to the lower courts and refrain from expressing itself clearly on the topic. Therefore, as it will be demonstrated from case law below, the

Supreme Court's contribution has been mostly of a procedural mediator in nature rather than beneficial to the substantive advancement of the right to health.

An important recent addition to the Ugandan jurisprudence on the protection of maternal health and the power of the judiciary from the Supreme Court is ***CEHURD & 3 Others v Attorney General as in Supreme Court Appeal No.1, 2013 out of Constitutional Petition No.16 of 2011 [2012]; UGCC 4, 2012) (Uganda Supreme Court, 2012).*** In this case, families of two women who died during childbirth and CEHURD claimed that the government failed to provide maternal health services in governmental hospitals and health facilities, and thus violated the right to health under Objectives XIV (b) XX, XV and Article 8A of the Ugandan Constitution, the right to life under Article 22, the rights of women under article 33, and the rights of children under Article.

The Constitutional Court dismissed CEHURD's petition on the grounds that it did not raise competent questions that required Constitutional interpretation and that the issues brought up by the petitioners could not be examined due to the Political Question Doctrine. CEHURD appealed the decision, arguing that the Constitutional Court erred in law in applying the Political Question Doctrine; in stating that the questions did not require constitutional interpretation under Article

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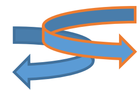
665 Civil Suit No. 675 of 2006

666 Civil Suit No. 285 of 2011

667 HCCS No. 111 of 2012

668 The Daily Monitor Newspaper of June 13th 2013 **14** Sunday Monitor Newspaper of April 23rd 2017



No.137; and in determining that the petition required them to review and implement health policies.

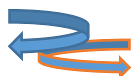
The Supreme Court sent the case back to the Constitutional Court to be heard again with new considerations. The Court held that Article 137(1) vests powers of interpretation of the Constitution in the Constitutional Court, and that Article No.137(3)(b) of the Constitution gives a right to any person who alleges that an act or omission of an authority is inconsistent with the Constitution to file a petition with the Constitutional Court to seek redress. It was thus concluded that the Political Question Doctrine has limited applicability under Uganda's current constitutional order and that the Constitutional Court erred in striking out the appellant's petition on the ground that there were no competent questions. Justice Kisakye explained that the interpretation of the Constitution is essential to public health, and that it is hence in the interest of justice that where an act may be unconstitutional, Article No.137 allow for the entertainment of a petition making such a claim. The Court's decision can be perceived as reticence to intervene on

On the other hand, ***CEHURD & 3 Others v Attorney General*** sets valuable precedent for advocates of the right to health. By holding that the Political Question Doctrine has limited applicability in Uganda, the Supreme Court emphasized that governmental policy, acts, and omissions in the delivery of health care services and other sectors are subject to judicial review to ensure their constitutionality. In doing so, the Court protected access to justice and took a step in recognizing the enforceability of the right to health and other socio-economic rights. This decision is also in line with CEHURD's appeal, which was largely based on the claim that the Constitutional Court's error in dismissing the petition. The case did not allow for the Supreme Court to provide clear substantive material on the maternal health treatment that should be given, but does restore confidence to litigators who had been discouraged by the precedent set by the Constitutional Court.

b. The Court of Appeal and the Constitutional Court.

In contrast to the Supreme Court, both the Court of Appeal and the Constitutional Court have entertained a significant amount of cases on professional malpractice by health personnel, maternal health and the broader right to health.

The right to health has often been undermined due to procedural matters and judicial restrictions, as illustrated by the Supreme Court judgement mentioned in the previous section. The judgment made by the Constitutional Court in the case of ***Ismail Serugo v Kampala City***. Technicalities have been obstacles to the enforcement of the right to health in several recent cases, including in the case of ***Joyce Nakacwa v A.G (Constitutional Petition No.2 of 2001)*** decided by the Constitutional Court of Kampala (Uganda Constitutional Court, 2001). Nakacwa delivered a baby girl on a roadside and proceeded to the Naguru Kampala City Council Clinic with the baby still attached to her. At the clinic, Nakacwa was referred to Mulago Hospital without a proof of referral and was forced to walk outside and sit outside with her baby while being dizzy from losing blood. She was later accused of stealing the baby and was subjected to a vaginal inspection with polythene



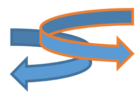
bags. She was arrested and detained for 45 days without a trial and was stopped from breastfeeding. The baby died at Sanyu Babies Home.

In its decision, the Constitutional Court dealt with preliminary objections brought up by the respondents, but did not address the allegations and substantive questions raised by the petition itself. The relevant objection to this discussion is the respondent's claim that the petition was time barred because it was not submitted within thirty days of the petitioner's release from custody. The Court held that each decision about the application of the time limitation rule must be confined to its own peculiar facts. In this case, the petition was not time barred because the 30-day period began after the petitioner learned about her child's death.

In the case of ***Uganda Association of Women Lawyers & 5 Others v Attorney General***, the court goes further in ruling that the thirty days began to run from the day the petitioner perceives the breach of the constitution and that each decision ought to be made in the spirit of the words of Supreme Court Justice Mulenga: "to make the rule workable and encourage, rather than constrain, the culture of constitutionalism" (Constitutional Petition No.2 of 2002) (Uganda Constitutional Court, 2002). . Litigators can thus enforce human rights during a more flexible period of time depending on the special circumstances of the case brought before the court.

In the case of **Law and Advocacy for Women in Uganda (LAWU) v Attorney General, (Constitutional Petition No.8 of 2007)** the Court held that female genital mutilation which is strongly practised among the Sabiny, Sebei and Pokot tribes, violated women's rights enshrined by Article 33 of the Constitution, as well as their right to life and freedom from torture (Uganda Constitutional Court, 2010).

In **CEHURD v Attorney General (Constitutional Petition No.16 of 2011)** the Constitutional Court got a golden opportunity to determine whether the state was obliged to provide basic health care for women (Uganda Constitutional Court, 2012). The facts arose from government's repeated failure to facilitate safe child delivery, and sought constitutional interpretation as to state obligations in fulfilling women's rights. Similar to the legalistic evasion manifested by the Supreme Court above, the Constitutional Court initially refused to determine the case on its merits. Instead it exonerated itself from enabling constitutional implementation on grounds that the issues for determination were political questions outside its mandate, and dismissed the petition. This petition arose out of the state's failure to provide basic health maternal supplies in government health centres and the imprudent and unethical behaviour of health workers toward expectant mothers, which the petitioners claimed was inconsistent with the Constitution. Initially the Constitutional Court held that their role, as stated in Article 137, is to interpret provisions of the Constitution, and tasked the petitioners to prove before court that the constitutional provisions had been violated. The petitioners had not raised the question of constitutional interpretation and despite the notoriety of the challenges of public health services in Uganda, the Constitutional Court was reluctant to hear the petition because of the Political Question Doctrine.



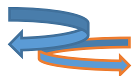
They instead shifted the implementation burden from the judiciary and noted that the Executive has the political and legal responsibility to determine, formulate and implement policies for the good governance of Uganda. They focused on the administrative preserve of the Executive and denied that the court could intervene, holding that if this Court determines the issues in the petition, the judiciary would be substituting executive mandate with its own discretion. As a result, the Constitutional Court dismissed the petition and thereby absconded from its duty to enforce health justice for pregnant women. The case demonstrated the low judicial enthusiasm to creatively enforce the right to health in Uganda, with preference given to claims of jurisdictional and hierarchical limitations of a particular court.

Another illustration of judicial reluctance and bureaucracy as a deterrent to implementation of the right to health by the Constitutional Court is **Uganda Network on Toxic Free Malaria Control Limited v Attorney General (Constitutional Petition No.14 of 2009) (Uganda Constitutional Court, 2009)**. The Court dismissed the petition for being brought by the wrong procedure, because the petition was brought under **Articles 50 and 137 of the Constitution** and was contending that government's action of spraying DDT in Oyam and Apac districts to control malaria was contrary to **Articles 20 and 39 of the constitution**. The Court dismissed the petition because the petition had no component of constitutional interpretation to it. A court sensitive to health justice should have recognized the violation, stayed the action of spraying and referred the matter to an appropriate court for redress. Their failure to recognize the violation on account of wrong procedure hindered the right to health via a clean and healthy environment. According to the Court, the parties should have sued under Article 50 which provides for redress from the high court when the right to health is threatened or contravened.

The High Court.

Article 50 of the Constitution gives the High Court unlimited original jurisdiction over all matters including the enforcement of rights. Indeed, the study found that the High Court compared to its superior courts has significantly succeeded in the advancement of maternal health care. The High Court's position has been clear and not evasive as seen in several of its decisions.

At the minimum, the state is obliged to provide basic medical services as per **Objective XX of the Constitution**. In the criminal case of **Uganda v Kyasimire Florence & Another, (High Court Criminal Session Case 63**, 2013) the accused were jointly charged in two counts of embezzlement of assorted medical items belonging to the Isingiro District Local Government (Uganda High Court, 2013a). The first accused was apprehended as she prepared to leave the Health Centre to go to her home in Mbarara. The second accused on the other hand was found with mattresses belonging to the Local Government and some assortment of drugs. The Court held that prosecution had diligently executed their evidential burden and standard of proof and found the accused guilty of embezzlement because the first accused had taken the items into her home, which was not a treatment room and the quantity of items she had taken were voluminous to dispel any intention of carrying out first aid as she had alleged. This case demonstrates the ability of the High Court to



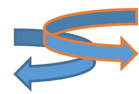
render criminal sanctions against people who intend to steal drugs and other maternal health supplies.

This case is progressive in the realisation of the right to health because it reinforces transparency and accountability by health service providers entrusted with public resources. The Constitution in **Objective XXVI and Article 164 (2**) require that public officers are held accountable in their offices. Transparency and accountability ensure continuous availability of medical supplies and services allocated for a given community. By finding the accused guilty of embezzlement of medical items contrary to the provisions of the Penal Code Act, the court upheld the right to health through ensuring that the availability health services was not curtailed by embezzlement of service providers.

Health Service Commission.

To achieve transparency and accountability in health systems requires regular monitoring. The constitution in Article 189(1) provides for specific duties of government in the sixth schedule, including the duty to establish a **Health Service Commission** that monitors health systems so as to identify the gaps and risks and take remedial actions. In the case of **CISE Dispensers (U) Limited. v. Executive Secretary, National Drug Authority (UGCA 38, 2010; Civil Appeal No.20 of 2009)** the court upheld the need for monitoring as key to promotion of the right to health. In the case, the Executive Secretary, on July 25, 2008, accompanied by the police, entered CISE Limited premises for inspection and impounded some essential and restricted drugs found there and closed the premises as they were not licensed (Uganda Court of Appeal, 2010). The Court of Appeal held that in line with both Sections 8 and 12 of the National Drug Policy and Authority Act, since restricted drugs were found at the appellant's premises, the respondent was rightly impounded them. By this holding, Court stressed the importance of monitoring health facilities and in particular the drugs they supply. In applying Section 12 of the National Drug Policy and Authority Act, the court protected people from harmful drugs and thus upheld and respected the right to health through monitoring.

In the case of **CEHURD & Others v Nakaseke District Local Administration (High Court Civil Suit 111, 2012)** the plaintiffs sued on behalf of a woman who died at the defendant's hospital due to lack of emergency obstetric care. It was alleged by the plaintiffs that the deceased had an obstructed labour condition but did not receive the appropriate medical care and attention due to the absence of a doctor assigned to her. The judge visited the hospital in locus to assess the evidence and held that the deceased's right to basic medical care was violated when the government hospital failed to provide a mother with access to emergency obstetric care. The defendant was also found to have breached **Article 33(3) of the Constitution** because the doctor on duty was absent without explanation to conduct the caesarean operation when needed. As a result of the patient waiting in pain for 8 hours without medical attention, she died due to a ruptured uterus. The state was found to have breached its duty to protect women's rights given their unique status and natural maternal functions in society.



Health workers in the public sector are collectively regulated by the **Health Service Commission which was created under the Health Service Commission Act of 2001 (Republic of Uganda**, 2001). The act recognizes the duty of health workers in relation to rights of patients by phrasing them as responsibilities. The Act recognizes the duty of health workers to act in the best interest of patients at all times, to ensure informed consent, respect the privacy and confidentiality of a patient, avoid conduct detrimental to the community and abide by all laws and regulations governing their professions. However, the law is silent on the rights of health workers as well as the Patients' Right Charter, though the Charter clearly specifies the rights of patients including the right to emergency medical care, the freedom from discrimination, the right to a clean and healthy environment, the right to participate in decision-making and the right to medical information among others. Unfortunately, the provisions of the Patients Charter are limited in effect because they do not have binding force of the law and can only be applied at the health worker's discretion.

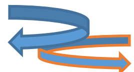
The Pharmaceutical Society of Uganda.

The Pharmaceutical Society of Uganda is established by **section 6(1) of Pharmacy and Drugs Act [669].** The body is a body corporate with capacity to sue or be sued in its corporate name.

According to section 7(1) of the Pharmacy and Drug Act, to be a member of the Pharmaceutical Society, the person must have passed the exams and completed relevant training. He can either be a degree, diploma or other qualification as approved by the council, 21 years of age and must pay a prescribed fee.

It is important to note that as a health official, pharmacists owe a duty to the patients. They should be concerned about the health, care and safety of patients. Concerning the case law, Uganda has not yet developed case law on the Pharmacists however cases of other countries are important to this effect.

[669] Pharmacy and Drugs Act Cap 280 laws of Uganda.



5.8 THE HIPPOCRATIC OATH

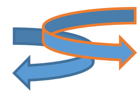
There is a tradition in some medical schools that requires taking the Hippocratic Oath usually at graduation. For matters as these, it is sufficient to examine what that oath has been, what forms it currently has, and the implications for physicians in today's healthcare environment. The changes in health economics affect physicians as they try to follow the oath's allegiance to the individual patient's needs. As medical students later on enter the real business world, there is a tendency to deviate from the Oath's allegiance in a direction towards making more business profit. Social attitudes and temporal moments also may interrupt the service delivery process in contravention of the Oath. At times, the oath's goals may conflict with the perspective of the financial world's controls of insurance companies and medical groups and institutions. This difference of the physicians' ethical perspectives from the business leaders regarding the philosophy of the value of the individual's health and life may be related to some aspect of physician burnout.

The oath is a very ancient document offering regulations for the practice of ancient medical practitioners. Its origin can be traced with the early Greek Philosophers and even though it invokes Greek gods and goddesses[670], addresses male doctors and forbids abortion and assisted suicide, it remains relevant up to now and sets standards for today's physicians. As of today, the oath is about 2,400 years old.

Ancient Greek schools of medicine were split into two, the Knidian and Koan on how to deal with disease. The Knidian school of medicine focused on diagnosis [671] while the Hippocratic school or Koan school achieved greater success by applying general diagnoses and passive treatments. Its focus was on patient care and prognosis, not diagnosis. It could effectively treat diseases and allowed for a great development in clinical practice.[672]

[671]Adams 1891, p. 15

[672]See Hippocrates From Wikipedia, the free encyclopedia posted and edited on 10th February 2018, at 12:57pm https://en.wikipedia.org/wiki/Hippocrates



Hippocrates believed that diseases were caused naturally, not because of superstition and gods. He was quoted

'*On the Sacred Disease'*to have said that***,"…It is thus with regard to the disease called Sacred: it appears to me to be no wise more divine nor more sacred that other diseases, but has a natural cause from the originates like other affections. Men regard its nature and causes as divine from ignorance and wonder…"***[673]

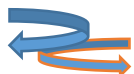
Medical practitioners always swore the oaths thus;

"*I swear by Apollo the Healer, by Aesculapius, by Health and all the powers of healing and to call witness all the gods and goddesses that I may keep this Oath and promise to the best of my ability and judgment …I will hand on precepts, lectures and all other learning to my sons, … I will use my power to help the sick to the best of my ability and judgment. I will abstain from harming or wrong doing any man by it… neither will I give a woman means to provide an abortion … I will go to help the sick and never with the intention of doing harm or injury… I will I will not abuse my position to indulge in sexual contacts with the bodies of women or of men whether they be freemen or slaves. Whatever I see or hear, whether professionally or privately which ought not to be divulged I will keep it secret and tell no one …"*

The original version of the Hippocratic Oath is a text written in all likelihood by a follower or a learned scribe, apparently from Pythagoras' school. Ever since it was composed, students of medicine have sworn to some version of it, freely re-fashioned over the centuries to fit the convictions of the time, ranging from pale, legalistic texts to Maimonides' prayer, a Jewish text composed in Spanish Cordoba in the twelfth century—arguably the most poetic one.

The key controversial aspects of Hippocrates' Oath have been its explicit injunctions against euthanasia, abortion, and surgery, all of which have been cautiously reworked in later versions of the text. It bears remembering that his words against administering a deadly medicine to a patient, "even if asked in extreme pain," have to be read in the context of the often fatal effects of ancient sedatives and anesthetics; that abortion was performed almost exclusively on adulteresses and prostitutes and thus imposed upon women by men; and that surgery was not yet integrated into the physician's craft, a practice performed at great risk to the patient by barbers and leather-workers. A mix of stern civic ethics and inspired humanitarianism, Hippocrates' text has endured to this day, not just by virtue of its literary merits, but because it is the first definition of the medical profession, a covenant for teachers, colleagues, and students of the healing arts. That is why the document has been rewritten and read out loud for centuries and why it is revisited now.

[673]See Hippocrates From Wikipedia, the free encyclopedia posted and edited on 10th February 2018, at 12:57pm https://en.wikipedia.org/wiki/Hippocrates



Hippocratic Oath has caused heated arguments and opinions by medical experts making Commentaries concerning the legality of Abortion and Euthanasia as shall be discussed later.

The Hippocratic Oath provides guiding principles that can regulate medical practitioners in their delivery of services to their clients. Written by Hippocrates, the oath is one of the oldest binding documents in history and is still held sacred by the medics. It provides for certain guidelines which in summary include; to treat the sick to the best of one's ability, to preserve a patients' privacy, to teach the secrets of medicine to the next generation and so on. Due to medical paternalism, the base of the Hippocratic Oath was replaced by the patient's rights, invoking the moral and legal autonomy of them forcing the physician to consider as prima facie duties, in addition to the autonomy duty, the beneficence and non-maleficenceones and due to the changes in modern medicine and law, there has thus been changes as the Oath in Uganda today is taken as follows.[674]

"I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.
I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death . If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
I will prevent disease whenever I can, for prevention is preferable to cure.
I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

[674]Romankow J. Hippocrates and Schweitzer's text book "comparison of their concepts of medical ethics. "Arch HistFiloz Med 1999;62:245-50.

> ***If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help."***[675]

However; circumstances have changed and we very well know the impossibility of uprooting a tree from England, planting it on Ugandan soil while expecting the same to germinate normally. Thence, so many changes have occurred which render strict performance of the over 2400 years old Oath unattainable. Accordingly, there is need to reform the law today regarding to the Hippocratic Oath.

There is need to change the law as it is today with regards to the Hippocratic oath for example there is still lack of clarity on the abortion legislation as the law on abortion is still confusing and ambiguous. Abortion is not entertained and advocated for under the Oath nor in the Constitution of Uganda, for it states that," **No person has the right to terminate the life of an unborn child except as may be authorized by law"**[676] with out there in elaborating what the law is and despite extended legal abortion to cases such as incest or rape or if the mother suffers from HIV or cervical cancer it is unclear as to whether or not these policies overrule or coincide with the Constitution. On the other hand ,the abortion rates are high in the country were according to the Health, Human Rights and Development, a Kampala based research and advocacy organization, each day 840 girls and women have unsafe, unlawful abortions in Uganda, and on average five die as a result.

Under the principle of confidentiality, the oath did not cater for series of deadly diseases like Ebola, were outbreak of such a disease requires national alarm leading to a break in the oath as medical practioners swear that they will respect the privacy of their patients, for their problems not to be known to the world. There is need to change the law with regards to confidentiality in such cases because such serious deadly diseases create a state of emergency in the nation.

Review

Hippocrates wrote the Oath for Physicians about 2,500 years ago, and numerous translations and variations have emerged for medical students to take, usually at graduation time. The actual date is between 600 before Christ (BC) and 100 anno Domini (AD), although frequently 450 BC is cited. In truth, there were many individuals involved in the creation of the Oath attributed to Hippocrates. That era of Western medicine had great changes so that an oath appeared necessary to protect the patients in those ancient times. The thrust of the Hippocratic Oath included not only

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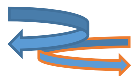
[675] Association of Physicians of Uganda (APU)dated 15th April 2015 http://www.ugphysicians.org/content/hippocratic-oath

[676] Article 22 of the Constitution of the Republic of Uganda(1995) As Amended.



the physician's competence and dedication but also the critical needs of each patient.[677] The goal to protect the health of the patients continued, and the Declaration of Geneva was accepted by the World Medical Association (WMA) at the General Assembly of 1948.[678] Numerous publications have called for amending the Oath since that time: many demands for changes increased after the Medical Device Amendments was signed into law in 1976 [679]. Most recently, on October 13, 2017, the WMA adopted a revised version of the substance to the Hippocratic Oath.[680]

The people who took the Oath in ancient Greece did so to try to serve the best interests of the patients. This goal made medicine a profession rather than a trade. The tradesmen were "physicians" but with the goal of treating the rich and looking out for themselves. To counteract this problem, the Hippocratic Oath was given at the beginning of training rather than after the completion of studies and training—the latter timing in most of our medical schools of today. In fact, the concept of the Oath and serving the best interests of the patient define our standards today or, at least, what physicians still try to achieve for their patients. Modern challenges demand that physicians deal more and more with insurance companies and corporate medicine. As financial entities increasingly try to control physicians, the practice of medicine may become less and less of a profession able to achieve ideal goals for the individual patients. Medicine, as a noble profession, faces the conflicting forces of health economics on a daily basis and even with varying forms of "economic credentialing."

At the same time as health care becomes more controlled and more infiltrated by businesses, the physician has been demoted to a "provider." And the definition of the doctor as a learned individual has become blurred with the other less extensively trained individuals in health care. More and more people talk of health care less as a noble profession and more as a business. At the same time as corporate influences in health care are increasing, there have been serious issues with transparency in the business world. Because of so many problems with the financial industries, Harvard Business School and some others have even developed a short oath. The latter encourages but does not require students to "take the Master of Business Administration (MBA) Oath"[681]. Many are deeply concerned that business school students and future leaders are losing the ability to empathize with people and need to focus on honesty and integrity. This lack of empathy

[677] Greek Medicine. "I swear by Apollo Physician … "Greek medicine from the Gods to Galen. (2012) accessed on 26th Nov 2021

[678] Professional Oaths: History, Usage, Content and Changes . (2009). Accessed: Dec. 26, 2021: http://www.cmda.org/resources/publication/tcd-spring-2009-professional-oaths.

[679] The Hippocratic oath hasn't yet been ammeded. (1977) accessed Dec. 26, 2021 at https://www.cmda.org/resources/publication/tcd-spring-2009-professional-oaths

[680] Parsa-Parsi RW: The revised Declaration of Geneva: a modern-day physician's pledge . J Am Med Assoc. 2017, 318:1971-1972. 10.1001/jama.2017.16230

[681] Anderson m, Eschar P: The MBA Oath: Setting Higher standard for business leaders Penguin Group, new York , NY; 2010

contributed to the Madoff Scandal, the Financial Crisis, and other financial headlines with the victims of these schemes being ruined. Although the business school oath might suggest that those students are worthy of trust, it is not taken by many students. It remains unclear what the consequence would be of a violation. Interestingly, in 2015, an article questioned: "Is the MBA oath still relevant?"[682]. The article depicts the "model of economic man rational and self-interested."

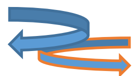
In medicine, the Hippocratic Oath for physicians was written specifically to prevent self-interested doctors from harming individual patients in ancient times. To better serve the present day needs and current ethics of physicians, a more inclusive pledge was written and adopted in October 2017. One key addition is *"I Will Respect* the autonomy and dignity of my patient" Also, *"I Will PRACTICE* my profession with conscience and dignity" was increased to "and in accordance with good medical practice" [6]. These phrases offer an effort to address ethical principles that have been more fully included in two documents:

1) WMA's Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects[683] *and*

2) The Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks[684]*. Ultimately, the physician is dedicating his or her life and actions to the needs of the individual patient, as well as to humanity.*

As the efforts continued to study the exact changes for the Oath of Physicians, a growing concern was the "burnout" of the medical profession. In this era, physicians' professional conduct emphasizes ethical standing and knowledge at the same time as society appears to value popularity in social media and poles about opinions. This difference in perspective of true quality based on study, training, and experience versus perceived value based on advertising and other business entities has resulted in confusion and stress for many physicians. There is even a worry that the Oath itself, i.e., that mindset of self-sacrifice, is contributing to the burnout. Currently, the updated version of the 2017 Revised Declaration of Geneva[685] contains the words: "I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard." There was an interesting study to try to answer the question: "Does the Hippocratic Oath promote

[682] Is the MBA Oath still relevant? (2015) accessed December 26, 2021) at https://www.ft.com/content /e853f5a2-fe41-11e4-8efb-00144feabdc0
[683] WMA declaration on Tapei on etheical considerations regarding health databases and biobanks (2016) accessed Dec, 19, 2021. At https://www.wma.net/policies
[684] World Medical Association: World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. J Am Med Assoc. 2013, 310:2191-2194. 10.1001/jama.2013.281053
[685] WMA statement on physicians well being. (2017). Accessed on Dec. 26th 2021 at https://www.wma.net/policies-post/wma-statement-on-physicians-well-being



burnout?" This was published on March 28, 2017 by Medscape Business of Medicine[686]. The findings were that the 2,600 physicians studied were mixed in their feelings about the danger of burnout by putting patients first as required by their oath: 20% were unsure, 34% said it did, and 45% said it did not. Many felt the intrusion of corporate medicine, not their physician's oath, was the culprit for burnout.

There remains a huge divide in the philosophy of a business enterprise, rational to the point of little to no empathy and self-serving, and with a large investment in advertising strategies, versus that of physicians who deal with individual patient care and life and death matters. An additional problem lies in the different perspectives among doctors themselves when dealing with business organizations. This can lead to conflicts and decreased respect between colleagues of different viewpoints, i.e., some physicians agree more with the financial models than others. By the name change itself from an Oath to a Physician's Pledge, perhaps there will be a difference in stress. At the same time, a pledge does not have the power in the word as does an oath. The latter word emphasizes that some principles in the care of the patient remain sacred.

In 1998, the Medical and Dental Practitioners Act[687] was established in to monitor and exercise general supervision and control over and maintenance of professional medical and dental educational.

Section 47 provided for offences and penalties where it thus tastes that;
Any person who—

1. *wilfully and falsely uses any name or title implying a qualification to practice medicine, surgery, dentistry;*
2. *not being registered or authorised under this Act practices whether openly or impliedly as a medical or dental practitioner;*
3. *wilfully procures or attempts to procure himself or herself to be registered under this Act by false or fraudulent representation either verbally or in writing;*

a) *having been summoned by the council fails—(i) to attend as a witness(ii) to produce any books or documents which he or she is*
b) *required to produce without reasonable cause;*
c) *refuses, without lawful excuse, to answer any question put to him or her in the course of the proceedings of the council; or*
d) *(f) contravenes any other provision of this Act,*
e) *Commits an offence and is liable on conviction to a fine of not less than three hundred thousand shillings and not more than three million shillings or to imprisonment for not less than three months and not more than one year or to both.*

[686] Does the Hippocratic Oath burnout? (2017) accessed on Dec. 26th 2021 at https://www.medscape.com/viewarticle/875993
[687] CAP 274

In 2002, the medical and Dental Practitioners council published The Code of Medical ethics. The code is a legal document which is derived from S. 34 of the Medical and Dental Practitioners act[688], Laws of Uganda and its implementation has a full legal force.

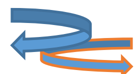
This code of professional ethics is intended to be used as a guide to promote and maintain the highest standards of ethical behavior by practitioners in Uganda. In order to maintain public confidence in the professional standards of practitioners, it is essential that high ethical standards be exhibited in carrying out their duties all principles embedded in the Hippocratic Oath.

Further, It should be observed that The **Declaration of Geneva**(Physician's Oath) as adopted by the General Assembly of the World Medical Association at Geneva in 1948, amended in 1968, 1983, 1994, editorially revised in 2005 and 2006 and amended in 2017[689]is seen revising the Hippocratic Oath to a formulation of the oath's moral truths to be comprehended and acknowledged in a modern way. It reads as follows:

- I solemnly pledge to dedicate my life to the service of humanity;
- The health and well-being of my patient will be my first consideration;
- I will respect the autonomy and dignity of my patient;
- I will maintain the utmost respect for human life;
- I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
- I will respect the secrets that are confided in me, even after the patient has died;
- I will practice my profession with conscience and dignity and in accordance with good medical practice;
- I will foster the honor and noble traditions of the medical profession;
- I will give to my teachers, colleagues, and students the respect and gratitude that is their due;
- I will share my medical knowledge for the benefit of the patient and the advancement of healthcare;
- I will attend to my own health, well-being, and abilities in order to provide care of the highest standard;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
- I make these promises solemnly, freely and upon my honor.

Where the original oath read "My colleagues will be my brothers," later changed to "sisters and brothers." Age, disability, gender, and sexual orientation have been added as factors that must not

[688] CAP 274
[689]https://en.wikipedia.org/wiki/Declaration_of_Geneva



interfere with a doctor's duty to a patient; some rephrasing of existing elements has occurred. Secrets are to remain confidential "even after the patient has died." The violation of "human rights and civil liberties" replaces "the laws of humanity" as a forbidden use of medical knowledge. "The health" in general of a patient is now the doctor's first consideration compared to the "health and life" as stated in the original declaration. This was apparently changed to free the medical profession from extending life at all cost.

The revisions[690] were approved including: respecting the autonomy of the patient; physicians to share medical knowledge for the benefit of their patients and the advancement of healthcare; a requirement for physicians to attend to their own health as well as their patients.

Drosimec.o from the department of surgery, university of Benin teaching hospital, Benin city, Nigeria in his book understanding medical ethics in a contemporary society observed that certain principles are obviously manifest with respect to medical ethics, the Hippocratic oath and physicians ought to be familiar with most of these principles embedded therein. Principles included; patient's autonomy[691], Non-malfeasance[692], honesty[693] among others. He thus recommended that if a doctor has mismanaged a patient, it is preferable to opt for alternative dispute resolution rather than litigation. The doctor should be alert at all times and seek to do what isn't right always regarding patient care.

> An article in the Daily Monitor Newspapers[694] on December 12th 2011, was published [695] referring to the Hippocratic Oath not a doctors suicide pact. Reading that***."The Hippocratic Oath, in its various iterations, is not a commitment to economic or physical suicide by doctors. There is nothing in the Hippocratic Oath that mandates doctors to provide free services to patients, or to accept dangerously substandard facilities and resources with which to treat their patients. The Oath does not include a promise to work without rest and without a fair wage. The fundamental commitments in the Classic Hippocratic Oath are respect and support for one's teachers and colleagues; scrupulously ethical practice; and adherence to the principle of primum non nocere (first, do no harm.)***Therefore advocating to view a doctor's expertise as a commodity despite the fact that they made an oath to uphold some of the core principles of health and humanity.

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[690]The 68th World Medical Association (WMA) General Assembly in October 2017 approved the revisions.

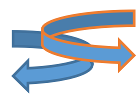
[691] He implied it as the right by the patient to decide what shall be done to his or her own body,.

[692] He described it as the principle of not causing harm to the patient.

[693] He described this to be of vital importance as a doctor who is honest to with a patient creates a smooth relationship built with trust between the him(the doctor) and the patient.

[694] The Daily Monitor is one of the leading publishers of information through news papers daily in Uganda.

[695] Article written by Muniini K. Mulera



Research conducted by Zain Rahimi on whether the Hippocratic oath can be applied in today's medicine" [696] discussed the Hippocratic Oath as follows "………Hippocratic Oath is not a specialized approach, but rather an existing notion from the time of Ancient Greek which, I believe, should still be regarded as the foundation and basis of the medical occupation." The Hippocratic Oath gives medical professionals a framework of the moral code of Ancient Greek medicine to maintain a harmony among the physician, the patient, and the illness. When talking about Hippocratic Oath, we have to keep in mind that medicine in early Greece was greatly influenced by the philosophical thoughts at the time. Philosophers such as Socrates encourage people to pursue knowledge by thinking deeply and raising questions. Hippocrates himself encouraged those in the field of medicine to "insert wisdom in medicine." Today, medicine has evolved. Medicine is not only viewed as a means to help the sick, but it is a profitable business and has a purpose of scientific advancement as well. Medicine today is not just a triangle between a physician, patient, and an illness. Rather, medicine is a balance between patients' expectations, financial and political realities, society's demands, and also developing medical and scientific knowledge. Alone Hippocrates's oath cannot be applied in today's medicine. For instance, the original oath required patients to be cured regardless of circumstances. Today, patient's autonomy has taken over the paternalistic medicine that Hippocrates refers to. Hence, I believe that Hippocrates Oath should still be the moral guidance for those in the medical field, but as a reference curriculum because it reminds those in the medical profession their ultimate reasons to get into this profession. As Pellegrino says, medicine is a profession that demands of physicians' extraordinary moral sensitivity as they respond to patient susceptibility. However, the entire burden on physicians is not fair. The problems surrounding medical malpractice, high insurance, etc. in medical profession are, perhaps, the reasons why a need for a modern oath or an amendment to Hippocrates Oath is crucial.

BASIC PRINCIPLES OF MEDICAL ETHICS

Four basic principles of biomedical ethics are seen embedded and still used to date in as far as the Hippocratic oaths is concerned. They thus include the following below; Respect for the autonomy of the patient, Beneficence, non-maleficence and distributive justice. These principles exist and are recognized in the various laws in Uganda and they include the following below;

A. Respect for Human Dignity

The 1995 Constitution of Uganda as amended provides for Protection of right to life where it states that, ***"No person shall be deprived of life intentionally except in execution of a sentence passed***

[696] http://www.ugphysicians.org/content/hippocratic-oath

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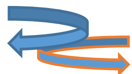


in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellate court."No person has the right to terminate the life of an unborn child except as may be authorized by law."[697]

The Constitution further provides for respect for human dignity and protection from inhuman treatment.[698] Where it provides that, ***"No person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment.***

B. Informed consent

But there is an exception to the above stipulated provision as espoused in the case of **Kloviss Njareketa Vs The Director Of Medical Services[699].**

On February 8, 1949, a very sick young man named **Klovis Njareketa 24**, was admitted to Mulago hospital with a swelling on one of his leg. When an x-ray was taken, the doctors diagnosed that the swelling was a result of a cancer and was spreading. The patient's condition continued to deteriorate over a period of 20 days and the doctors were of the opinion that the cutting off (amputation) of that leg was essential to save the young man's life. On Monday February 28, a senior African Assistant Medical Officer, explained to the patient the gravity of the situation and what must be done to save his life. The patient consented to the operation, which the scheduled for Thursday March 3.

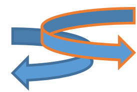
C. Change of Mind

However, the father of the patient visited him that morning and advised his son against undergoing the operation. By Wednesday the patient's condition had worsened and the surgeon, Dr. Mc Adam decided that an immediate operation was necessary. The patient declined. This decision was reported to the surgeon, who nevertheless, directed the operation to proceed on"humanitarian considerations". The Surgeon was of also of the opinion that the patient was not in a fit enough state to make up his mind. The operation went ahead and the patient's leg was cut off. The patient improved and was later discharged. He however, sued the surgeon and Director of Medical Services, the employer of the surgeon. The patient claimed damages in respect of the operation performed on him by the surgeon, an operation he did not Consent to, but done at the insistence of the surgeon.

The Ruling in Njareketa Vs The Director of Medical Services 1949

The trial judge, on evidence, found that the patient did give his consent to the amputation a day or two before the operation but that subsequently, he retracted his consent and consciously and expressly refused the operation, did in fact commit a trespass to the person of the patient and awarded damages and with to the patient.

[697] Article 22 of the Constitution of Uganda, (1995 As Amended)
[698] Article 24 Abid
[699] 2015



Appealing The Ruiling in Njareketa Vs The Director of Medical Services 1949

An appeal was filed against the judge's decision. The appeal was on the grounds that the judge had withdrawn his consent to the operation and that the patient had suffered any damages. The surgeon was also dissatisfied with the amount of damages. The surgeon was also dissatisfied with the amount of damages awarded to the patient. The court of Appeal was however satisfied that the trial judge was right in holding that the surgeon that the trial judge that the trial judge was right in holding that the surgeon had committed a technical trespass against the patient when on the morning of the operation and had no medical evidence to the effect that the patient was not in a fit enough state to make up his mind.

The surgeon at the initial trial had stated "the patient would most certainly have died, he was dying, and he would not have possibly survived for more than 14days (without the operation)".

No contrary or rebutting evidence was presented by the patient and there was no suggestion of negligence on the part of anyone at the hospital.

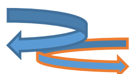
The patient told the court that before the amputation, he had a flourishing milk distribution business but because of the action of the surgeon of amputating his leg to render him a disable person, he was unable to earn enough to keep his wife and children.

Second Ruling in Njareketa Vs The Director of Medical Services 1949

The appeal court noted that the patient was very much alive and apart from his disability he was in excellent health. Court also noted with concern that it seemed to be beyond the mental comprehension of the parties to understand that had it not been for the decision of the surgeon to amputate his leg, the patient's children would be fatherless and his wife a widow.

Court was upset that instead of the patient expressing gratitude to the surgeon, the patient was now pressing for payment from the doctor for injury purportedly done to him. Court could hardly find similar cases as this and it seemed to be because there must be very few people like **KLOVISS NJAREKETA** (the patient) anywhere in the world, who would have the audacity to come to court for a claim against a doctor in such circumstances.

Court reasoned that had the operation not been performed, the patient would at most have lived seriously ill for a fortnight. However, because of the surgeon's courage and professional skill, the patient was alive and well and inconvenienced as he may have been, he was by no means suffering from anything approaching total disability.Court concluded that the patient therefore suffered no damage by reason of the trespass and drastically reduced the damages earlier. This to court, was necessary to protect doctors from unscrupulous claims of this nature.



This provision of the law is Non-derogable[700], meaning it is absolute, any derogation however slight from it is totally unacceptable. While the right to life is derrogable. The Constitution therefore does not however provide for the notion of euthanasia. Euthanasia is the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma[701].It is classified in to three types; Voluntary, non-voluntary and involuntary. Voluntary euthanasia as per the case of **Cruzan Vs Director, Missouri Department of health**[702] the involvement or when a patient brings about his or her death with the assistance of a physician.

Involuntary euthanasia is on the other hand conducted against the will of the patient and Non-Involuntary is conducted when the consent of the patient is unavailable. Countries like Belgium legalized euthanasia for adults in Beligium, let alone amended the law, in December 2013 that extended the treatment to any child irrespective of the age.[703]However, certain conditions and procedures to administer the treatment go as follows;

Conditions include;

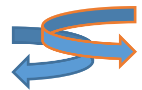
1. *The patient must be at the most conscious moment of making his request.*
2. *The request must be voluntary, well considered, repeated and not a result of any external pressure.*
3. *The patient must be in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.*

Procedures for the treatment

1. The Patient makes a written request to the physician.
2. The physician may then inform the patient about his/her condition and life expectancy.
3. The physician must be certain of the patient's constant physical and mental suffering.
4. The Physician must then consult another physician about the serious incurable character of the disorder and inform him/her about the reasons for the conclusion.

5. The attending physician must the consult another physician aout the serious incurable character of the disorder and inform him/ her about the reasons for the consultation.
6. The Consultant shall review the medical record, examine the patient, must be certain of the patients constant and unbearable physical, mental suffering that cannot be alleviated.
7. The consultant must then make his written reports and finding.
8. The attending physician then informs the patient of the results of consultation.
9. The attending physician must then allow at least one month between the date of the patients request and the act of euthanasia.

[700] Article 44(a)
[701] Oxford law dictionary
[702] 497.U.S.261(1990)
[703] The Beligium Act on Euthanasia of May 28th, 2002



10. The attending physician shall then perform the act, fill in the registration form, deliver it to the federal control and evaluation commission.

Due to the standard, strict procedure and time one is given before the act of euthanasia is done. The fact that one decides where and whom to marry, where to work, and at the last hurdle of your life, i believe one should be allowed a right to die before death would otherwise occur. This notion is not only not recognized under the constitution[704] but deemed unconstitutional and an illegal practice in Uganda.

Medical and Dental Practitioners Act[705] which monitors and exercises general supervision and control over and maintenance of professional medical and dental educational standards.it provides for the following functions that are seen existent in the Hippocratic oath;

1. To disseminate to the medical and dental practitioners and the public, ethics relating to doctor- patient rights and obligations.[706]
2. To protect society from the abuse of medical and dental care and research on human beings[707].
3. To exercise disciplinary control over medical and dental practitioners.[708]

Furthermore, there is a code of professional ethics established by the Uganda Medical and Dental Practitioners Council[709]is a body that registers and licenses medical and dental practitioners in Uganda. It fosters good medical practices, high standards of medical education and advises government on issues pertaining to the medical profession.

It provides guidelines with respect to complains against medical and dental practitioners thereby outlining the procedures through which complaints are handled by the council; provide a list of the different categories of offences and types of penalties that are handled out to errant practitioners.

The code is intended to be used as a guide to promote and maintain the highest standards of ethical behavior by practitioners in Uganda. In order to maintain public confidence in the professional standards of practitioners, it is essential that high ethical standards be exhibited in carrying out their duties.[710]

It also recognizes principles found in the Hippocratic Oath where amongst them include;

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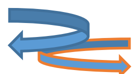
[704] The Constitution of Uganda, 1995(As Amended)
[705]CAP 272 of 1998
[706] Section 79(h)
[707] Section 7, abid
[708] Section 2 ,abid
[709](UMDPC) centenary 1913 – 2013 code of professional ethics
[710] Rule 1, Abid



D. Respect for persons[711]

Were it provides that a practitioner shall not;-Discriminate in the management of patients basing on gender, race, religion, disability, HIV status or any other indication of vulnerability.[712]Act violently or indecently towards a patient, a professional colleague or the general public.[713]

E. Protection of privacy[714].

A practitioner shall observe the patient's confidentially and privacy and shall not disclose any information regarding the patient except-

With the express consent of the patient; or in the case of a mirror with the consent of a patient or guardian; or in the case of a mentally disadvantaged or unconscious or deceased patient, with the consent of his or her authorized next of kin.[715] To the extent that it is necessary to do so in order to protect the public or advance greater good of the community. [716]

F. Integrity[717].

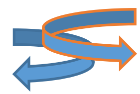
A practitioner shall not- Aid in any form to inflict violence, torture, or degrading punishment or treatment to a person by the state or a private individual[718]; conduct any intervention or treatment without consent except where a bonafide emergency obtains.[719]

A practitioner shall; - (a) Not use his or her professional skills to participate I any actions that lead to violations of human rights (b) Report to the Council if there has been a violation of human rights; (c) Not carry out any specific actions that constitute a violation of bill of rights enshrined in the Constitution of Uganda and international human rights law.

However, not only do both statues not recognize the law on abortion in Uganda but since the enactment of the constitution[720], the Parliament has not fulfilled this obligation and has not created a law to prescribe instances in which a person can be permitted to terminate pregnancy. However, despite the Penal code of Uganda[721] providing for criminal sanctions to several aspects of abortion and, in the absence of any other law, it remains the authority on instances in which abortion is or is not permitted.

Section 212 of[722]provides that,"***Any person who through any act or omission prevents child, who is about to be delivered from being born alive can be punished upon conviction with***

[711] Rule 5
[712] Rule 5(a)
[713] Rule 5(b)
[714] Rule 6
[715] Rule 6(a)
[716] Rule 6(b)
[717] Rule 7
[718] Rule 7(a)
[719]Rule 7(b)
[720] October 1995
[721] CAP 120
[722]The Penal code Act CAP 120



imprisonment for life." The act or omission mentioned in the offence under section 212 has to be of such nature that if the child has been born alive then died, the person would have been deemed to have killed the child.

Criminalization of abortion can lead to an increase and prevalence of unsafe abortions[723].Blocking women from safe abortion services means that women have resolved to terminate their pregnancies will access the same clandestinely and often using unsafe methods.

Teenage pregnancy is still widely shunned in Uganda and girls who get pregnant always find themselves having to deal with stigma from their peers at school and from their parents who attimes marry them off to the person responsible for the pregnancy. In addition to dealing with the physical and health effects of their pregnancies, teenage girls have to deal with rejection from parents, their spouses, expulsion from home and school and rebuke from the community.[724]In many consequences, the fear of facing these socio-cultural consequences of teenage pregnancies compels girls to seek abortion services often involving unsafe health conditions and unqualified personnel.

Other principles of medical law include the following;

1. Allowing Treatment:

It could be argued that doctors have an ethical duty to provide treatment to those in need. The basis for such a duty could be found in the Hippocratic Oath itself, which states:

> *"I swear… to keep according to my ability and my judgement the following oath… I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone."*[725]

If such a duty does exist then the law could assume the role of furthering that duty. Such a role would be achieved through doing everything possible to make treatment lawful. It could be argued that this is simply abdicating, to the medical profession, the decision of when a particular treatment should be lawful. This would be incorrect though as the courts would be encouraging doctors to come to a decision in favour of treatment rather than unquestioningly accepting medical decisions. A guiding principle of allowing treatment could, therefore, offer assistance to the medical duty to treat without blindly accepting medical opinion.

Further to that, the guiding principle of allowing treatment could also take account of the doctrine of sanctity of life. Whilst it could be argued that sanctity of life ought to constitute its own guiding principle this could be problematic as there is some dispute over the exact meaning of the doctrine.

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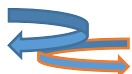
[723]MulumbaM.Hasunira ,R&Nabweteme.F (2014) , Criminalization of Abortion and Access to post Abortion care in Uganda.Community experiences and perceptions in Manafwa district, Kampala

[724724]AtuyambeL.Mirembef;Tumwesigye,N.M,Annika J, Kirumira,E.K&faxelid.

[725] Similar statements can also be found in the Declaration of Geneva, the International Code of Medical Ethics and the Declaration of Tokyo which describes the doctor's fundamental role as alleviating the distress of fellow men regardless of any counteracting motive.



Keown, for example, argues that the courts are constantly being presented with a more overly vitalistic definition of the doctrine than is appropriate.[726] Also, it could be argued that the term 'sanctity' involves religious undertones. Yet the doctrine has also been used in non-religious contexts and is still seen to be of importance in an increasingly secular world. If, therefore, there is both a religious and a secular version of the doctrine, then which is to be adopted as the correct one?

By bringing the doctrine of sanctity of life within the guiding principle of allowing treatment, and combining it with a desire to protect any duty which the medical profession may have to provide treatment, these problems may be overcome. Any conflict between religious and secular notions is removed and the desired meaning is made clear and unambiguous. It must be recognised, however, that whilst the doctrine of sanctity of life may oppose any treatment which shortens life, this need not be true of the guiding principle of allowing treatment. The guiding principle of allowing treatment provides an obvious and simplistic aim for the law, one that remains free of the confusion that can be caused by subjective assessments.

2. Self-Determination:

The importance of autonomy and consent in medical law has already been emphasized. It is submitted that these two factors can be combined to form the guiding principle of self-determination. The law, both in the medical context and in more general scenarios, can be seen as placing great importance upon the idea that adults who are of sound mind ought to be able to determine their own lives and that nothing ought to be done to, or for, that person without his express permission or approval. The guiding principle of self-determination would acknowledge, and protect, the individual's right to control his own life and the right of that individual to be free from the undesired interference of others.

Whilst the law may place limits upon what a person can do, by attaching criminal or tortuous liability for example, this is not necessarily a denial of the importance of self-determination. Rather, it is an acknowledgement of the fact that one person's right to choose to do something must be balanced against another person's right to choose not to have that thing done to him.[727] Melden argues that any person possessing a right must accept that it may have to yield to other considerations,[728] whilst Dworkin states that self-determination free from the constraints of external influences is impossible.[729] It could be argued, therefore, that the individual's right to choose not to have something done to him is stronger than the right to choose to do something. If this is the case then the guiding principle of self-determination will be of greatest importance when the desire of the patient is to refuse treatment.

[726] J. Keown, 'Restoring Moral and Intellectual Shape to the Law After Bland' (1997) 113 LQR 481, at pp.499500

[727] D. Feldman, *Civil Liberties and Human Rights in England and Wales* (Oxford: Oxford University Press, 2nd, 2002), p.6

[728] A.I. Melden, *Rights and Persons* (Oxford: Basil Blackwell, 1977), p.21

[729] G. Dworkin, *The Theory and Practice of Autonomy*, p.12

3. **Best Interests:**

The term 'best interests' is perhaps one of the most frequently used terms in medical law cases, especially in relation to children and incompetent adult patients. In ***Re J (A Minor)(Wardship: Medical Treatment)***[730] Taylor LJ stated that it was settled law that the prime and paramount concern of the court when dealing with children must be the best interests of the child in question[731]. In relation to incompetent adults Butler-Sloss LJ stated that:

> "*Medical treatment can be undertaken in an emergency even if, through a lack of capacity, no consent had been completely given, provided the treatment was a necessity and did no more than was reasonably required in the best interests of the patient.*"[732]

It would appear clear, therefore, that the best interests of the patient will be one of the main influences upon whether or not treatment is lawful. Consequently, it would be unwise to attempt to identify any structure to the law in this area without accepting the possibility that best interests will be the decisive concern. It is for this reason that one of the guiding principles suggested in this thesis is that of best interests.

The guiding principle of best interests seeks to ensure that treatment will only be given if it benefits the individual in question in some way. It is important to note that for this guiding principle to apply there must a truthful examination of the specific interests of the individual patient involved. It is possible that the courts will use the term 'best interests' in relation to a less individualistic assessment of interests which comes closer to a blanket approach. If this is the case then it may not be the guiding principle of best interests which applies. Rather, it will be another guiding principle which applies and the reference to best interests will be nothing more than a judicial smokescreen designed to hide the reality of the law.

4. Doctor Protection:

One of the main criticisms that is levelled towards medical law is that it is too ready to adopt, without question, the opinions and decisions of medical professionals.[733] Such criticisms usually stem from *Bolam v. Friern Hospital Management Committee*[734] which decided that a doctor would not be negligent so long as he was acting in accordance with an accepted body of medical opinion. Whilst *Bolitho v. City and Hackney Health Authority*[735] held that this would only be the case if

[730] [1990] 3 All ER 930

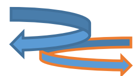
[731] ibid, at 943

[732] *Re MB (Medical Treatment)* [1997] 2 FLR 426, at 432

[733] It has been argued that to leave decisions purely to the medical profession would be an unjustified derogation from an area of legitimate public concern, see J.K. Mason, R.A. McCall Smith & G.T. Laurie, *Law and Medical Ethics*, p.22

[734] [1957] 2 All ER 118

[735] [1997] 4 All ER 771



the body of opinion was logical, it did little to reduce such criticisms due to the rarity of cases where medical opinion was held to be illogical. Montgomery argues that:

> *"The most plausible explanation for [the continued use of the Bolam test] lies in the acceptance by the judiciary that doctors are altruistic, working under considerable pressure in the public interest and generally undeserving of liability"*[736]

Whilst Lord Woolf accepts that, in the past the courts have given too much deference to the medical profession he argues that this is no longer the case.[737] He argues that the approach has shifted from one of 'doctor knows best' to 'doctor only knows best if he acts reasonably and logically and gets his facts right'. Lord Woolf argues that whilst medical opinion is one of the most important sources of evidence it is the courts which constitute the final arbiters.[738]

Lord Woolf has stated that when the medical profession faces a problem in deciding whether or not treatment is lawful then they can rightly expect the court to provide an answer and, in doing so, define what is lawful and unlawful behaviour.[739] The question is whether or not, in determining such issues, the court will go beyond simply finding the dominant medical opinion or claiming that all medical opinions are valid. A wholesale adoption of the guiding principle of doctor protection would represent a desire, on the part of the court, to abdicate its decision-making responsibility to the medical profession. If this guiding principle is dominant then the role of the courts in shaping the law will be minimal and amount to little more than rubber-stamping the opinions of doctors.

A COMPARATIVE ANALYSIS WITH OTHER JURISDICTIONS;

All health professionals are expected to act in accordance with professional codes, ethical principles, Codes with minimum standards and upper limits of behavior beyond which a practitioner must not go. Each healthcare encounter is formed by facts;-

Patient's history, Examination findings, investigation results and Evidence of effectiveness of treatment options. According to the American Medical Association it stipulates for medical ethics[740].

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[736] J. Montgomery, 'Time for a Paradigm Shift? Medical Law in Transition', at p.378

[737] Lord Woolf LCJ, 'Are the Courts Excessively Deferential to the Medical Profession' (2001) 9 Med L Rev 1, at p.1

[738] ibid, at p.13

[739] Lord Woolf MR, 'Medics, Lawyers and the Courts' (1997) 16 CJQ 302, at p.303. Lord Woolf has also argued that the rising number of questions relating to medical ethics shows that there is a real disagreement and uncertainty within the profession and that the court is best suited to providing answers, see Lord Woolf LCJ, 'Are the Courts Excessively Deferential to the Medical Profession', at p.4.

[740] Article 4.

The Yale Journal of Health Policy, Law, and Ethics Volume 2 stipulates for the following;-

- A physician shall be dedicated to providing competent Medicare, with compassion and respect for human dignity and rights.
- Both stipulate that a physician shall respect the rights of parties, colleagues and other health professionals, and shall safeguard patient confidences and privacy with in the constants of law.
- A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- A physician shall while caring for a patient, regard responsibility to the patient as paramount.
- A physician shall support access to medical care for all people.

Numerous citation to the Hippocratic oath in contemporary judicial opinions indicate that it remains an extraordinarily important definition of medical practice. References to the oath arise in a wide range of cases, including those that involve employment[741] , physicians disciplinary proceedings[742]the first Amendment [743]and the disposition of frozen embryos [744].This focuses on only those U.S cases whose opinions have devoted more than passing references to the Hippocratic oath[745].

Position of the Law

The word "injustice" appears twice in the Hippocratic Oath. The Oath taker swears to keep the sick from harm and injustice and promise that they themselves will remain. Free of all international injustices [746]. This momentary allusion to patients' rights the Hippocratic oath in fact expresses much greater concern about the role of the physician indeed, it is telling that the oath is sometimes called The Physician oath[747].

The Oath places the physician in the foreground. The patient recedes into the distance, the unabated object of the physician's artistry. The oath devotes much greater attention to the quality of the physicians relationships with his gods, his teacher and his students, then with his patients. The very order in which these parties are discussed underscores an implied hierarchy that places the

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[741] E.g., Aiken V Employer Health Serves., No. 95-3196,1996 U.S.App.LEXIS 6060[10th Cir. Mar. 26, 1996] [affirming judgement that physician was not wrongfully discharged from his employment , despite physician's reliance on the Hippocratic oath to establish he had served the interests of his patients].

[742]E.g ., U.S. V Rachels, 820 F.2d 325[9th Cir.1987].

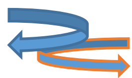
[743]Malnak V Yogi, 440F. Supp.1284[D.N.J.1977][holding that the teaching of the scince of creative intelligence/ Transcendental Meditation in New jersey public schools violates the establishment clause of the first amendment, despite defendants' attempt to analogize the puja chant to the Hippocratic Oath].

[744] Davis V Davis, No. E-14496, 1989 WL 140495[Tenn.Cir.Ct1989].

[745] For a brief discussion of the use of the Oath in England and in Germany,seeNutton,supra note 17, at 61.

[746] EDELSTEIN, supra note 1, at 3.

[747] LEVINE, supra note 7, at 56. The first Generation of medical ethicists in 1960s and 1970s attacked the Hippocratic Oath because it left out the person whose rights above all should determine medical ethics- the patient. Nutton, supra note 17, at 51.



gods at top and the ignorant, passive bearer of sickness and disease-a mere object to be examined and treated-rather than an autonomous, full participants in the healing process.

Next the Oath positions the physician in relation to his teacher and students. Here the physician becomes part of a new family, as he vows to treat his teacher like a part and his teacher's children like his brothers. At the same time, the physician promises to pass down his knowledge to his own sons, as well as to his teacher's sons and to all the other pupils who have signed the convenant and have taken an oath to the medical law but to no one else[748].

The very fact that judicial opinions refer to the oath so extensively indicates its status as a symbolic marker imbued with profound social meaning derived from generations upon generations of medical students swearing to follow its words. A kind of secondary performance effect of the Hippocratic Oath thus emerges beyond the linguistic performance effect of Hippocratic Oath thus emerges beyond the linguistic performativity it may possess in certain circumstances. This additional character that the oath assumes is, in Austin nomenclature, prelocutionary[749]. Prelocutionary acts may be referred to those acts that we bring about or achieve by saying something[750], a case in point by convincing, persuading, deterring, surprising and misleading[751].

Another pivotal comparison not the forget is that the court's references to the Hippocratic oath subtly convince the reader that the oath remains a persuasive statement that continues to unite the medical profession. Interestingly even while citing the Hippocratic oath, courts have rejected some of the oaths most important prohibitions most notably those barring from providing an abortive remedy or administering a deadly drug.[752]

Traditional Hippocratic Oath.

According to Dr. KIKOMEKO SHARIF the Hippocratic Oath and its relationship to the principles of ethics can be divided into 12 items

Covenant with deity; I swear by Apollo the physician…….

Covenant with teacher; Pledge of collegiality and financial support.

Commitment to students; Promise to teach those who swear the Oath.

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[748] EDELSTEIN, supra note 1, at 3. Ludwig Edelstein argues that the Hippocratic Oath was Inspired by the Pythagoreans, a religious sect from the fourth century whose doctrines included a belief that a student should honor his teacher like an adoptive father.see id. At 43, 47-48. Some classicists contend that the the practice of taking the Hippocratic oath was the equivalent of a de facto adoption , in that the pupil became like a son within a closed family guild of physicians.This arrangement served to ensure that knowledge remained within the family See BURKERT, supra note 9,at 44-45; EDELSTEIN, supra note 1, at vii,39,47. It also sparked the development of schools and apprenticeships of rationalist medicine.

[749]Id at 121.

[750] Id at 109

[751]Id.

[752]EDELSTEIN,supra note 1,at 3.

Covenant with patients; Pledge to use ability and judgment

Appropriate means; Use of standard dietary care

Appropriate ends; the good of the patient not the physician.

Limits on ends; Originally proscribed abortion and euthanasia

Limits on means; Originally proscribed surgery for renal stones, by deferring to those more qualified.

Justice; Avoiding any voluntary act of impropriety or corruption

Chastity; Originally proscribed sexual contact with patients

Confidentiality; Not to repeat anything seen or heard.

Accountability; Not to repeat anything seen or heard.

Accountability; Prayer that the physician be favored by the gods if the Oath is kept, and punished if it is not kept.

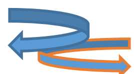
RECOMMENDATIONS ON THE BEST UTILITY OF THE HIPPOCRATIC OATH IN THE MODERN UGANDA

Revisiting and properly understanding of the Hippocratic Oath is very necessary in the light of present issues of ethical malpractices not only in Uganda but throughout the world.

Due to the drastic change of authority of decision making. Unlike the earlier years were the Hippocratic tradition and placed all authority in the hands of the physician, today, the modern version of the oath by the world medical Association[753] that has led to the utmost consideration of values, care and negligence. This is stipulated in the Hippocratic oath were it is provides that, ***"I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God."***

There is therefore need to create more awareness in Uganda thereby emphasizing to teach medical ethics in graduate courses for high standards of personal and professional values and that the knowledge of the ethical and legal aspects of medicine is important for comprehensive health-care.

[753] The world medical association is an independent and international confederation of free professional medical associations, therefore representing physicians worldwide .It was formally established on September 18,1974.



Legalizing principles

Ugandan laws allow abortion under certain circumstances, but laws and policies on abortion are unclear and are often interpreted inconsistently, making it difficult for women and the medical community to understand what is legally permitted. The Uganda constitution states that ***"No person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellate court."***

"No person has the right to terminate the life of an unborn child except as may be authorized by law."[754]This means that abortion is permitted if the procedure is authorized by law, but many of the medical workers cannot perform abortion because of failure to interpret the law.

Under the 2006 National policy guidelines and services standards for sexual and Reproductive Health and Rights, pregnancy termination is permitted in cases of fetal anomaly, rape and incest, or if the woman has HIV.

According to the Penal code[755], a doctor who thinks that an abortion is justified to save the life of the mother, must write to the director general of medical services in the health ministry, seeking approval to terminate the pregnancy, who also convenes a medical team to scrutinize the case. The bureaucratization of this process alongside a life in danger may be dangerous, as a medical doctor waits for an approval.

I believe being aware that abortion results from unplanned pregnancy, it therefore follows that preventing unintended pregnancy is a major step is preventing unsafe abortions. We ought to think of legalizing safe abortion and thereby allowing qualified and certified medical practioners to operate abortion clinics through which women will be given a chance to have safe abortion.

The assumption of the power to tell another human being what they can or cannot do with their bodies is a violation of a woman's individual rights granted by our Constitution. It is only fair that women be allowed to have control over their bodies. Men and women need to be empowered to make the best choices, to access contraceptives and to be able and ready to use them. They should also have the freedom to raise babies they can love and take care of. Condom use and contraceptives is not just for women, men need to be empowered too and girls and boys below 18 should be allowed to access and use contraceptives once they start to be sexually active.

The government should let abortion be a choice and not a crime. It should let the young people be given a choice. Abortion is the best choice in cases where a woman (girl) is raped, conceive through incest, still in school, or pursuing a career that cannot allow her to carry a pregnancy, when she is medically unable to have a child, or financially incapable of taking care of a pregnancy and a baby. In such a situation, safe abortion is the only remedy.

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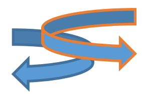
[754] Article 22 of the Constitution of Uganda, (1995 As Amended)
[755] CAP 120



Uganda being a member of many international human rights conventions that seek to uphold the standards of maternal health. Motivated by the Universal Declaration of Human Rights[756], Uganda has signed both regional and international human rights instruments such as the international covenant on civil and human rights, the African charter on Human and people's rights, convention on the elimination of all forms of discrimination against women, convention on the rights of the child, and convention on the rights of persons with disabilities, which addresses good health in all forms as an inalienable right that must be protected by law.

The country is also bound by domestic legal instruments, which affirm access to good health as a human rights and freedom of individuals, which are inherent and, therefore, not granted by the state. The right to good health is not treated in exemption. Article 21[757] disregards all forms of discrimination including on grounds of gender, while Article 22[758] emphasis the right to life to which women and girls are also entitled. Human dignity is brought into the equation by Article 24[759] which bars Ugandans, including women and girls from being subjected to inhuman, cruel, degrading treatment, and torture.

One of the principles embedded in the Hippocratic Oath states that, ***"I will prevent disease whenever I can, for prevention is preferable to cure."*** The government, institutions in Uganda can use the basis of the need to prevent diseases in society today by working hand in hand with the international bodies that advocate for the same there by in joint partnership, we can be able to carry out extended research that would not only be helpful in curing diseases but also saving lives of many Ugandans.

The World Health Organization focuses on the health of women during pregnancy, child birth and postpartum period, as an era averting hemorrhage, infection, high blood pressure, unsafe abortion and obstructed labor which may lead to morbidity and ultimately.

Conclusion

Ultimately, the world has many different cultures and values to words. Some graduating medical students have opted even to write their own oaths, a fact that means the pledge is to oneself and may or may not have the lasting impact as the original concept of Hippocrates. The question of the Hippocratic Oath and its many variations, of the Revised Declaration of Geneva Physician's Pledge, and of personal oaths or pledges will continue to evolve as the perspectives on the value of the individual's human life continues to change. Different cultures and pressures from changes in economic values will continue. One way to decrease burnout for future physicians may include discussion of the Hippocratic Oath at the beginning of medical school, as had been done in the

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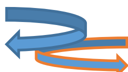
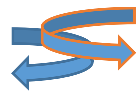
[756] UDHR was proclaimed by the United National General Assembly in paris on 10th December, 1948
[757] The constitution of Uganda7u7
[758758]abid
[759]abid



era of Hippocrates. Then the medical students, who later swear in the graduation ceremony to his or her version of the Oath, will understand more fully the challenges that will be faced in a professional medical career. Medicine offers a life based on knowledge, skill, and service to the critical needs of each patient. No matter what the era or place of medical school, physicians must strive to maintain the goal of the profession, namely, to earn continued trust by protecting and treating safely the individual patient.

CHAPTER SIX

TRADITIONAL MEDICAL PRACTITIONERS



TRADITIONAL MEDICAL PRACTITIONERS

The National Council Of Traditional Healers and Herbalists Associations of Uganda, defines traditional medicine as ways of protecting and restoring health that existed before the arrival of modern medicine with medicinal plants being the world's oldest known health care products.

Traditional medicine plays a critical role in the promotion of health of the people in urban and rural areas. People in rural areas find traditional medicines more accessible, available and at a free cost. They also find them more economically accessible and culturally acceptable than the modern or conventional medicines.

There is commercialization of traditional medicines in the urban areas. Most people dealing in traditional medicines make dubious advertisements to attract the customers. They include *Maama Phiina, Senga Namatovu* and *Senga Ainebyoona* among others.

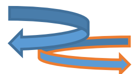
In their advertisements, they always emphasize that their medicines can break the curses and bondages, provide healthy, provide fertility for women, man hood for the men and reshape the body by making some one slender or enabling them to obtain hips . They also claim that their traditional medicines is also used to treat sexual and erectile challenges in men.

Whether their advertisements are true and not mere puffs intended to attract buyers is a question of doubt and the right answers can only be obtained from those that have sought medication from them.

What is important to note is that traditional medicine is that traditional medicines are perceived to be more natural, energy, efficient and with less side effects than the conventional therapies where people's attitude to them is patronizing and condescending. The WHO estimates that more than 80% of African populations attend traditional healers for health reasons and that 40%–60% of these have some kind of mental illness. However, little is known about the profiles and outcome of this traditional approach to treatment.

The WHO director in an international Conference on Traditional Medicines emphasized that traditional medicines are of proven quality, safety, efficacy, thus contributing to access of medicines to all. He also emphasized that for many people, traditional medicines, herbal medicines, traditional treatments and traditional practitioners are the main source of medical care. And that this traditional medical care is too close to their homes, accessible, culturally acceptable for a number of people.[760]Some women utilize traditional birth attendants when it is time for labor and child delivery and even after birth instead of using hospitals where some people die during the cesarean section. It should however be noted that the use of traditional medicines raises questions on safety, quality, practice, administration and discipline of traditional medicines and traditional

[760] Speech by Dr Margaret Chan ,at International Conference on Traditional Medicine for South East Asian Countries at New Delhi 14-12-2013



medical personnel.In Uganda, it is important to note that there is no law that specifically addresses the registration, practice and discipline of traditional medical practitioners.

However, the National Drug Authority, established guidelines for the manufacture, registration and sale of herbal medicines. They are called the **NDA Guidelines for Regulation of Traditional or herbal Medicines in Uganda 2004**. The guidelines however do not cover the practice of herbal medicine which will be handled under the auspices of the various professional organizations that unite all herbalists in the country. The organization that governs traditional healers is called NACOTHA. The role of the organizations includes promotion, research, and development of traditional medicine in the country.

ETHICS AMONG TRADITIONAL HEALERS

The traditional medicine and Complementary Medicine Act, 2019 has its preamble which states that; "*An Act to define traditional and complementary medicine in relation to modern, to establish a council to control and regulate the practice of traditional and complementary medicine, to register and license practitioners and to provide or related matters.*"

Within the Act, the **code of conduct** expected of traditional medical practitioners is listed in ***section 53.*** It provides that; the following shall be followed as a code of conduct of practitioners of traditional and complementary medicine_

(a)*respect for patients*

(b) non exploitation of patients

(c) respect for community values and acceptable moral and societal norms.

(d) promotion of beneficial aspects of traditional medicine

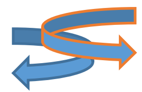
(e) elimination of harmful practices

(f) promotion of social justice through safe, acceptable and cost effective traditional medicines and practices; and

(g) the informed consent of the patient.

This is a great usage of the law to ensure professionalism in this medical branch of traditional medicine. **Section 53** provides the ethical principles governing transitional medical practitioners. It provides that;

In the practice of traditional and complementary medicine the following ethical principles shall be maintained_



Protection of the individual or patient, Confidentiality, Informed consent of the parties, Respect for the dead, Adequate compensation for services rendered and for injuries, damages or losses arising from malpractice, among others

Suing a traditional healer for professional misconduct.

The authority in ***section 53*** of the Traditional medicine and Complementary Medicine Act, 2019 is good ground for one to apply to court for a remedy against the misconduct of a traditional healer. One can sue a traditional healer on grounds of treatment without consent, disturbing the peace of the dead, infringement of intellectual property, breach of confidentiality, exploitation or extortion and for any other remedy or compensation.

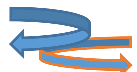
More to this, ***section 14*** of the ***The Local Governement (Kampala City Council) Traditional Healers and Herbalists) Ordinance, 2006*** prohibits traditional healers from using indencsent language. **Section 14** provides that;

(1) A healer shall not use any language, sign or display any picture on his or her premises which is obscene, vulgar or indecent or which arouses suspicion that it is obscene, vulgar or suggests indecency or is damaging to public morals.

(2) A healer who contravenes the provisions of subparagraph (1) of this paragraph, commits an offence. (3) The court convicting a healer under this paragraph may, in addition to any penalty it may impose, order for the cancellation of his or her permit issued under this Ordinance, the closure of his or her premises or order the destruction of the offending any sign, picture or material.

Section 16 of the same Act provides for the offences and penalties sanctioned against these professionals. It provides that a person who contravenes any provisions of this ordinance is liable on conviction to a fine not exceeding 2 currency points or to a term of imprisonment not exceeding six months or both.

In conclusion, traditional and medical practitioners play a great role in enabling a realization of the right to health and access to medicines as provided in the national objectives and directive principles of state policy. This creates an obligation upon government to inject more resources in the development and innovations sector of traditional herbs and complimentary medicines. As already mentioned in the chapter regarding mental health, traditional healers have a great role they have played in the realization and treatment of mental health in Uganda. However, the same professionals are not immune to civil and criminal action in respect to their actions of misconduct as discussed herein.



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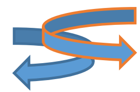

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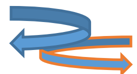

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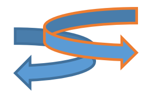

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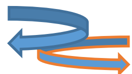

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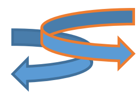

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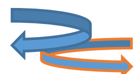

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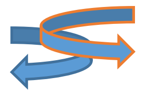

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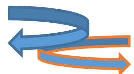

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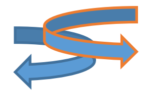

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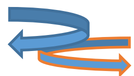

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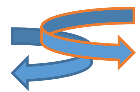

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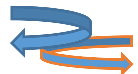

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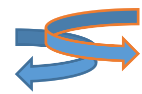

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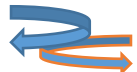

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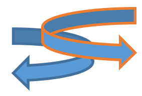

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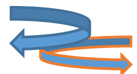

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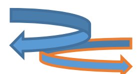


APPENDIX ONE. Freda Kasaira V. The Registered Trustees Of Nebbi Catholic Diocese

THE REPUBLIC OF UGANDA

IN THE HIGH COURT OF UGANDA SITTING AT ARUA

CIVIL SUIT No. 0020 OF 2016

1. FREDA KASAIRA }
2. AJILI PETER }
3. HARRIET MANZONI }
4. NANCY AKUJE } …………… PLAINTIFFS
5. JOAN MASINDA } s
6. FIONA ASIMBA (6th plaintiff a minor suing } through next friend ONZIMA NYAKUNI)}

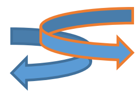
A.

THE REGISTERED TRUSTEES OF NEBBI CATHOLIC DIOCESE …… DEFENDANT

Before: Hon Justice Stephen Mubiru.

JUDGMENT

The plaintiffs jointly and severally sued the defendants for the recovery of general and special damages for the wrongful death of Ms. Angucia Lucy which occurred on 12th September 2015 at Angal St. Luke Hospital alleged to have been caused by employees of the defendant who were at all material time acting in the scope of their duty and course of their employment as medical workers at a medical facility founded and operated by the defendants. The plaintiffs are children and dependants of the deceased. Their case is that the deceased was on 8th September 2015 admitted at the defendant's said hospital complaining of appendicitis. The deceased underwent surgery for that condition on 10th September 2015 during which a number of negligent acts occurred including; failure to properly administer anesthesia, to ensure an effective and constant supply of oxygen to the patient during the operation, failure to monitor the vital signs of the patient during the operation, failure to install the monitoring equipment of those signs during the

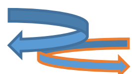


operation, lapses in handing over the patient to the ward staff and generally failure to exercise professional care and skill to the required standard. As a result, the deceased never regained consciousness and eventually died at the said hospital on 12th September 2015.

In their written statement of defence, the defendants refuted the claim that the death of the deceased was a result of any negligence on their employees' part. Contrary to the advice of the doctor, the deceased left the hospital premises after admission and being informed that her condition required surgery. Complications arose while she was being operated upon in the hospital theatre including difficulty with intubation resulting in cardiac arrest and all efforts made to revive her brain function were unsuccessful such that she was in a vegetative state at the time she was taken out of the hospital theatre. In the circumstances, her death was the inevitable result of a series of medical complications that the medical team could not reverse despite their exercise of professional care and skill to the required standard. the deceased was properly advised of the possibility of those complications and she willingly gave her informed consent to the surgical operation.

P.W.1 Driciru Salome, a sister in law of the deceased, testified that her husband advised the deceased to seek medical attention at Angal St. Luke Hospital after she complained of stomach pains. On 8th September 2015, upon being examined by a doctor at the hospital, her condition was diagnosed as appendicitis and it was suggested to her that she needed to undergo a surgical operation. She was taken into the surgical theatre on 10th September 2015 at around 8.00 am and was brought out of the theatre at around midday. She was unconscious and still had two tubes inserted in her mouth and on drip. At around 2.00 pm concerned that the patient was not regaining consciousness, she alerted the nurses. The nurse, upon looking at the patient said there was a problem. She replaced the intravenous drip with another unit and returned after about twenty minutes to check on the patient and re-connected oxygen supply. By 4.00 pm she still had not regained consciousness and monitoring by the nurses had intensified. At around 5.00 pm the doctor who conducted the surgery checked on the patient but did not explain what was wrong with her. The plaintiff's brother returned at around 6.00 pm and upon seeing the patient began to shed tears and told the witness that the doctor who had conducted the operation had called him earlier and told him that something had gone wrong during the operation. he told her the patient was already dead. The deceased was kept on oxygen supply overnight and the following day the nurses came and removed all the tubes and began preparing her body. The hospital staff took the body to church for a requiem mass and later helped the family return it to her home and she was buried the following day.

P.W.2 Ocokuru Zena, a business associate of the deceased, testified that the deceased was a trader dealing in silver fish and was a member of the Arua Women Business Enterprise Uganda Limited, an association of dealers in fish. Their trade involved buying dried silver fish from fishermen on Lake Victoria at Buikwe landing site in Buikwe District. The traders would hire a truck jointly and each would load their merchandise onto it at the cost of shs. 30,000/= per sack full, at the total cost of shs. 1.8 - 2 million for a return journey. On return to Arua, each of them would re-sell their



fish on wholesale and retail basis. Each trader ordinarily made a profit of shs. 165,000/= per sack full of fish. The average volume of sales was 6 to 7 sacks per week when business is at its peak and about 4 to 5 sacks per week when business was low. Their major customers are from South Sudan and the Democratic Republic of Congo although some traders would come from the towns, Districts and counties neighbouring Arua such as Terego and Odramacaku. Each member pays an annual subscription fee of shs. 50,000/= to their association but the land on which they operate was bought by the company and thus they do not pay monthly rent but a charge of shs. 7,000/= per bag. The deceased's business turnover averaged 30 sacks full per month.

P.W.3 Candiru Grace testified that she has been in the fish trade for over eighteen years. The deceased was her employer and she was responsible for selling off the fish delivered by the deceased. A sack full would cost shs. 700,000/=, all expenses included, at the point of delivery in Arua. The deceased had a business turnover that averaged at 30 sacks full per month, give or take two sacks full. A sack full would be sold at the whole sale price of shs. 1,100,000/= for customers from South Sudan and at a retail price of shs. 865,000/= to other customers. the average profit per bag was shs. 165,000/= at retail price and shs. 200,000/= at wholesale price.

P.W.4 Onzima Nyakuni Ben, a brother of the deceased, testified that upon receiving the sad news of the passing of his sister, he left his duty station in Kampala and travelled back to Arua. He met the management of Angal St. Luke Hospital seeking to find out what had caused his sister's death. The medical Superintendent of the hospital Dr. Odaga told him the anesthetist could have committed an error during the surgery. He made arrangements for the burial and was in charge of all necessary purchases of such items as the coffin, foodstuffs for the mourners, hire of a public address system and so on.

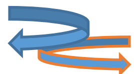
The deceased was a single mother who lived together with her children at Ediofe in a house provided by him. Occasionally, her brothers would provide her with financial assistance, especially with school fees for her children, but she largely met all her financial needs and those of her children. The first plaintiff Kasaira Freda now 32 years old was at the time undertaking a secretarial course, the second plaintiff Ajili peter now 28 years old was undertaking a plumbing course, the third plaintiff is now aged 26 years, the fourth plaintiff Nancy Akuje now aged about 23 years was in her third year. The fifth plaintiff Joan Masinda is about 21 years old. The last born, Fiona Asimba was in Senior Four at the time. The deceased also had two dependant nieces; Brenda aged 24 years and Asia aged about 11- 12 years and is now in primary seven. None of her children had been able to find gainful employment and this they all depended on her. Having been a sole proprietor, her business collapsed following her death after all her stock had been sold off.

P.W.5 Ajili Peter, the second plaintiff and son of the deceased testified that his mother died in September 2015 at Angal Hospital. She had gone for treatment but she never came back alive. She had six biological children. She was also looking after two dependants. At the time of her death five of her children were above eighteen and one of her dependants was below eighteen years. She

was doing everything for them. She used to provide school fess, clothing, feeding, medication, parental guidance, and so on. She also provided accommodation by the house his uncle had built her. She was doing her business of selling Mukene (silver fish) in Arua Market. He is holder of a certificate in Craft 1, plumbing. Four of his siblings were still in school. Two are still in school. One is in primary seven, the dependant Asianzu Harriet. the sixth plaintiff Asimba Fiona is in senior six. After her death there is no one to provide for them anymore. She was spending about two million shillings per month her children and dependants. I still feel the pain up to now because of all that she was doing for us. Although five of them were above eighteen and she had sponsored their education, they had not found jobs yet. They were still searching for employment but in vain. When his mother died, he felt the world had ended for them. He holds the hospital responsible because it is where she lost her life. He prayed court to help them secure compensation for her death and suggested seven hundred million shillings.

P.W.6 Wikole Simon Bob, the brother of the deceased was the Hospital Administrator of Angal St. Luke Hospital at the time of his sister's death. As hospital administrator he facilitated the work of the medical team through provision of supplies and the rest. He is a Health services manager at Masters Level with a degree from Uganda Martyrs University Nkozi. He also oversaw employee performance. He stated that the defendants are the legal owners of the hospital. His sister was admitted and operated for appendicitis and she never woke up. Being the next of kin, it is him who signed her consent form. The content was explained to him as acceptance of the outcome if everything is done very well. It is for acceptance for risks but not negligence. If the patient came with a pre-existing medical condition it would be covered. After the operation the doctor who performed it, Dr. Dan Okello, went to him and informed him that "I have operated your sister but the outcome is bad. This was after two or three hours after she had left the theatre. He then went to see her for the first time after she came out of the theatre, and found she was convulsing. The doctor had already told him that there was no hope of resuscitation. The doctor had told him that during the operation he realised dark blood on the operation site. He immediately alerted the anesthetic officer and he then realised there was no monitor connected to the deceased. The oxygen was connected but it was not being monitored and when he checked on her eyes, he found the pupil dilated and fixed meaning brain death. The cause of death is indicated on the death certificate is Hypoxia with brain esecma due to cardiopulmonary arrest. It was issued on 25th September 2015. As a next of kin he was part of the committee that made arrangements for her burial. the coffin cost, shs. 500,000/= while hire of public address system cost 250,000/=

He asked Dr. Odaga to convene a clinical audit into the death. The Audit team was convened. All the doctors in the hospital participated. There were four doctors. Augustine, Tugume, Justin and Ondaga. He too participated as the next of kin. The doctor who handled the operation presented what he did and what happened before, during and after the operation. It was attended by the doctor and the operating team; the doctor, nurses (theatre attendants- four or five of them) and the anesthetic officer (he is the only one who did not say anything though he was asked). The nursing team was asked to speak and they agreed with the doctor. After the open discussion, Mr. Onzima



was called for briefing. The conclusions and recommendations reached were contained in a report and he was given a copy of the report. No post mortem examination was done on the body since they did not request for it. I was requested to sign on the consent form as next of kin. The Doctor who conducted the operation did not tell him whether the appendix was successfully removed. They requested for an apology but it was not forthcoming. There was need to reprimand the staff and the board convened the disciplinary council.

P.W.7 Dr. Odaga Jimmy, testified that he is a surgeon in general surgery. He qualified in 2005 from Mbarara University of Science and Technology and did internship from Lacor Hospital. He practiced in Apac for one year and in December 2007 joined St. Luke Angal Hospital until August 2012 when he left to undertake a Masters programme at Makerere University. In 2015 June he returned to the hospital where he worked up to July 2016 Muni University as a lecturer. He also practices medicine at Arua Regional Referral Hospital as a honorary Surgeon seconded by the University.

In June 2009 he was the Acting Medical Superintendent up to 2012. In 2014, that appointment was terminated when another medical officer was substantively appointed in that position. He resumed as a medical officer on return. He signed the death certificate in respect of the deceased Angucia Lucy based on clinical diagnosis. The cause of death was heart and lung failure due to brain death for lack of oxygen. Since the patient was given anesthesia, she was supposed to be put on oxygen supply. During surgery the pulse oxymeter measures the amount of oxygen in the blood. It is attached to the fingers. If no oxygen is detected, the remedy is to re-insert the tube because it could be blocked. The oxygen source, the connectors and monitors should be checked. This is work of the anesthetist but the doctor supervises. The doctor made most of the explanation at the death audit meeting. The anesthetist did not say anything at that meeting. The meeting relied on the doctor for information regarding what transpired during the surgery. The monitors would have helped to detect the problem early if they had been connected.

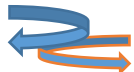
When they realized the patient had suffered a cardiac arrest, they started compressions to the chest or resuscitation drugs. They were supposed to record major occurrences but there were no records. The doctors were in the doctors' room but they were not invited. There was no follow up in the ward. The tube was left in the patient up to the ward and neither the anesthetist nor any of the surgical team made a follow up. There was no transition through the recovery room. The tube should have been removed at the table after reversing the anesthesia the drugs are short acting. In the ward the nurses should have continued to monitor using the available monitors. The nurses did not know how critical the patient was. The information on the chart was only the doctor's treatment. There were many but avoidable errors. The team did not meet the medical standards right from the start. There were three attempts at intubation and the difficulty could be a result of the expertise or anatomy of the patient. The alternative would be spinal anesthesia. The monitors were not in place. It is standard practice to have the monitors. She should not have been taken her off oxygen support. Lack of oxygen caused the brain death. The information contained in the report was from the surgical team; the doctor, the anesthetist and the theatre staff. The operating Doctor

was the only one who gave the meeting this information. The others contributed in the discussions. The anesthetist was requested to make a submission but he did not. A post mortem is done by a pathologist. A certificate of death is proof of a probable death. The post-mortem states the cause as established.

The purpose of a consent form means the doctor has explained the procedure, how it will be done, possible complications, and the patient has understood. Only adults sign such a form. It is routine as a matter of procedure. Complications during anesthesia may arise. A doctor should explain how it will be mitigated. There could be pre-op or intra-op complications. The anesthetic agents are drugs that can affect all organs hence the monitors to pick e.g. heart failure. If they occur intra-op, the anesthetist is the first person to detect the complication. The anesthetist is not on the surgeon side but on the anesthetic side. They are trained to inform the surgeon who is the lead person. He should stop the procedure and join the anesthetist in the resuscitation process. The anesthetist did not record the major occurrences. When complications occur, the primary thing is to save life. One of the importance of records is for continuity of care. After the life is saved, there has to be records of what was done. The next team therefore did not know what to do and what could have happened because there was no record. At the bottom of exhibit P. Ex. 3 of the first page are directive to the ward. The Audit Committee noted the absence of vitals recorded. The vitals include the pulse and blood pressure. Indication of respiratory arrest did not make sense in absence of an indicator of satisfactory condition at leaving the ward. The tube was left in the patient and thus indicated that the patient had not maintained breathing. If the recording is not done in the theatre it should be done in the recover. The columns in the form represent the intervals.

Clinical death Audit is mandatory in the event of every death that occurs in the hospital. Some hospitals do it monthly and others quarterly. The Committee interviewed the team involved which included the surgeon the other surgical staff and reviewed the medical forms from the theatre after surgery. In doing all this, they were guided by clinical standards which are policy statements by the Ministry of Health. They are the Uganda Clinical Guidelines and they also referred to medical text books. The anesthetist was part of the surgical team but he did not say anything. Most of the information the Committee relied on was from the operating doctor. He told the Committee how he detected lack of oxygen. Intubation is done in the presence of the doctor. That is why he was able to relate the difficulty that was experienced at that stage.

The death report should be issued by the attending Doctor, the one who was present when the patient died. This doctor may or may not be the surgeon. This was a clinical diagnosis and not a post mortem report. A post mortem report is not required by the guidelines. Where the cause of death cannot be explained by the clinician, a post mortem is mandatory. Recording on a patient chart is mandatory upon each review by a doctor. According to exhibit P. Ex. 1, on 8th September the admitting doctor omitted a full examination of the patient. The next entry was on 10th September. There is no entry for 9th September and the witness did not know why. If the patient was not in the ward then it should have been indicated. The audit team did not look at the pre-op

period for that relied on what the doctor said. Entries of the day before surgery should have been indicated on that form. It is unacceptable for a patient to leave the ward and go home and from home and go straight to theatre, save in emergencies. The nurses said they did not know what to do because the patient came with a tube from the theatre. The nurses too did not perform their work fully for they should have detected. She was brain dead in the theatre. After that point whatever is done thereafter would be pointless.

The doctor realised cardio and respiratory arrest. Resuscitation was attempted. They did chest compresses and gave drugs. The methods were not documented but they said they performed CPR. The patient was not supposed to be given to the nurses. The patient did not recover from the cardiopulmonary arrest. It is a patient who has recovered after CPR that is placed in intensive care. During the surgery, the doctor expressed his dissatisfaction with the anesthetist on account of; difficulty in intubation, not using the monitors and the anesthetist was not monitoring. It is the doctor who detected the cardio-respiratory arrest. He made those statements in the presence of the anesthetist before the audit team. The anesthetist was persuaded by the staff and management team to say something but he elected to keep quiet. The brain death resulted from negligence. If the brain is deprived of oxygen 3 -5 minutes a person would be dead. That was the close of the plaintiffs' case.

D.W.1 Dr. Daniel Okello, testified that he has practiced since 2009. He did internship training for one year and has worked for seven years. He graduated in June 2009 and stared working on 3rd or 4th July 2010. Before that he was on internship at Gulu Regional Referral Hospital as a general practitioner. He recalled that it was a Tuesday in August 2015, at around 4.00 pm while he was at the Trading Centre where he had gone to fix my shoes when the then Hospital Administrator Mr. Simon Wikole called him on phone saying he had a sick sister. I had briefly left my work station and went to the. He went straight to the female ward where he found a lady, Angucia Lucy, waiting in the duty room with an attendant. He asked her what the problem was, and took her history, she had a pile of medical forms. She pointed to the lower right side of the abdomen. He proceeded to do a full clerkship on that day.

He got to know her demography, the name age around 51 -52, she said she came from Arua and the next of kin was Simon Wikole, the then Hospital Administrator. He asked her why she came to the hospital and she said she had been brought by her brother for treatment. He took her history, did the examination and it revealed she had appendicitis. He placed her on intravenous antibiotics because she was running a fever from what appeared to be an infection from the appendicitis. She had had that problem for over a month. She was produced because she was refusing to get care. He admitted her and they preferred to be in a private ward. This meant they were to be attended to by the doctor in charge of the female ward. They instead went home.

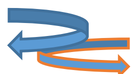
He went to the ward in the night and she was not there. The attendant told him she had returned home. The attendant said there was no space yet it was there and there were no bed sheets. He was not unhappy with the attendant. There was a break in the continuity of care because the drugs had

to be administered intravenously before, during and after the operation. He passed the information to Dr. Odaga Jimmy who was in charge of the female ward and the private wing. The next time he saw the patient was on Thursday morning the day she was to undergo surgery.

He had scheduled the surgery in consultation with the doctor in charge of the private wing. He admitted her on Tuesday and she spent a good part of Wednesday at home. Ideally there should have been a re-scheduling but they were under pressure from the patient and the Hospital Administrator to perform the surgery. He reviewed the patient in theatre but she was not on the table. She was fit and ready for the operation and the fever she had had before had gone down. He was no longer under pressure from the patient or the administration. He handed her over to the anesthetist and he did his test and gave a go ahead. They then went through the procedures leading to surgery.

After washing the hands with antiseptic he waited to start putting on the gown. The aesthetic stared the procedure of endo-trachea intubation, i.e. through the mouth. She would then be put on endo-ventilation (breathing through the machine). He was observing the intubation. It was done according to procedure except that the anesthetist had difficulty at intubation. He made three attempts. At first attempt he connected but the air was not going in. On second attempt it went to one lung. The third time he said we can go ahead. He could not establish what the problem was. Sometimes the airway gets constrained as a reaction to the tube. There was a monitor that was attached to the arm. It is was this witnesses' obligation to ensure that all vitals were ok. He admitted it was an oversight on his part not to check the vital readings. The anesthetist told him to go ahead with the surgery. He draped and asked the anesthetist whether he could make the incision and he if it could be done. When he cut, the blood had a dark colour. He asked the anesthetist what the circulation was. It was then that he put the machine on and circulation was established. The ventilator was on, the tube was in place but when the monitor was turned on the circulation of oxygen was low and that meant that the tube was probably not in the right place.

The time lag from the moment the tube was inserted to the time the monitor was turned on was about three minutes during which he was putting on the apparel as the anesthetist was preparing his side. When the blood indicated a lack of oxygen, he asked the anesthetist to check whether the lungs were getting oxygen and he found the patient was not breathing and the heart had stopped beating. He asked the anesthetist to remove the tube and re-intubate but at that time the airway had gone into spasms, it had already constricted and it was more difficult to re-intubate. He did CPR for about five minutes. He was trying something out of desperation. the patient was given adrenalin and she started breathing again but at a very low rate and the heart had started beating gain. He asked the nurse to open the eyes and the pupils were fixed and dilated and that is a sign of brain death. Even if some recovery of other vital functions was achieved, they would not support life again.



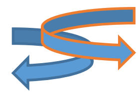
The team had come to the point where it had to all it could in the hope that something good would result, akin to a miracle. They finished the surgery although the patient was in a critical state. The patient was put in the recovery area on oxygen. She was then transferred back to the private ward. She was in the recovery room for about two hours. The nurses were instructed to monitor vital signs every fifteen minutes and to report to a doctor in case of complications. Two hours after the operation he was called back by the attending nurse and he was told the patient was twitchy. The oxygen circulation was again going low, fever had come in and there were no signs of recovery. He instructed that she gets back to oxygen and the airway should not be removed. He tried calling his supervisor but he had gone with the Administrator to Purongo. They said they were on the way back and the team should continue with the management.

He later explained to Dr. Odaga and the Administrator what had happened in the theatre and the condition of the patient and they went and saw the patient together. Dr. Odaga examined and recorded his findings on the medical form and recommended some strategies. He re-adjusted the tube and added more anti-biotics and the oxygen was to continue. The patient never improved. The central nervous system was not functioning and she was on brain stem functioning; breathing was erratic and rolling of the pupils. The cognitive function was non-operative. Two days after the surgery at about 4.00 or 5.00 pm she succumbed.

Under cross-examination, he stated that he appeared at the clinical audit. The deceased had been receiving treatment in other clinics in Arua and she had medical forms. She did not have a referral notes and medical forms from other hospitals are not kept in their records except referral notes. He would have kept that record had he known that litigation was likely. There were no bed-sheets at the time she was admitted. There was a breakdown in care. Ms. Salome Wikole was the attendant and she is wife to the hospital administrator and she was working in the pharmacy as a storekeeper. The attendant in the ward had several of the medications he had prescribed, which is contrary to standard practice since drugs should be kept and administered by nurses. On 8th September one gm of Ampicilin and Gentocymin was administered at her home by Zako Scovia. They could have disqualified the patient from surgery because of this break in treatment but she was fit.

Before intubation some drug is injected to paralyse the airway so that the tube can go in without resistance. It remains effective for a few minutes within which there should be a successful insertion. If it fails you put a face mask and bag the patient. That would be sustained for as long as the surgery goes on and the patient wakes up. He was faced with a personality clash in the theatre. The anesthetist was a retired Principal Anesthetist who had worked in Arua Hospital for many years but was recruited by Angal hospital to work on contract. But he had a big personality problem which all staff had learnt to tolerate. He would not readily respond to instructions. For the time he worked with him he was efficient save for that personality problem..

The surgeon is the head of the operating team. The anesthetist would supposedly be subordinate to him. The tube was not in the right place because the blood was dark coloured. He attended the death audit although he never saw the minutes afterwards. The team made findings but he has



never seen the report. If all that he testified to in court is in the audit report, he would though acknowledge the contents. The anesthetist was in the room but he refused to speak. The rest of the surgical team corroborated his version.

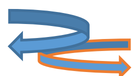
D.W.2 Tugume Bernard the Medical Superintendent of Angal St. Luke Hospital premises since July 2017 testified that he knew Angucia Lucy as a sister to the then Hospital Administrator Mr. Simon Wikole. She passed on at the hospital but he could not remember the year. He was involved in the audit meeting that was carried out after her death as a member in attendance. It was chaired by the then Medical Superintendent Dr. Odaga Jimmy. The purpose was to identify gaps if at all they existed in the service delivery system that led to her death. His role was to listen to the events that led to the death and discern whether there were any gaps that existed and derive solutions to prevent reoccurrence.

He only attended the meeting which took approximately two hours. He was not assigned any other tasks prior to that meeting. He was not aware whether any other member was assigned any other task. He reviewed the report of the Audit, exhibit P. Ex. 9 and Minute 04/26/09/2015 is about the findings. There were no other steps taken after the meeting. He was aware of two meetings in relation to this death. The first one was informing them of the audit meeting and deriving the people who would attend and the second was the one he attended. The documents were presented to the meeting by Dr. Daniel who was the one operating. The members looked at the admission Chart and the anesthetic monitoring chart. Everyone who was involved was present at the meeting. The meeting obtained all the information required from the personnel and the documents except the anesthetist who declined to say anything. The report is not disputed. It was brought out that the intubation had difficulty and the monitors had not been turned on at the commencement of the operation. that was the close of the defence case.

In their joint memorandum of scheduling, the parties agreed on the following issues for the determination of this court;

1. *Whether the defendant's agents were negligent in conducting the medical operation or procedure on the deceased.*
2. *What remedies are available to the parties in the circumstances?*

In his final submissions, counsel for the plaintiffs Mr. Renato Kania argued that the plaintiffs had proved that the defendants agents were negligent in that the cause of death was heart and lung failure caused by brain death due to lack of oxygen. This was primarily because the deceased was placed under anesthesia without external oxygen supply. Although the ventilator machine had been installed, the medical team did not attach a pulse oxymeter and was therefore unable to detect in time that there was no oxygen supply to the patient, most probably as a result of a faulty intubation. Having found that intubation was difficult after three attempts, they failed to devise alternative methods that were readily available. The testimony of P.W.7 on this errors was corroborated by that of D.W.1 and D.W.2. He cited the case of *Bolam v. Friern Hospital Management Committee,*



[1957] 2 All ER 118 at 121 regarding the standard of care required of medical practitioners and concluded that the medical team in the instant case had failed to meet that standard and were therefore negligent. As regards remedies, citing *Cuossens v. Attorney General [1999] 1 EA 40 at 46* and *Benham v Gambling [1941] 1 ALL ER 7 at 10*, he submitted that the plaintiffs should be awarded general damages for loss of expectation of life in the sunm of shs. 250,000,000/=. Citing *Gulbanu Rajabali Kassa v. Kampala Aerated Water Co. Limited [1965] EA 587* and *Jane Gaffa v. Francis X. S. Hatega, H.C.C.S No. 1158 of 1975*, he submitted that the plaintiffs should be awarded damages for loss of dependency using a multiplier of eight based on their respective age at the time of the death of the deceased, hence a sum of shs. 192,000,000/=. They should also be awarded special damages of shs. 6,781,000/=, interest on the decretal sum and costs.

In reply, counsel for the defendants Mr. Peter Rukwiya Nyero submitted that the cause of death was incorrect since the method used, clinical observation, did not take into account the fact that the deceased spent two post surgery days in the ward. The possibility of intervening causes was never ruled out and the procedure used in the death Audit was very unreliable considering that it focused only on the pre-op and intra-op procedures and not the post-op management and by reason of the fact that the Chairperson of the Committee Dr. Odaga was never called as a witness. The post surgical management of the patient involved her being put on oxygen and lack of oxygen supply to the brain therefore could not have been the cause of her death. The death audit team did not take into account that the deceased avoided monitoring after admission when she returned home and continued with self-medication. Lack of continuous monitoring before the surgical operations creates the possibility of death resulting from other complications which were never ruled out by a conclusive post mortem examination since none was done. All surgical operations involve a degree of risk and this was explained to the deceased prior to giving her consent (exhibit P. Ex. 2). When they realised the patient had developed complications, the team did all it could to resuscitate her. Citing *Sarah Watsemwa Goseltine and another v. Attorney General, H.C.C.S. No. 675 of 2006*, he argued that not every error of judgment made by a doctor may be classified as negligence. It must be proved that the health worker adopted a practice that no professional or ordinary person would have taken, which the plaintiffs have failed to prove.

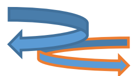
As regards the claim for the various heads of relief, he submitted that St. Luke Angal Hospital is a charity based hospital offering low cost medical care and solely relies on donations. The sums demanded by the plaintiffs are not supported by any cogent evidence and are exorbitant. Citing *Lusiya v. K.C.C. [1972] EA 240*, he submitted that contrary to established judicial practice, the dependants were never produced in court and their age was not ascertained. With regard to special damages, receipts proving a sum of only shs. 750,000/= were produced. He concluded that in the event of the defendants being found liable, the plaintiffs should be awarded only that sum as special damages, otherwise the suit should be dismissed with costs to the defendants.

First issue: Whether the defendant's agents were negligent in conducting the medical operation or procedure on the deceased.

Medical negligence is constituted by an act or omission by a medical professional that deviates from the accepted medical standard of care. Medical negligence occurs when a doctor, dentist, nurse, surgeon or any other medical professional performs their job in a way that deviates from this accepted medical standard of care. Medical professionals are required to conduct themselves at least in accordance with the standard of their professional peers, but they are not expected to guarantee the success of their procedures or the perfect safety of their patients. The test was articulated in *Bolam v. Friern Hospital Management Committee, [1957] 1 WLR 582, [1957] 2 All ER 118*, thus;

Where some special skill is exercised, the test for negligence is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising or professing to have that special skill. It is the duty of a professional man to exercise reasonable skill and care in the light of his actual knowledge and whether he exercised reasonable care cannot be answered by reference to a lesser degree of knowledge than he had, on the grounds that the ordinary competent practitioner would only have had that lesser degree of knowledge. This is not a gloss upon the test of negligence as applied to a professional man. That test is only to be applied where the professional man causes damage because he lacks some knowledge or awareness. The test establishes the degree of knowledge or awareness which he ought to have in that context. Where, however, a professional man has knowledge, and acts or fails to act in way which, having that knowledge he ought reasonably to foresee would cause damage, then, if the other aspects of duty are present, he would be liable in negligence by virtue of the direct application of Lord Atkins' original test in *Donoghue v Stevenson*. 'it is not enough to show that another expert would have given a different answer . . the issue is . . whether [the defendant] has acted in accordance with practices which are regarded as acceptable by a respectable body of opinion in his profession' and 'How do you test whether this act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man in the street. He is the ordinary man . . But where you get a situation which involves some special skill or competence, then the test of whether there has been negligence or not is not the test of the man on the top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.

Not every error of judgment made by medical professionals constitutes negligence (see *Sarah Watsemwa Goseltine and another v. Attorney General, H.C.C.S. No. 675 of 2006*). The test of professional negligence is the standard of the ordinary skilled man exercising and professing to have that special skill (see *Maynard v. West Midlands Regional Health Authority, [1985] 1 WLR 685, [1985] 1 All ER 635*). Doctors and other medical professionals have a duty to their patients, to provide treatment that is in line with the "medical standard of care," defined as the level and type of care that a reasonably competent and skilled health care professional, with a similar



background and in the same medical community, would have provided under the circumstances that led to the alleged malpractice. A doctor who professes to exercise a special skill must exercise the ordinary skill of his specialty. The true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care.

It is well settled that medical professionals have a duty to conduct their practice in accordance with the conduct of a prudent and diligent medical professional in the same circumstances. In the case of a specialist, such as a surgeon, the surgeon's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in that field. While conformity with common practice will generally exonerate medical professionals of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be so where the standard practice is fraught with obvious risks such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise.

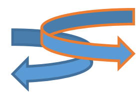
For the plaintiffs to succeed in an action of this nature, they must therefore prove that; (a) a doctor-patient relationship existed, (b) the medical professionals were negligent, (c) the medical professionals' negligence caused the death. It would be necessary for the court to be satisfied that the defendants vicariously failed to have or to exercise the knowledge, skill and understanding expected in accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances.

a. <u>Existence of the doctor / patient relationship</u>.

It is common ground between the parties that the deceased went to St. Luke Angal Hospital on 8th September, 2015 complaining of stomach pains in the lower right side of the abdomen. She was attended to by D.W.1 Dr. Daniel Okello, who took her history, reviewed the pile of medical forms she had in her possession. He proceeded to do a full clerkship and diagnosed appendicitis thereby recommending surgery. He placed her on intravenous antibiotics to stem a fever from what appeared to be an infection from the appendicitis. He admitted her to a private ward in the hospital. He undertook a surgical operation on her on 10th September, 2015 at the hospital theatre. I am therefore satisfied that the plaintiffs have proved to the required standard that a doctor / patient relationship existed between the deceased and D.W.1 Dr. Daniel Okello.

a. <u>Negligence of the medical professionals</u>.

It is common ground between the parties that St. Luke Angal Hospital is a facility under the stewardship of the defendants and it is not disputed that all staff employed at that health facility are in law agents of the defendants. According to the decision in *Muwonge v. Attorney General [1967] EA 17*, an act may be done in the course of employment so as to make the master liable

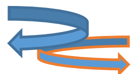


even though it is done contrary to the orders of the master, and even if the servant is acting deliberately, wantonly, negligently, or criminally, or for his own behalf, nevertheless if what he did is merely a manner of carrying out what he was employed to carry out, then his master is liable. For the defendant's to be found vicariously liable, it must be established that the medical professionals at the hospital failed to have or to exercise the knowledge, skill and understanding expected in accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances.

Most medical procedures, treatments or tests involve some risk. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo such. It is the medical professionals' responsibility to give the patient information about a particular treatment or procedure so that the patient can decide whether to undergo the treatment, procedure, or test. Risks that are statistically likely enough to make disclosure worthwhile should be disclosed. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. One of the factors relevant to, but not decisive of, the question of what a reasonable medical practitioner ought to have foreseen is the state of medical knowledge at the time when the duty should have been performed. A reasonable medical practitioner cannot be expected to have foreseen an event wholly un-comprehended by medical knowledge at the time. The law demands no more than what was reasonable in all the circumstances of the case.

In the instant case, the plaintiffs tendered in evidence exhibit P. Ex. 2 titled "Pre-operative Preparation and Consent form." It is a standard from that has provision by way of blank spaces for inserting information such as; the patient's demographic data, diagnosis, pre-operative procedures done, pre-operative medication and two options towards the bottom requiring only a tick to the statement "Consent for procedure Obtained (Yes / No)." Under the space reserved for "Pre-operative Procedures Done," were inserted the following handwritten remarks; "Consent gained from the patient. IV line passed *in situ*. Catheter *in situ*." There is no indication anywhere on the form as to any information given to the patient relating to the nature and range of the more or any significant risks involved in the suggested surgical procedure for which her consent was being sought. The information on this form does not meet the requirement of proof that the deceased gave her informed consent to the surgical procedure.

If a patient is to undergo a surgical procedure it is necessary for such patient to receive information from the medical team about the benefits and the risks of the procedure prior to the procedure being carried out. After having heard the possible risks and benefits, if the patient deems that they wish to go ahead with the surgical procedure they must sign a consent form, outlining the nature and range of the more or all significant risks involved in the suggested surgical procedure of which they have been fully advised, whereby their signature would then signify that they have understood



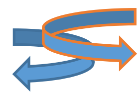
and accepted the potential risks "inherent" in the procedure. This is what informed consent requires. Failure to fully brief a patient about the possible ill effects of the procedure prior to the surgery and thereby depriving the patient of the ability to give his or her full informed consent, could of its own be a basis for a claim of medical negligence.

Common law imposes a duty on a medical practitioner to warn a patient of material risks inherent in the proposed surgical procedure; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This standard does not deal with the foreseeability of the risk in question, save to the extent that the risk must be "inherent" in the procedure. In this respect the general law of negligence still applies. Once there is a risk which is generally known to the profession, there is a duty to warn. In the circumstances of this case, in the absence of any evidence, written or oral as to the nature and range of the inherent risks involved in the surgical procedure of which the deceased is alleged to have been advised, there is no basis for the finding suggested by counsel for the defendants that by signing exhibit P. Ex. 2, she gave her informed consent to the surgical process or that she accepted the potential risks involved.

Moreover, even though the patient's informed consent dictates that the patient is aware that certain complications can occur, it does not mean that this covers negligent techniques or mistakes that occur during the surgery, that are not inherent in the procedure itself. The conduct of medical professionals must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence. The conduct of the procedure must reflect the current state of knowledge as to the risks involved in the use of that procedure. However, the standard to be observed by medical practitioners is not to be determined solely or even primarily by medical practice. Rather, it is for the courts to judge what standard should be expected from the medical profession (see *Maynard v. West Midlands Regional Health Authority, [1985] 1 WLR 685, [1985] 1 All ER 635*).

In his own admission, D.W.1 Dr. Daniel Okello as head of the surgical team in the theatre at the material time did not take the trouble to ascertain and record readings of the vital signs before making the first incision. Had he done so, he would have discovered that although the ventilator machine had been installed, the anesthetist had not attached the pulse oxymeter and would therefore be unable to detect in time that there was no oxygen supply to the patient and advise him accordingly during the operation. He chose instead to rely on the anesthetist verbal confirmation for commencement of the surgical procedure and by the crude method only of placing his ear near the chest of the patient to detect breathing.

I do not find this omission to be inherent in the surgical process. In any event, it is inconceivable that in signing exhibit P. Ex. 2, the deceased was advised that the risk of not attaching the pulse



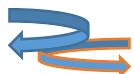
oxymeter before commencement of the surgery was so inextricably involved with that procedure and that when she was so advised, she did not attach significance to it. The more reasonable conclusion to draw is that she was either not advised so since a reasonable person in her position, if warned of such a risk, would be likely to attach significance to it or that it was not one of the inherent risks involved in the procedure. Either way, it was not one of the risks understood and accepted by her as a potential risk when she signed exhibit P. Ex. 2.

The factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. I have considered the fact that as a result of the anesthetist's' failure to attach a pulse oxymeter, he was unable to detect in time that there was no oxygen supply to the patient, most probably as a result of a faulty intubation. Having found that intubation was difficult after three attempts, the team failed to devise alternative methods that were readily available for conduct of the surgical operation in a safer manner. The team not only had the necessary equipment in place within their reach and failed to use it appropriately, but also had the knowledge and skill to adopt alternative methods which they inexplicably never did.

I do not find this to be consistent with exercise of standard of knowledge, skill and understanding expected in accordance with the standards of the medical profession as would be provided by reasonably competent and skilled health care professionals, with a similar background and in the same medical community, under the circumstances. Their efforts to resuscitate the patient later were the proverbial too little too late. The omissions that occurred in the recovery room and the private ward were insignificant since at that time the deceased was already brain dead. I am therefore satisfied that the plaintiffs have proved to the required standard that two of the key defendant's medical professionals involved in the surgical procedure, D.W.1 Dr. Daniel Okello and the anesthetist, were negligent.

a. <u>The medical professionals' negligence caused the death</u>.

The surgical operation was performed on 10th September, 2015 yet the deceased died on 12th September, 2015, two days after the surgery. In circumstances such as this, where there is a significant degree of remoteness between the negligent act or omission and the result, in this case death, where the eventual result may be the product of additional factors which are more directly connected than is the conduct of the tortfeasor, the function of the law of causation is to identify the conditions under which the result may nevertheless be attributed to the tortfeasor. An intervening cause will break the chain of causation if it is independent of the acts of the tortfeasor and so potent in causing the death, but a tortfeasor will be held responsible for the final outcome if it is a substantial and operating result of what the tortfeasor did.



The common law has always recognised that there are two fundamental questions involved in the determination of causation in tort: the first relates to the factual aspect of causation, namely, the aspect that is concerned with whether the negligent conduct in question played a part in bringing about the harm, the subject of the claim. The second aspect concerns the appropriate scope of liability for the consequences of tortious conduct. In other words, the ultimate question to be answered when addressing the second aspect is a normative one, namely, whether the defendant ought to be held liable to pay damages for that harm. Causation will be established if, on the balance of probabilities, the harm would not have occurred "but for" the defendant's breach of his or her duty of care.

At common law, if it is an established fact that conduct of a particular kind creates a risk that injury will be caused to another or increases an existing risk that injury will ensue; and if the two parties stand in such a relationship that the one party owes a duty not to conduct himself or herself in that way; and if the first party does conduct himself or herself in that way; and if the other party does suffer injury of the kind to which the risk related; then the first party is taken to have caused the injury by his or her breach of duty, even though the existence and extent of the contribution made by the breach cannot be ascertained (see *McGhee v. National Coal Board [1973] 1 WLR 1*). The precise and particular character of the injury or the precise sequence of events leading to the injury need not be foreseeable. It is sufficient if the kind or type of injury was foreseeable, even if the extent of the injury was greater than expected.

If at the time of death, effects of the original act or omission are still an operating and substantial cause, then the death can properly be said to be the result of the act or omission, albeit that some other cause of death is also operating. Only if it can be said that the original act or omission is merely the setting in which another cause operates, can it be said that the death does not result from the act or omission. In other words, only if the second cause is so overwhelming as to make the original act or omission merely part of the history can it be said that the death does not flow from the act or omission (see for example *R v. Smith [1959] 2 QB 35; Cheshire v R. [1991] 3 All ER 670*and *People v. Lewis 57 Pac 470 (1899) (Cal SC)*.

In the instant case, according to the Medical Certificate of Cause of Death, exhibit P. Ex. 4, the deceased died of cardiopulmonary arrest with brain ischema as a result of prolonged hypoxia. It was the testimony of both P.W.7 and D.W.1 that the deceased was confirmed brain dead even before she was taken off the operation table in the theatre. She remained in this irreversible vegetative state for the next two days until her death. She became brain dead as a result of the defendants' negligence. That there could have been some other intervening cause remains a remote, fanciful but not in any way probable possibility, in light of the evidence before court. There certainly is no evidence of a supervening cause of such a nature as was capable of breaking the chain of causation. I am therefore satisfied that the plaintiffs have proved to the required standard that the defendants' negligence during the surgical operation was an operating and substantial cause of the deceased's death. Therefore, even if some other cause of death could also have been operating, which has not been proved, her death can properly be said to be the result of the

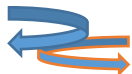
negligent acts and omissions of the defendants' agents while she was in the operation theatre undergoing the surgical operation.

Second issue: <u>What remedies are available to the parties in the circumstances?</u>

In their plaint, the plaintiffs seek an award of general and special damages for loss of expectation of life, loss of dependency, bereavement, interest on the ward and costs. The principles upon which court must assess general damages for loss of dependency were well laid down in *Gulbanu Rajabali v. Kampala Aerated Water Co. Ltd [1965] E.A. 587* and in *Jane Gaffa v. Francis X.S. Hatega, H. C. Civil Suit No. 1150 of 1975*. These principles generally require that:- the court takes the last earnings of the deceased person as the starting point. The Court may consider the deceased's earnings at the time of death, the last known earnings if unemployed, and potential future earnings. Out of those earnings is assessed the pecuniary benefit regularly accruing to the defendants; court then determines the appropriate multiplier. This is the number of years during which the benefit of the dependency would have continued to be available to the dependants if the deceased had lived beyond the date of death and continued making earnings; the determination of the multiplier is guided by the age at which the deceased died and what his or her working life expectancy would have been had he or she not met his or her demise in the fatal accident; the total lost dependency or benefit is obtained by multiplying the annual lost benefit by the multiplier; the total lost dependency benefit is then apportioned among the dependants. If the deceased was the husband, the widow is entitled to a more substantial share of the damages in recognition of the fact that her dependency upon her husband's support would ordinarily continue longer than that of the children. If the wife was the bread winner in the family and she is the one who met her death, the surviving dependant husband would be treated in a similar manner. In apportioning the damages court would award the younger children relatively larger portions in recognition of the fact that their dependency, upon the deceased, would have lasted longer than that of older children.

General damages for loss of dependency include loss of wages and future earnings, loss of consortium, loss of support, and loss of companionship. A child might be entitled to compensation for the personal loss of a parent as well as the amount of financial support the child would have received from the deceased parent while a minor, a wife would recover damages for loss of her husband's love and companionship and a lifetime of expected support, while a parent would be limited to damages for loss of companionship but not support. may recover medical and funeral expenses in addition to the amount of economic support they could have received if the decedent had lived and, in some instances, a sum of money to compensate for grief or loss of services or companionship.

Determining the amount of damages in a wrongful death action requires taking into account of many variables. To compute compensation, the income that the deceased could have earned may be multiplied by the number of years he or she most likely would have lived and can be adjusted for various factors, including inflation and other imponderables of life. The court may be guided



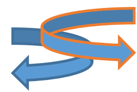
by the life expectancy of particular groups identified by age or gender. The decedent's mental and physical health, along with the nature of his or her work, may also be taken into consideration.

In the instant case, it was the testimony of P.W.2 Ocokoru Zena, P.W.3 Candiru Grace, P.W.4 Onzima Nyakuni Ben and P.W.5 Ajili Peter, the deceased was a sole proprietor in the silver fish trade. Her monthly turn over averaged at 30 sacks full per month out of which she earned an average of shs. 165,000/= per sack hence a total of shs. 4,950,000/= as her gross income per month. In the absence of any records verifying this to have been her average income over any considerable period of time, I consider this to be a mere estimate of her income. I have as well taken into account the testimony of her brother P.W.4 Onzima Nyakuni Ben, her income was inadequate to meet the school fees requirements of her school going children and from time to time her brothers would give her financial support. The said gross monthly income is therefore is on the higher side. A sum of shs. 3,000,000/= appears to be a more reasonable estimate of her average gross monthly income.

According to the Medical Certificate of the Cause of Death, exhibit P. Ex. 4, the deceased was 51 years old at the time of her death. It is generally accepted that a person in Uganda would work up to 60 years both in the formal and informal sector (see *Awino and four others v. Luwaga and another, H. C. Civil Suit No. 139 of 2006*). Therefore, all things being equal, she would have had another nine or so years of active self employment. However, considering the imponderables of life, the exigencies of her trade that required her to travel long distances to the landing site and back to Arua frequently and the toll such physical exertion would have had on her life, the fragility of her business as a sole proprietor that was demonstrated by the more or less instant collapse following her death, the multiplier of eight years suggested by counsel for the plaintiffs is on the higher side. I am inclined instead to apply a multiplier of five years. Consequently, with an annual gross income estimated at shs 36,000,000/= her gross income in the five year period would be shs. 180,000,000/=

It was the testimony of P.W.4 Onzima Nyakuni Ben that at the time of her death, she was in the process of constructing her own house. She was therefore spending a considerable part of her income on that project. She also employed P.W.3 Candiru Grace and must have been paying her salary from that income. Her other business overheads as well would be drawn on that income. She would also use it for her own needs and sustenance, including medication as evidenced by the medical forms she presented to D.W.1 Dr. Daniel Okello on 8th September 2015 when he examined her and diagnosed appendicitis. In light of all that, it would seem that she was spending only a half of her income on the sustenance of the plaintiffs and her other defendants.

No amount of money can ever compensate for a life lost in the circumstances of this case. No amount of money can ever console the family of the deceased for their bereavement and deep sense of loss. The court can only determine a sum appropriate to ease some of the financial hardships that befell the family as a result of the sudden loss of life of their bread winner and to assuage, to the extent reasonably possible under the peculiar facts of the case, their deep sense of loss. Therefore, bearing in mind and all the principles set out earlier, the loss of dependency and



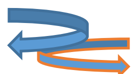
expectation of life proved by the plaintiffs is shs. 90,000,000/= and that sum is accordingly awarded as general damages.

As regards special damages, not only must they be specifically pleaded but they must also be strictly proved (see *Borham-Carter v. Hyde Park Hotel [1948] 64 TLR*; *Masaka Municipal Council v. Semogerere [19982000] HCB 23* and *Musoke David v. Departed Asians Property Custodian Board [1990-1994] E.A. 219*). The plaintiffs pleaded expenditure of shs. 6,781,000/= as funeral expenses but produced receipts for only a total of shs. 750,000/=. It is trite law though that strict proof does not necessarily always require documentary evidence (see *Kyambadde v. Mpigi District Administration, [1983] HCB 44; Haji Asuman Mutekanga v. Equator Growers (U) Ltd, S.C. Civil Appeal No.7 of 1995* and *Gapco (U) Ltd v. A.S. Transporters (U) Ltd C. A. Civil Appeal No. 18 of 2004*). I have scrutinized exhibit P. Ex. 5 which is a tabulation of the various items on which expenditure is said to have been incurred. None of the items listed is can be categorized as unnecessary. The majority of the items are not of the nature which in the ordinary conduct of affairs of this nature, receipts or other documentary proof of expenditure would be expected. The amounts do not appear to be exaggerated in any way. I am therefore satisfied the evidence before court is cogent and sufficiently proves to the required standard that the plaintiffs incurred that expense. The plaintiffs are accordingly awarded shs. 6,781,000/= as special damages.

It was the testimony of P,W,4 that the first plaintiff Kasaira Freda now 32 years old was at the time undertaking a secretarial course, the second plaintiff Ajili peter is now 28 years old was undertaking a plumbing course, the third plaintiff is now aged 26 years, the fourth plaintiff Nancy Akuje is now aged about 23 years was in her third year of tertiary education. The fifth plaintiff Joan Masinda is about 21 years old. The last born, Fiona Asimba was in Senior Four at the time. The deceased also had two dependant nieces; Brenda aged 24 years and Asia aged about 11- 12 years and is now in primary seven. None of her children had been able to find gainful employment and this they all depended on her. In his final submissions, counsel for the defendant contended that since only the second plaintiff testified in court and court did not have the opportunity to see and verify the age of the rest of the plaintiffs, they do not merit any award.

I have considered the authority cited by counsel. The decision appears to have been based on the peculiar facts of that particular case and cannot be said to have laid down a principle of law of general application. During the cross-examination of all the plaintiffs' witnesses, the authenticity of the stated ages was never brought in issue as to require specific proof. In any case, the existence in fact and age of the various family members and dependants named does not go to the quantum of general damages to be awarded by court but only to the apportionment of the award among them. I have not been presented with any evidence suggesting that the named plaintiffs and dependants do not exist in fact or that their respective ages were misstated. To find to the contrary would be against the weight of the evidence before me.

Following the decision in *Jane Gaffa v. Francis X.S. Hatega, H. C. Civil Suit No. 1150 of 1975*, the court is required to apportion the award of Shs. 90,000,000/= among the plaintiffs guided by



the principle that in apportioning the damages, court should award the younger children relatively larger portions in recognition of the fact that their dependency, upon the deceased, would have lasted longer than that of older children. The general damages awarded to the plaintiffs are accordingly apportioned as follows: the minor will take 60% of the award, the adult dependants will take 30% of the award to be shared equally among them and the dependants and 10% of the award is to be shared between the dependant relatives, the minor taking two thirds of that and the adult one third, hence;- Plaintiff No. 1. Kasaira Freda: she was 32 years old at the time undertaking a secretarial course, was unemployed and still fully dependent upon support from her mother. She is awarded Shs. 5,400,000/=.

Plaintiff No. 2, Ajili peter; he is 28 years old and had completed a course in plumbing but was unemployed and still fully dependent upon support from her mother. He is awarded Shs. 5,400,000/=.

Plaintiff No. 3, Harriet Nanzoni; she was aged about 26 years, unemployed and fully dependent upon support from her mother. She is awarded shs. 5,400,000/=.

Plaintiff No. 4, Nancy Akuje; she was aged about 23 years and in her third year of tertiary education. She fully dependent upon support from her mother. She is awarded shs. 5,400,000/=.

Plaintiff No. 5, Joan Masinda; she was aged about 21 years old, unemployed and fully dependent upon support from her mother. She is awarded Shs. 5,400,000/=.

Plaintiff No. 6, Fiona Asimba; was the youngest of the deceased's children at 15 years of age and still in school in Senior Four at the time, dependent entirely upon the deceased. She is awarded shs. 54,000,000/=.

Dependant No. 1, Brenda.

She is aged 24 years and was fully dependant on the deceased. Being an adult dependant relative, she is awarded Shs. 3,000,000/=

Dependant No. 2, Asia

She is aged about 11- 12 years and is now in primary seven. Being a minor dependant on her deceased Aunt, she is awarded Shs. 6,000,000/=

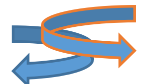
In summary, the court makes the following awards;-

a. General damages of shs. 90,000,000/=

b. Special damages of shs. 6,781,000/=

c. Interest on the awards in (a) and (b) above at the rate of 8% per annum from the date of judgment until payment in full.

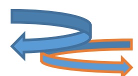
d. The costs of the suit



Stephen Mubiru

Judge,

26th October, 2017.



APPENDIX TWO. CEHURD & Anor v. A.G (2011)

THE REPUBLIC OF UGANDA

IN THE CONSTITUTIONAL COURT OF UGANDA AT KAMPALA

CONSTITUTIONAL PETITION NO. 64 OF 2011

1. CENTRE FOR HEALTH, HUMAN RIGHTS AND DEVELOPMENT (CEHURD)

2. IGA DANIEL PETITIONERS VERSUS

THE ATTORNEY GENERAL RESPONDENT

CORAM:

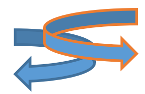
HONORABLE MR. JUSTICE REMMY KASULE JCC HONORABLE MR. JUSTICE ELDAD MWANGUSYA JCC HONORABLE LADY JUSTICE FAITH MVVONDHA JCC is

HONORABLE MR. JUSTICE RICHARD BUTEERA JCC HONORABLE LADY JUSTICE SOLOMY BALUNG1 BOSSA JCC

JUDGMENT OF COURT

The Center for Health, Human Rights and Development (CEHURD) (hereinafter referred to as the Center) is a Ugandan not-for-profit company limited by guarantee. It works towards ensuring an effective, equitable, people centered public health system that ensures the full realization of the right to health and promotes respect for human rights. CEHURD filed this petition contesting the constitutionality of laws, practice and usage towards persons with mental disabilities in the *criminal justice system embodied in the provisions of sections 45(5) and 86(2) of the Trial on Indictments Act (TIA) Cap 23 and section 130 of the Penal Code Act (PCA) Cap 120.*

In their petition, the petitioners allege that Uganda has ratified a wide range of international and regional human rights treaties relating to protection of the rights of persons with mental disabilities, including the United Nations Convention on the Rights of Persons with Disabilities and the African Charter on Human and People's Rights. That notwithstanding, the provisions of sections: 45(5), 82(6) of the Trial on Indictments Act and Section 130 of the Penal Act regarding the procedure in



case of insanity or other incapacity of an accused person or the victim and derogatory language used under Section 130 of the Penal Act are unconstitutional in as far as they run contrary and against Articles 20, 21(1), (2) and (3), 23, 24, 28 and 35 of the Constitution of the Republic of Uganda.

More specifically, the Petitioner alleges, inter alia that;

1. Section 82(6) of the Trial on Indictments Act is discriminatory in so far as it provides that if the accused is acquitted, he or she shall be immediately discharged from custody unless he or she is acquitted by reason of insanity thereby setting different treatment between other people and persons with mental disabilities contrary to Article 21 of the Constitution;

2. Section 45(5) of the Trial on Indictments Act adjudges a person who is not proven guilty as a criminal by referring to him as a criminal lunatic contrary to Article 28(3) (a) of the Constitution

3. Section 130 of the Penal Code Act is unconstitutional so far as it refers to persons with mental disabilities as idiots and imbeciles as the same discriminates on the ground of disability contrary to Article *21 of the Constitution.*

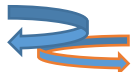
4. Section 130 of the Pencil Code Act is unconstitutional in so far as it refers to persons with mental disabilities as idiots and imbeciles and as such subjecting them to inhuman and degrading treatment contrary to Articles 24 and 35 of the Constitution.

5. To the extent that mental illness is a disability, the practice of detaining persons regarded as mentally ill as enumerated in section 82(6) of the Trial on Indictments Act and without due process constitutes discrimination by the section failing to meet the standards of anti-discrimination and equal protection of the law contrary to Article 21 of the Constitution.

6. The implementation of the above sections of the Trial on Indictments Act and the Pencil Code Act, and the conditions, under which persons with mental disabilities are detained under those Acts, together constitute violations of respect for human dignity of persons with mental illness contrary to Article 21of the Constitution.

7. The impugned sections referred to above are by virtue of Articles 35 and 45 of the Constitution contrary to and against the spirit of the international legal instruments which Uganda has ratified, particularly the United Nations Convention on the Rights of Persons with Disabilities which guarantees the rights of persons with disabilities.

8. The above cited provisions of the Trial on Indictments Act and the Penal Code Act fail in themselves to promote the dignity, respect, autonomy and nondiscrimination of people with mental disabilities or to incorporate safeguards against abuses related to involuntary admission and treatment.



9. The Constitution is the supreme law of the land under Article 2(1) and sections 45(5) and 82(6) of the Trial on Indictments Act are inconsistent with and in contravention of the Constitution and should be struck down.

The parties filed a joint scheduling memorandum and asked this Court to resolve the following issues;

1. Whether sections 45(5), 82(6) of the Trial on Indictments Act contravene the right to liberty and freedom from discrimination of the persons with mental disabilities guaranteed under Articles 23 and 21 of the Constitution.
2. Whether section 130 of the Pencil Code Act contravenes the right to dignity of persons with mental disabilities guaranteed under Article 24 of the Constitution.
3. Whether section 130 of the Penal Code Act contravenes the right to freedom from nondiscrimination guaranteed under Article 21 of the Constitution

At the hearing, Counsel Kabanda David appeared for the Petitioners while Counsel Kosiya Katsibayo, a State Attorney, represented the Respondent. Counsel for the Respondent at the outset informed Court that he was not opposing the Petition. Counsel argued issues 1 and 3 together and issue 2 separately. We have resolved issue no. 1 first and resolved issues 2 and 3 together.

Submissions of the parties

Counsel for the Petitioner submitted that;

The state has failed to protect the rights of persons with mental disabilities by maintaining sections 45(5) and 81(6) of the Trial on Indictments Act (cap 23) and section 130 of the Penal Code Act (Cap 120) which violate the rights of persons with mental disabilities in respect of the procedure they prescribe in case of the insanity or other incapacity of an accused person.

Uganda has ratified a wide range of international and regional human rights treaties related to the enjoyment of human rights on equal basis and without discrimination, particularly on the ground of disability. Equality and freedom from discrimination are guaranteed under the Constitution.

Under Article 35 of the Constitution, the State and society are obliged to take appropriate measures to realize the full mental and physical potential of persons living with disabilities. Mental illness was a disability under Section 2 of the Persons with Disabilities Act "Disability" was also defined under the same section. Discrimination against persons with disabilities was prohibited by Article 35 of the Constitution.

Regarding section 45(5) of the Trial on Indictments Act, the letter and spirit of section 45(5) of the Trial on Indictments Act is that it presumes criminality instead of innocence by using the words "criminal lunatic". Article 28(3) (a) of the Constitution enshrined the principle of presumption of innocence. Section 45(5) of the Trial on Indictments Act contravenes the presumption of innocence in this regard. Furthermore, the word "lunatic" was dehumanizing, and devoid of any form of dignity. Mentally ill persons have a right to human dignity.

Regarding section 82(6) of the Trial on Indictments Act, Counsel for the Petitioner submitted that it sets and gives different treatment to other persons and persons with mental illness by virtue of their disability contrary to Article 21 of the Constitution.

On the right to liberty, Counsel submitted that section 82(6) of the Trial on Indictments Act violates the right to liberty of an acquitted person because of insanity. He prayed for an order that the acquitted person should not be kept in custody because of insanity. Such person should be referred to a mental health facility.

Sections 45(5) and 82(6) of the Trial on Indictments Act set a different standard in the criminal justice system and give different treatment to 5 other people in contrast to persons with mental illness. This amounted to discriminating against persons with mental illness contrary to Article *20 of the Constitution.* Counsel called for an expert body to be set up to review persons with mental disability so that they are not put in jail. He also prayed that both sections be declared null and void.

On section 130 of the Penal Code Act, Counsel submitted that the words "idiot" and "imbecile" used in that section were derogatory in nature and should not be on the statute books. Counsel prayed that the section be found to contravene Article 24 of the Constitution.

He prayed that section 130 of the Penal Code Act be found in contravention of Article 24 of the Constitution in as far as the language in it was derogatory.

Counsel for the Respondent on his part:-

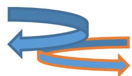
* Submitted that the Respondent concedes that Uganda has ratified a wide range of international and regional human rights treaties related to the protection of the right of persons with mental disabilities, including the United Nations Convention on the Rights of Persons with disabilities and the African Charter on Human and People's Rights.

He did not however agree that section 82(6) of the Trial on Indictments Act violates the right to liberty of a person with a mental illness.

On setting up an expert body, he submitted that this was a huge and broad task. However, he prayed that court should order that the laws be reviewed to create clarity on how people with insanity should be handled.

Preliminary observations

There is no dispute between the parties as to what is at stake in this petition. In fact, learned Counsel for the State concedes to the Petition. In effect, this means that he agrees to what is stated in the Petition and supporting evidence in the accompanying affidavits of Mulumba Moses; that the impugned provisions are discriminatory against people with mental disabilities and do not afford them equal protection. The provisions simply prescribe detention of mentally disabled persons for



long and indefinite periods without subjecting such detention to due process. They also denigrate the personal integrity and dignity of mentally disabled persons by referring to them as “idiots” and “imbeciles”. They therefore contravene the stated provisions of the Constitution.

Constitutional principles

In spite of the concessions made by learned Counsel for the Respondent on the alleged violations, it is incumbent upon this court to examine the language and substance of the impugned sections scrupulously, so as to determine whether they violate the Constitution and whether or not this Court should grant the reliefs sought. In this task, Court is guided by the following constitutional principles;

- *Equal protection of the law*
- *Due process*

The Court is also guided by the following applicable International Instruments namely; the Universal Declaration of Human Rights 1948, Article 1, the International Covenant on Civil and Political Rights (ICCPR) Article 14(1), the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Article 2, 5, 14, 15, and 17, and the African Charter on Human and Peoples Rights Article 2, 3, 5 and 6. The same are set out here below:-

Article 1 UDHR:

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 14(1) ICCPR:

All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligation in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.

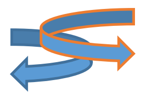
Articles of UNCRPD

Article 2: Definitions

“Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.

Article 5: Equality and non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equals benefit of the law.



Article 14: Liberty and Security of the person

1. States Parties shall ensure that person with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others,[30]

a. Entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principals of this Convention, including by provision of reasonable accommodation.

Article 15:

1. No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medial or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 17:

Every person with disabilities has a right to respect for his or her physical

and mental integrity on an equal basis with others.

Articles of the African Charter:

Article 2:

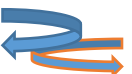
Every individual shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, color, sex, language, religion, or any other opinion, national or social origin, fortune, birth or other status.

Article 3:

Every individual shall be equal before the law.

Every individual shall be entitled to equal protection of the law

Article 5:



Every individual shall have the right to the respect of dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man, particularly slavery, slave trade, torture, cruel, inhuman and degrading punishment and treatment is prohibited.

Article 6:

Every individual shall have the right to liberty and to the security of his person.

No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained.

We note that all the above international and regional instruments have as one of their core principles respect for human rights and fundamental freedoms without discrimination. The UDHR stipulates that all human beings are born free and equal in dignity and rights. The ICCPR and the African Charter provide for equality before the law and equal protection of the law and non-discrimination. The right to liberty and security of persons is guaranteed by both the ICCPR; the UNCRPWD and the African Charter.

The Vienna Declaration and Program of Action 1993 captured it aptly when it declared that "all human rights are universal, indivisible, interdependent, and interrelated." Indeed, the above principles are enshrined in the various articles of the 1995 Constitution quoted throughout this judgment.

Specific protection is given to people with disabilities particular note of

Article 35 of the Constitution. It provides;

"35(1) Persons with disabilities have a right to respect and human dignity, and the State and society shall take appropriate measures to ensure that they realize their full mental and physical potential.

(2)..."

We also note that section 2, which is the interpretation section of The Persons with Disabilities Act, 2006 defines a person with disability. It also defines "Disability". It provides:

Interpretation

In this Act, unless the context otherwise requires-

("Person with disability " means a person having physical, intellectual, sensory or <u>mental impairment</u> which substantially limits one or more of the major life activities of that person.

"Disability" means a substantial functional limitation of daily life activities caused by physical <u>mental</u> or sensory impairment and environment barriers resulting in limited participation (emphasis ours)

From the above definitions, we conclude that mental illness is a disability under Section 2 of the Persons with Disabilities Act of2006.

Resolution of issue 1

With the above observations in mind, we now move to resolve the issues. Counsel for the Petitioner challenged the provisions of Section 45(5) of the Trial on Indictments Act as being unconstitutional. It is important to appreciate the meaning and context of the entire section 45.

Section 45(1) of the Trial on Indictments Act provides;

Inquiry by the court as to the insanity of the accused _

(1) When in the course of a trial the High Court has reason to believe that the accused is of unsound mind and consequently incapable of making his or her defence, it shall inquire into the fact of such unsoundness.

We note that the subsection requires a court to conduct an inquiry as to the insanity of an accused person to establish whether he/she is of unsound mind and consequently incapable of making his/her defense. This in our view requires medical evidence, preferably from a psychiatrist, regarding the status of the mind of the accused. The accused on his/her part, if he/she is able, should also be given an opportunity to be heard. The issue of due process arises with the subsequent sub-sections of Section 45. But first, we need to address the meaning of due process.

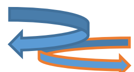
Black's Law Dictionary, in its sixth edition, at page 500, defines "due process";

Due process of law implies the right of the person affected thereby to be present before the tribunal which pronounces judgment upon the question of life, liberty, or property in its most comprehensive sense; to be heard by testimony or otherwise, and to have the right of controverting by proof, every material fact which bears on the question of right in the matter involved. If any question of fact or liability be presumed conclusively against him, this is not due process of law...

An orderly proceeding wherein a person is served with notice, actual or constructive, and has an opportunity to be heard and to enforce and protect his rights before a court having power to hear and determine the case...

Fundamental requisite of due process is the opportunity to be heard, to be aware that a matter is pending, to make an informed choice whether to acquiesce or contest, and to assert before the appropriate decision making body the reasons for such choice. "

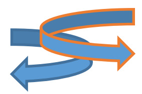
We understand this to mean that before any decision is made that affects a fundamental right or freedom of any person, such person must be *12* given an opportunity to be heard. We consider that the language of subsection (5) of Section 45 of the Trial on Indictments Act poses a problem in this regard. It provides as follows: *Inquiry by the court as to the insanity of the accused*



> ***(1)*** ……
>
> ***(2)*** Notwithstanding subsection (1), if the court is of the opinion that it is expedient so to do and in the interests of the accused person, the court may postpone the inquiry mentioned in that subsection until anytime up to the opening of the case for the defense; and if before the inquiry is made the court acquits the accused person on the count or each of the counts on which he or she is being tried, the inquiry shall not take place.
>
> ***(3)*** If as result of an inquiry made under this section, the court is of the opinion that the accused person is of unsound mind and consequently incapable of making his or her defense, it shall postpone further proceedings in the case.
>
> ***(4)*** The court shall order the accused to be detained in safe custody in such place and manner as it may think fit and shall transmit the court record or a certified copy of it to the Minister.
>
> ***(5)*** Upon consideration of the record, the Minister may, by warrant under his or her hand directed to the court, order that the accused be confined as a criminal lunatic in a mental hospital or other suitable place of custody; and the court shall give any directions necessary to carry out the order.
>
> ***(6)*** Any such warrant of the Minister shall be sufficient authority for the detention of the accused person until the Minister shall make a further order in the matter or until the court finding him or her incapable of making his or her defense shall order him or her to be brought before it again in the manner provided by sections 46 and (emphasis ours).

The import of subsections 2, 3 and 4 is that the court is given latitude to postpone the inquiry until any time up to the opening of the case for the defense, if it is expedient to do so and it is in the interests of the accused person. If the accused person is acquitted at that stage, the court need not go ahead with the inquiry. But if after the inquiry, the court is of the opinion that the accused is not capable of making his or her defense, the court is obliged to postpone the trial and order that he/she should be detained in safe custody in a designated place. The problem stems from the language of subsection (5), which empowers the Minister after considering the record, to order by warrant that the accused be confined as a "criminal lunatic". The phrase "criminal lunatic" is unfortunate for various reasons, which we discuss below. First, we have already established that mental illness/impairment is a disability. The potential of persons living with disability cannot be realized if their dignity is not ensured. Therefore, the language used in all statutes must respect the dignity of such persons, and indeed of all individuals. It must also uphold their equality with is other persons.

We further observe that under Article 35 of the Constitution, the State and society are obliged to take appropriate measures to realize the full mental and physical potential of persons living with disabilities; and that Section 32 of the Persons with Disability Act obliges all organs and agencies



of government and all persons to respect, uphold and promote the constitutional rights and freedoms of persons with disabilities enshrined in Chapter Four of the Constitution. It provides;

"Section 32

The fundamental rights and freedoms enshrined in Chapter Four of the Constitution shall be respected, upheld and promoted by all organs and agencies of government and by all persons in respect to persons with disabilities."

The courts and all other persons mentioned in Section 32 of the Persons with Disability Act are obliged by national and international law to do likewise.

We also take cognizance of the provisions of Article 24 of the *Constitution.*

Article 24

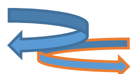
No person shall he. subjected to any form of torture or cruel, inhuman or degrading treatment or punishment. This is one of the non-derogable rights under Article 44 of the Constitution.

In conclusion, we find that the language of sections 45(5) of the Trial on Indictments Act is derogatory and thus contravenes Article 24 of the Constitution that provides for respect for human dignity and protection from inhuman treatment. It strips mentally disabled/impaired persons of dignity.

In reaching this conclusion, we have drawn inspiration from the case of Purohit and Moore v. The Gambia, African Commission on Human and Peoples Rights, Communication No. 241/2001 (2003). The applicants in that case challenged the Lunatics Detention Act (LDA) of the Gambia. One of the grounds for their complaint was that the provisions of the LDA condemning any person described as a lunatic to automatic and indefinite institutionalization are incompatible with and violate Articles 2 and 3 of the African Charter. Section 2 of the LDA defines a "lunatic" as including "an idiot or person of unsound mind." The complainants argued that to the extent that mental illness is a disability, the practice of detaining persons regarded as mentally ill indefinitely and without due process constitutes discrimination on the analogous ground of disability.

The African Commission held that human dignity is an inherent basic right to which all human beings, regardless of their mental capabilities or disabilities, as the case may be, are entitled to without discrimination.

It reiterated its earlier decision in the case of *Media Rights Agenda v Nigeria,* where it stated that "cruel, inhuman or degrading punishment and treatment" is to be interpreted so as to extend to the widest possible protection against abuses, whether physical or mental. The Commission also relied on its earlier decision in the John K. Modise Vs Botswana (2000) AHRLR 25 (ACHPR 1997) where it held that exposing victims to personal suffering and indignity violates the right to human dignity.



The above case interpreted the provisions of a Gambian statute vis-a-vis the African Charter that is worded in a similar language to the Uganda section 45(5) of the Trial on Indictments Act. We consider it to be a persuasive authority. It is absolutely essential that before subjecting any person to a criminal trial, the trial court ascertains and establishes that he/she will follow and understand the proceedings. We thus come to the conclusion on this aspect, section 45(5) violates the letter and spirit of Article 24 of the Constitution as it subjects persons living with mental illness/impairment to inhuman and degrading treatment in the language used to describe them, contrary to Article 24 of the Constitution.

Second, it prejudges an individual who is presumed to be mentally ill/impaired as a criminal lunatic before such person has been tried. This is not only discriminatory but also contravenes the principle of the presumption of innocence. Non-discrimination is a constitutional principle embodied in all the cited international instruments reproduced above, namely the UDHR Article *1, the ICCPR Article 14(1), the UNCRPD Articles 2 and 5 and the African Charter Article 3.*

Article 2 of the UNCRPD defines “discrimination on the basis of disability” to mean any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on equal basis with others, of all human rights and fundamental freedoms in political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation. Uganda is signatory to this Convention. The Persons with Disabilities Act does not give a definition of discrimination on the basis of disability. Instead it provides in Section 32 as follows;

“The fundamental rights and freedoms enshrined in Chapter Four of the Constitution shall be respected', upheld and promoted by all organs and agencies of government and by all persons in respect of persons with disabilities. ”

However, one of the freedoms guaranteed in Article 21 of the Constitution is nondiscrimination. It provides;

21. All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law.

(1) Without prejudice to clause (1) of this article, a person shall not be discriminated against on the ground of sex, race, color, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

(2) For the purposes of this article, “discriminate” means to give different treatment to different persons attributable only or mainly to the respective descriptions by sex, race, color, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability. ”

The definition of discrimination in that Article specifically mentions disability. The Constitution of Uganda Articles 20, 21 and 35, among others, incorporate this principle as well. We have reproduced the said Articles below;

"20 Fundamental rights and freedoms of the individual are inherent and not granted by the State.

(1) The rights and freedoms of the individual and groups enshrined in this

Chapter shall be respected, upheld and promoted by all organs and agencies of Government and by all persons.

"35 Rights of persons with disabilities

(1) Persons with disabilities have a right to respect and human dignity, and the State and society shall take appropriate measures to ensure that they realize their full mental and physical potential.

(2) Parliament shall enact laws appropriate for the protection of persons with disabilities. "

Our view is that Section 45(5) of the Trial on Indictments Act gives different treatment to persons with mental illness/impairment from other people with or without disabilities in that it imputes criminality on the person of the mentally ill/impaired who has not been adjudged a criminal. This is discriminatory. Uganda, being a signatory to both the UNCRPD and the African Charter should have taken and ought to take steps to align section 45(5) of the Trial on Indictments Act with the Constitution and with its international obligations. Our judgment is that the presumption of innocence should apply to all without discrimination.

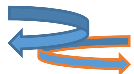
Thirdly, at the stage where section 45(5) of the Trial on Indictments Act comes into play during criminal proceedings, the defense has not been heard and the trial has not been concluded. There is no judgment against the accused person convicting him/her of any offence. Nevertheless he/she is labeled a "criminal lunatic" by statute. The term "criminal lunatic" imputes to the mind of the accused guilt for an offence for which he/she may not have been fully tried. This contravenes the constitutional principle of the presumption of innocence embodied in Article 28(3) of the Constitution. Article 28 provides; Right to a fair hearing (1) in the determination of civil rights and obligations or any criminal charge, a person shall be entitled to a fair, speedy and public hearing before an independent and impartial court or tribunal established by law.

(3) Every person who is charged with a criminal offence shall-

(a) be presumed to he innocent until proved guilty or until that person has pleaded guilty,(The emphasis is ours)

We therefore consider that Counsel for the respondent has rightly conceded that the use of the words "criminal lunatic" in section 45(1) of the Trial on Indictments Act violates the presumption of innocence enshrined in Article 28(3) (a) of the Constitution.

We now revert to the issue of due process and whether the powers given to the Minister in section 45(1) of the Trial on Indictments Act to detain the accused accord with this principle. To establish whether the accused is fit to stand trial, a trial court is required to conduct an inquiry. But when it



comes to determining whether a particular accused person should be detained, no guidance whatever is given to the court or the Minister to determine whether the accused poses any risk. Yet the Constitution offers ample guidance in Articles 23(1) (f). It provides;

(l) No person shall be deprived of personal liberty except in any of the following cases_

(f) <u>In the case of a person who is or is reasonably suspected to be of</u> <u>unsound mind</u> or addicted to drugs or alcohol, <u>for the purpose of the</u> <u>care or treatment of that person or the protection of the community</u>

The Trial on Indictments Act, predates the 1995 Constitution. Therefore, section 45(1) of the Trial on Indictments Act must be construed with such modifications, adaptations, among others, to bring it in conformity with the Constitution in accordance with Article 274 5 reproduced below:

"Existing Law

1.Subject to the provisions of this article, the operation of the existing law after the coming into force of this Constitution shall not be affected by the coming into force of this Constitution but the existing law shall be construed with such modifications, adaptations, qualifications and exceptions as may be necessary to bring it into conformity with this Constitution.

2. For the purposes of this article, the expression "existing law" means the written and unwritten law of Uganda or any part of it as existed immediately before the coming into force of this Constitution, including any Act of Parliament or Statute or statutory instrument enacted or made before that date which is to come into force on or after that date. "

When section 45(5) of The Trial on Indictments Act is read subject to Article 274 and the provisions of Article 23(f) are taken into account, it becomes clear that when it comes to the detention of the accused, a matter that involves denying him/her the right to liberty, whether directed by the Court or the Minister, there is no clear indication as to what standards the detention order of such accused should comply with before it is issued. After having found that the accused person is of unsound mind and consequently incapable of making her/his defense, the court is enjoined to order the detention of the accused in safe custody in such place or manner as it may deem fit. The purpose of such detention is not stated. It is also not stated how the court should go about establishing that such an accused is a person that deserves to be detained.

The problem is further compounded when section 45(5) of The Trial on Indictments Act grants powers to the Minister to act, where he/she deems it fit, by warrant under his/her hand directed to the court, to order that the accused be confined as a criminal lunatic in a mental hospital or other suitable place of custody. The Minister, by merely looking at the record, has power to label the accused a "criminal lunatic". He/she is not obliged to seek professional/ medical or other professional advice regarding the propriety of the detention nor the length of it. The court is then required to implement the Minister's decision by giving directions thereon.

Article 23(1) (f) of the Constitution, stipulates that such an accused who is, or is reasonably suspected to be, of unsound mind, should be deprived of his/her liberty only for the purpose of the care or treatment of that person or the protection of the community generally. Section 45(5) of is The Trial on Indictments Act is silent on the purpose for detaining a mentally ill person and as such contravenes Article 23(1) (f) of the Constitution in this regard. The process of determining whether or not an accused person should be detained should be left to the trial Court only. Such detention should be strictly for medical treatment. It is the Court that should also determine when the accused is ready to stand trial or be released to the community, based on concrete medical evidence, provided by a psychiatrist. The entire procedure to declare a person unfit for trial, the duration and place of his detention, and the time when he should be released should be determined by the court, after full inquiry based on medical evidence, in full compliance with due process.

We have already found guidance in the case of Purohit and Moore v. The Gambia, African

Commission on Human and People's Rights, (supra), to which we revert In that case, the complainants also challenged the automatic detention of persons considered "lunatics"under the provisions of the LDA and argued that this violates the right to personal liberty.

The African Commission held and we quote;

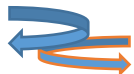
Article 6 of the African Charter guarantees every individual, be they disabled or

not, the right to liberty and security of the person. Deprivation of such liberty is only acceptable if it is authorized by law and is compatible with the obligations of States Parties under the Charter... Article 6 of the African Charter further states that no one may be arbitrarily arrested or detained. Prohibition against arbitrariness requires among other things that deprivation of liberty shall be under the authority and supervision of persons procedurally and substantively competent to certify it. "(Emphasis added)

We have found this jurisprudence persuasive, especially as the African Charter is similar to Article 23of the Constitution. Both protect the liberty of the individual. We therefore conclude that the Minister is procedurally and substantively not a competent person to certify the is deprivation of the liberty of the alleged mentally ill accused person, without first seeking medical advice and without according the affected person a hearing.

The consequence of the current procedure is that it contains great potential for injustice as it may deprive an accused person of personal liberty for an indefinite period of time. There is a very real risk of _ mentally disabled persons disappearing in the criminal justice system without proper standards being set for involuntary confinement and procedures for review. This has already happened in the case of ***Uganda v. Tesimana***[761], where Egonda J., as he then was, stayed the criminal proceedings after the accused had spent 8 years in the criminal justice system without

[761] HC Criminal Revision Case No. MSK-00-CR-CV-0013 of 1999



being tried. The trial court in that case triggered this unfortunate state of affairs when it ordered that the accused should be taken to hospital for mental examination after she looked to be of unsound mind. This order was not followed up and she stayed in prison for 8 years without being tried and without receiving proper treatment. There is dire need to avoid a recurrence of such injustice.

We therefore find that section 45(5) of the Trial on Indictments Act contravenes Articles 20, 21(1), and (3), 23, 24, 28 and 35 of the Constitution and we so declare.

Whether Section 82(6) of the Trial on Indictments Act contravenes the Constitution.

The section provides; " Verdict and sentence"

(1) When the case on both sides is closed, the judge shall sum up the law and the evidence in the case to the assessors and shall require each of the assessors to state his or her opinion orally and shall record each such opinion. The judge shall take a note of his or her summing up to the assessors.

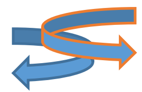
15 *(2)* The judge shall then give his or her judgment, but in so doing shall not be bound to conform with the opinions of the assessors.

Where the judge does not conform with the opinions of the majority of the assessors, he or she shall state his or her reasons for departing from their opinions in his or her judgment.

The assessors may retire to consider their opinions if they so wish and during any such retirement or at any time during the trial, may consult with one another.

(2) If the accused person is convicted, the judge shall pass sentence on him or her according to law. *(6)* If the accused is acquitted, he or she shall be immediately discharged from custody unless he or she is acquitted by reason of insanity." We note that under sub-section (6) of the above section, an acquitted person should be freed, unless he/she is being detained on some other lawful charge. However, if such person is acquitted by reason of insanity, then the law provides that he/she should be detained.

Consider that the reason such person is detained is because he/she is found to have committed the act that would amount to an offence if he/she was of sound mind, but is only acquitted because he/she is deemed not to have known what he/she was doing or that it was wrong. This is different from someone acquitted, for example, for lack of evidence. It is therefore not discrimination to detain such a person, as the purpose for the detention is not punishment for any offence but it is for the person's security, safety and health care as well as the security of the community. What needs to be put in place is a process of review of the detention of such a person so that he/she is not detained indefinitely. We are therefore, constrained to construe section 82(6) of the Trial on Indictments Act in accordance with Article 274 of the Constitution with such modifications, adaptations, and qualifications and exceptions as may be necessity to bring it in conformity with the Constitution. We accordingly modify it to cater for the purpose of the detention, the duration



of the detention, and for the place of detention. The details of the modifications to section 82(6) will appear below in the course of resolving issues 2 and 3.

Resolution of the Issues 2 and 3

1. *Whether section 130 of the Penal Code Act, contravenes the right to dignity of persons with mental disabilities, guaranteed under Article 24 of the Constitution.*
2. *Whether section 130 of the Penal Code Act contravenes the right to freedom from nondiscrimination guaranteed under Article 21 of the Constitution*

For convenience, we have combined the resolution of these two issues together.

Section 130 of the Penal Code Act provides as follows; Any person who, knowing a woman or girl to be an idiot or imbecile, has or attempts to have unlawful carnal knowledge of her under circumstances not amounting to rape, but which prove that the offender knew at the time of the commission of the offence that the woman or girl was an idiot or imbecile, commits a felony and is liable to imprisonment for fourteen years.

Article 24provides that: No person shall be subjected to any form of torture or cruel, inhuman or degrading treatment or punishment.

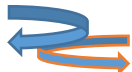
Under Article 35 of the Constitution, the State and society are obliged to take appropriate measures to realize the full mental and physical potential of persons living with disabilities. This potential cannot be realized if their dignity is not ensured.

Furthermore, Section 32 of the Persons with Disability Act obliges all organs and agencies of Government and all persons to respect, uphold is and promote the constitutional rights and freedoms of persons with disabilities enshrined in Chapter Four of the Constitution.

As a preliminary matter, we observe that the objective of the section is to safeguard women and girls who are mentally handicapped from being sexually abused. However, the language “idiot” and “imbecile” used to describe women and girls who are mentally handicapped is dehumanizing of these people.

One of the arguments of the complainants in the Purohit and Moore v. The Gambia, African Commission on Human and People’s Rights

case (supra), which we have found persuasive, was that under the LDA, persons with mental illness had been branded as “lunatics” and “idiots”, terms which were dehumanizing and denied them any form of dignity. The African Commission decided that the terms were dehumanizing and denied them any form of dignity in contravention of Article 5 of the African Charter.



Following the reasoning and decision in the above case, we find that the language of section 130 of the Penal Code Act is dehumanizing. The words “idiots” and “imbeciles” are derogatory and detract from the dignity that should be accorded to all disabled persons under Article 24. We find this is not permissible and justifiable as the language contravenes Articles 20, 21(1), (2) and (3), 23, 24, 28 and 35 of the Constitution.

We however find that striking out the section would leave mentally handicapped/disabled women and girls unprotected. Accordingly, and in accordance with Article 274 of the Constitution, we construe section 130 of the Penal Code Act with “such modifications, adaptations, qualifications and exceptions as may be necessary to bring it into conformity with this Constitution. The words “idiot” and “imbecile” are struck out from section 130 of the Penal Code Act and are replaced with the phrase “woman and girl to be mentally ill or impaired” For avoidance of doubt, the modified section 130 of the Penal Code Act the modified section is set out in full in the disposition.

Prayers for remedies

Counsel for the Petitioners made the following prayers.

(a) A declaration that section 45(5) of the Trial on Indictments Act is unconstitutional in as far as it adjudges a person who is not proven guilty as a criminal by referring to him/her as a criminal lunatic contrary to Article 28(3) (a) of the Constitution.

(b) A declaration that section 82(6) of the Trial on Indictments Act is unconstitutional in as far as it violates the right to liberty and freedom from discrimination of the persons with mental illnesses contrary to Article 23 of the Constitution.

(c) A declaration that section 130 of the Penal Code Act as amended is unconstitutional in so far as it is contrary and violates the right to dignity guaranteed under Article 24 of the Constitution.

'(d) A declaration that section 130 of the Penal Code Act violates the right to freedom from discrimination under Article 21 of the Constitution.

(e) An order that the provisions of sections 45(5) and 82(6) of the Trial on Indictments Act and section 130 of the Penal Code Act (as amended) be struck out for being in contravention of Articles 20, 21(1), (2) and (3), 23, 24, 28 and 35 of the Constitution and the Convention on the Rights of Persons with disabilities.

(f) Any other or further declaration that this Honorable Court may deem fit to grant.

Disposition

In light of the contraventions of the Constitution that we have found; we proceed to make the following declarations and orders;

1. Section 45(5) of the Trial on Indictments Act is unconstitutional in as far as it adjudges a person who is not proven guilty as a criminal by referring to him/her as a "criminal lunatic" contrary to Article 28(3) (a) of the Constitution.
2. *Section 82(6) of the Trial on Indictments Act is modified in accordance with Article 274 of the Constitution to read as follows:*

a. The trial Court is to order for the detention of such a person for a specific period, for purposes of care or treatment of that person by a qualified psychiatrist or other qualified medical officer, in accordance with Article 23(1) of the Constitution.

b. The period of detention is to be specified in the order of detention and is to be periodically reviewed by Court to ascertain the mental status of the detained person based on medical evidence from a psychiatrist or other qualified medical officer.

c. When the court is satisfied that such a detained person is mentally fit and is no longer a danger to him/herself and/or to the community, it may order for his/her release.

3. *The words "idiot" and "imbecile" that appear in Section 130 of the Penal Code Act, are declared to contravene articles 20, 21(1),*

(2) and (3), 23, 24 and 35 of the Constitution by reason of their being derogatory, dehumanizing and degrading. They are accordingly struck out from section 130 of the Penal Code Act The section is modified in accordance with Article 274 of the Constitution to read as follows:

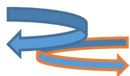
Any person who, knowing a woman or girl to be mentally ill or mentally impaired, has or attempts to have unlawful carnal knowledge of her under circumstances not amounting to rape, but which prove that the offender knew at the time of the commission of the offence that the woman or girl was mentally disabled or mentally handicapped, commits a felony and is liable to imprisonment for fourteen years

Section 130 of the Penal Code Act does not violate the right to freedom from discrimination under Article 21 of the Constitution.

The State is hereby directed, as a matter of urgency;

a. To Review the status of persons with mental disabilities so that they are removed from jails and prisons and are instead taken for care and treatment in appropriate places.

b. To review and amend the Trial on Indictments Act and the Penal Code Act with a view to providing clarity on how people with mental disabilities amounting to insanity should be handled through the criminal justice system, in accordance with and in compliance with the Constitution and this judgment.



This being a matter of public importance, and the State having conceded to the violations of the Constitution alleged by the Petitioner, we make no order as to costs. It is so ordered.

Dated and signed at Kampala this 30th day of October 2015

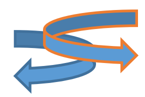
Honorable Justice Remmy K Kasule JCC

Honorable Justice Eldad Mwangusya JCC

Honorable Lady Justice Faith Mwondha JCC

Honorable Justice Richard Buteera JCC

Honorable Justice Solomy Balungi Bossa JCC



APPENDIX THREE. Kabiito v. A.G & ors (2012)

THE REBUPLIC OF UGANDA

IN THE HIGH COURT OF UGANDA AT FORT PORTAL

HCT – 01 – CV – CS – 026 OF 2012

5 KABIITO TELESPHORUS...PLAINTIFF

VERSUS

1. ATTORNEY GENERAL

2. DR. KWIKIRIZA NICHOLAS ....DEFENDANTS

3. THE MEDICAL SUPERITENDANT

10 FORT PORTAL REFERAL HOSPITAL

BEFORE: HIS LORDSHIP HON. JUSTICE WILSON MASALU MUSENE

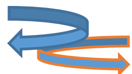
Judgment

The Plaintiff, Kabiito Telephorus, filed this suit against the three Defendants, namely;

15 Attorney General, Dr. Kwikiriza Nicholas and the medical superintendent Fort Portal Referral Hospital. M/s Kaahwa, Kafuuzi, Bwiruka & Co. Advocates represented the Plaintiff, while the Defendants were jointly represented by Attorney General's Chambers, Fort Portal. Background:

The Plaintiff brought this suit as a husband of Katusabe Elizabeth alias E.G Katusabe the

20 deceased on his own behalf and on behalf of the family for the benefit of the estate of the deceased under the Law Reform (Miscellaneous Provisions) Act claiming special, general damages for negligence, unlawful death, loss of life, loss of dependency, care, pain and suffering, interest on damages above at 26% per annum from the date of the cause action till payment in full and costs of the suit.



The Plaintiff founded his action in negligence and the particulars of negligence pleaded under paragraph 6 of the plaint were; lack of proper medical attention towards the deceased who was in labour, failure by the Defendant's workers to provide lifesaving blood, sill and equipment, leaving the deceased to bleed without rescue which resulted into her death, sheer and outright lack of care and indifference towards patients, poor health care and standards in the 1st Defendant's hospital, lack and absence of drugs and facilities.

The Defendants on the other hand averred that the deceased had at all times attended antenatal checkups carried out by Dr. Arthur Ssebuko (DW1) who testified that he discovered that she was expecting a big baby who would not be delivered vaginally. He described her as a risky expectant mother. That he advised her not to go into labour and instead planned a caesarean delivery within two weeks before the delivery. However, she did not attend the said 10 appointment. By the time the deceased reported to Hospital, she was already in labour. The Defendants did all they could to salvage the situation but could only save the baby's life. That it was therefore the deceased who was negligent in failure to adhere to the strict guidelines of a fragile situation.

Issues:

1. Whether the Defendants were and liable in negligence?

2. Whether the Plaintiff is entitled to the remedies sought?

Issue 1: Whether the Defendants were and liable in negligence?

Counsel for the Plaintiff submitted that in order to resolve this issue there is need to first investigate the questions as whether there existed a doctor-patient relationship, whether the 20 2nd and 3rd Defendants owed the deceased a duty of care, whether the said duty was breached by the Defendants and if so under what circumstances (the nature of the beach) and whether the actions and omissions of the 2nd and 3rd Defendants hold the 1st Defendant vicariously liable.

Counsel for the Plaintiff submitted that PW1 testified that the deceased was his wife died and at the age of 35 years and was employed as a nursing assistant at the 3rd Defendant. That her death was due to the negligence of the 2nd and 3rd Defendants coupled with the lack and absence of drugs. It was further submitted that on 23rd March 2011 at 3:00pm she was taken to the hospital in labour, still alive and not bleeding. That DW2 admitted to having operated the deceased, removed the baby and successfully enabled the deceased to leave the operating 30 table and theatre still alive and that he advised she be transfused with blood.

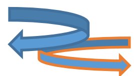
Counsel for the Plaintiff added that the cause of death was haemorrhagic shock due to or following bleeding after delivering which was due to failure of the uterus to contract. And further that during cross examination DW2 claimed that he found the deceased's uterus having ruptured and that he repaired it and it stopped bleeding. However, the case for the 5 Plaintiff was that this is not true because the cause of death was bleeding after delivery and there was no blood transfusion. That DW2's claims fall short of professional competency and efficiency in a sense that if the uterus had

proved to continuously bleed, then it should have been removed. Thus, DW2 failed to exercise such care and skill a reasonably prudent and careful person would use under similar circumstances. That he should have followed up to 10 ensure that the patient had received proper care and had blood transfused since he is the one that had worked on her.

Counsel for the Plaintiff added that the evidence of DW1 that the deceased had a big baby and could not deliver vaginally and the same was indicated on her antenatal card is false and cannot be sustained. That the deceased reported to the hospital at 3:00pm only to be taken to 15 theatre at 5:00pm, and her being a high risk patient she should have been treated as an emergency. Also, that DW1 did not bother to record and make entry of the deceased's condition in the antenatal care register operated by the outpatient department at the 3rd Respondent's hospital to enable other practitioners to rely on the same so as to manage the deceased's risky condition. Therefore, DW1 and DW2 as professional obstetrics and 20 gynaecologists fell short of the professional standard and were negligent making the 1st and 3rd Respondents vicariously liable.

Counsel for the Defendants on the other hand submitted that the deceased failed to take hid of the doctor's advice and chose to come while in labour yet she had been advised to come in two weeks earlier. That in the circumstances there was contributory negligence that led to her 25 death. He defined contributory negligence as per Black's Law Dictionary 10th Edition at page 403 as the principle that completely bars a Plaintiff's recovery if the damage suffered is partly the Plaintiff's own fault. That from the evidence of DW1,the deceased did not show up for the doctor's appointment for the operation well knowing that she had a risky pregnancy. That in the circumstances the deceased who came while in active labour and already bleeding was operated on and the baby saved however, her condition was escalated by her own making.

This Court has considered the evidence on record by both sides and the submissions. I have also analysed the pleadings, including the plaint and the written statement of Defence. It is clear from the pleadings that the Plaintiff lost his wife; Katusabe Elizabeth during child labour at Fort Portal Regional Referral Hospital as a result of what the Plaintiff claims was due to negligence by employees of the Government of Uganda represented by the 1st Defendant, the Attorney General. The Defendants, under paragraph 4 of the written statement of Defence averred that the Plaintiff's suit was not based on any reasonable cause of action, that it was frivolous, vexatious, premature and in breach of the law. During the hearing, the Defendants, through Dr. Ssebuko Arthur (DW1) and Dr. Nicholas Kwikiriza Magambo 10 (DW2) testified that the deceased was admitted when she had escalated into labour, that the deceased reported to hospital late contrary to the doctor's instructions which actions amounted to contributory negligence was not raised or pleaded in the Written Statement of Defence. That was prejudicial to the Plaintiff's case as PW1 was not confronted during cross examination with any averments of DW1 and DW2 and consequently the Plaintiff could not 15 be re-examined on those crucial matters of alleged contributory negligence. That amounted to a departure from the pleadings which is not allowed under Order 6 Rule 7 of the Civil Procedure Rules which provides;



"No pleading shall, not being a petition or application, except by way of amendment, raise any new grounds of claim or contain any allegation of fact inconsistent with the previous 20 *pleadings of the party pleading that pleading."*

It is therefore clear as was held in Bat "U" 1984 LTD versus Selestino Mushongore, Supreme Court Civil Appeal No. 26 of 1994, that contributory negligence should be pleaded and particulars thereof be given.

In the case of Uganda Breweries Ltd versus Uganda Railways Corporation, SCCA No. 6 of 2001, it was held that the complaint against departure from pleadings would stand depending on whether the party complaining had a fair notice of the case he had to meet, and whether departure from pleadings caused a failure of justice to the party complaining or whether the departure was a mere irregularity and not fatal to the case of the party whose evidence departed from the pleadings.

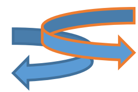
In the present case, the Plaintiff had no fair notice as contributory negligence was not raised in the Defendant's Written Statement of Defence and that was greatly prejudicial to the Plaintiff's case as already noted. Therefore reference by Counsel for the Defendant to Black's Law Dictionary 10th Edition at Page 43 on the definition of contributory negligence is misplaced as contributory negligence was neither pleaded nor particulars given. Be that as it may, I shall now proceed to consider whether there was professional negligence and vicarious liability on the part of the Defendants.

The law relating to medical professional negligence and misconduct as well as the vicarious liability of the medical practitioner and the Hospital has been summed up in the following legal prepositions in a number of decided cases including Stanley Kamihanda versus Attorney General, HCCS No. 1201 of 1998 reported in KALR [2003] page 333, and the Kenyan case of Kimmy Paul Semenye versus Aga Khan Hospital and 2 Others [2006] 10 KLR.

It is articulated as follows;

"There exists a duty of care between the patient and the doctor, hospital or health provider, and once that relationship is established, then the doctor has a fourfold duty. A party who holds himself as ready to give medical advice or treatment impliedly undertakes that he is 15 *possessed of skills and knowledge for the purpose and such person whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment and a duty of care in his administration of that treatment."*

Negligence is defined as the act of doing something or an omission by a reasonable man, guided upon considerations which regulate the conduct of human affairs. Further, that in case of negligence there should be a duty of care owed, a breach of that duty and damage suffered by the person to whom the duty was owed. The standard of care in medical negligence differs from that of ordinary cases of negligence. If a professional man posses an art, he must reasonably be skilled in it. He must also be careful, but the standard of care, which the law 25 requires, is not insurance



against accidental slips. It is such a degree of care as normally skillful member of the profession may reasonably be expected to exercise in the actual circumstances of the case, and in applying the duty of care to the care of a surgeon, it is peculiarly necessary applying the duty of the different kinds of circumstances that may present themselves for urgent attention.

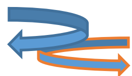
It is pertinent to not that a charge of professional negligence against a medical practitioner is a grave and serious matter. It stands on a different footing to a charge of negligence against the driver of a motor car. The consequences are far more serious. It affects his professional status and reputation. The burden is to prove that the damage was caused by negligence and was not a question of misadventure, and that burden must be discharged on a preponderance of evidence. In medical cases the fact that something has gone wrong is not in itself any 5 evidence of negligence. The test used to establish whether there was medical negligence or not is whether there has been negligence or not is not the test of the man on top of the Clapham omnibus, because he has not got this special skill.

The test is the standard of the ordinary skilled man exercising and professing to have that special skill and the true test of establishing negligence and treatment on the part of the 10 doctor is whether he has been proved to have been guilty of such failure as no doctor of ordinary skill would be guilty of it acting within ordinary care or whether it is a case of misadventure or medical negligence. See: also Blyth versus Birmingham Co. [1856] 11 Exch. 781-784 and Hlasbury's Laws of England Volume 26 Page 17.

Applying the law as outlined above to the present case, this Court finds and holds that there 15 was a patient doctor relationship between the deceased and the 2nd Defendant, and no doubt the 2nd and 3rd Defendants owed the deceased a duty of care. As will be summarised below from the evidence on record, the said duty of care was breached by the Defendants and therefore further finding and holding of this Court is that the actions and omissions of the 2nd and 3rd Defendants hold that the 1st Defendant vicariously liable.

The Defendants' submissions on the issue of professional negligence was solely based on contributory negligence that the deceased negated on the appointment and advice of the doctors to attend to Hospital for an operation because her pregnancy was a risky one and that she could not wait to go into labour.

This Court has already faulted the Defendants for not pleading contributory negligence and 25 particulars thereof in their Written Statement of Defence. I have already I held that the Defendants cannot depart from their pleadings. A close analysis of the evidence on record reveals that PW1 testified that he is the husband of the deceased Katusabe Elizabeth who was aged 35 years old and working as a nursing assistant at the 3rd Defendant Government Regional Referral Hospital. PW1's further testimony was that 23/3/2011, the deceased was 30 taken to Hospital in labour at 3:00pm. DW2 admitted to have received and admitted the deceased to theatre while the deceased was still alive and not bleeding.



DW2's further evidence was that he operated the deceased, removed the baby and successfully enabled the deceased to leave the operating table and theatre alive. DW2 also advised that the deceased be transfused with blood which was never done.

PW1 on the other hand exhibited PEX2, the medical certificate of cause of death dated 30/8/2011 by Dr. Anzivua Sylvester indicating that deceased died of Haemorrhagic shock due to post-partum Haemorrhage following uterine atony. DW1 and DW2 explained that "the cause of death was haemorrhagic shock due to bleeding after delivering as the uterus did not contract." During cross-examination, DW2 stated that he found the deceased's uterus having ruptured and that he repaired it, but at the same time DW2 admitted 10 that the deceased was not transfused with blood. He also stated that he was not aware whether the post theatre care and treatment was administered onto the deceased mother. Failure to transfuse the deceased after the bleeding led to her death and who was to blame other than the doctors and other staff of the Hospital. It is also the finding and holding of this Court that DW2's claim that he repaired the ruptured 15 uterus and it stopped bleeding was not true because the bleeding did not stop. DW2 therefore failed to exercise such care and skill reasonably expected of a prudent and careful doctor of his status.

DW2 never followed up to confirm whether blood was being transfused on the deceased and even post theatre care treatment, particularly when the deceased was a fellow workmate. The 20 claim by DW1 that the deceased came late was not the cause of death.

In my view, the 2nd and 3rd Defendants should have considered the deceased's situation as an emergency. it is therefore the finding and holding of this Court that in the circumstances, DW1 and DW2 fell short of the professional standards as obstetrics and gynaecologists and were negligent, thereby making the 1st Defendant vicariously liable. I agree with the 25 testimony of PW1 that his wife's death was caused by the negligence of the 2nd and 3rd Defendants and other employees as there was ultimately no proper medical attention towards the deceased who was in labour. Furthermore, there was failure by the Defendants' workers to provide life saving blood leaving the deceased to bleed without rescue and resulting into her death.

Finally, I find and hold that there was lack of care and indifference towards patients and poor health standards in the 1st Defendant's Hospital and moreover a Regional Referral Hospital. All that is borne out of the evidence of PW1 and even DW1 and DW2. The 1st issue is therefore resolved in the positive and in favour of the Plaintiff.

Issue two: Whether the Plaintiff is entitled to the remedies sought?

Counsel for the Plaintiff submitted that the Plaintiff prayed for special damages to a tune of UGX 16,300,000/= for medical and funeral expenses though the documentation was lost during the period of the funeral. He also prayed for general damages to a tune of 72,455,400/= due to the loss of dependency and benefits that would accrue to him and the children of the deceased. He prayed for further general damages of UGX 3 billion based on the negligence, unlawful death, loss of life, loss of care, pain and suffering, mental and 10 psychological torture, anguish, pain, the dependants

being left motherless by loss of a parent and the Plaintiff being made a widower. Counsel relied on a Kenyan case of JNB (Deceased) versus The Archdiocese of Nairobi Kenya Registered Trustees & 2 others, High Court of Kenya Civil Case No. 30 of 2010, which awarded general damages separately to each individual member of the family because the loss is individual as well as the resultant longtime effects.

He concluded that in the instant case there are 4 family members and each of them would be apportioned UGX 750million for their survival which is appropriate in the circumstances.

Counsel for the Defendants submitted that notwithstanding the fact that the deceased contributed to her own death the remedies as prayed for b the Plaintiff are exorbitant, 20 exaggerated, inflated and made in bad faith. That damages are awarded at the discretion of court depending on the prevailing conditions and prior decisions relevant to the case in question as per the case of Moses Ssali aka Bebe Cool versus AG and Other, HCCS No. 86 of 2010.

A close scrutiny of the written statement of defence reveals that the Defendants don not plead 25 the claims raised by Defence Counsel in the submissions.

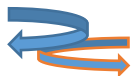
The Plaintiff on the other hand prayed for special damages under paragraphs 7 and 9 of the plaint. PW1's witness Statement on oath under paragraphs 5, 6, 7, 8 and 9 allude to the specifics of the damages, Shs. 16,300,000/= is claimed for medical, post-mortem report and funeral expenses.

PW1 indicated that most of the documents to support his claim were lost during the funeral period. In Kyambadde versus Mpigi District Administration [1983] HCB 44, Court held that funeral expenses as pleaded would be awarded although as special damages proof thereof is strict. However, failure to attach receipts of expenditure in proof of funeral expenses was 5 excusable because at the time of bereavement, it may not be possible to attend to details such as asking for receipts. This Court therefore finds that special damages were proved by the Plaintiff and I do hereby award Shs. 16,300,000/= as special damages.

Secondly, there was a claim of general damages which the Plaintiff classified as loss of dependency and benefits that would accrue to him and the children of the deceased as alluded 10 in paragraphs 8 and 9 of the plaint to the time of UGX 72,455,400/=.

Although the above was not opposed or replied to by Counsel for the Defendants, I decline to grant the same because it will be covered under damages based on negligence, unlawful death, loss of life, loss of care, pain and suffering, mental and psychological torture, anguish, pain and the Dependants being left motherless by loss of a parent and the Plaintiff being a 15 widower which was alluded to in paragraph 8 of the evidence in Chief. The Plaintiff claimed further general damages to the tune of UGX 3 billion.

The right to life is not only protected under the Constitution, but it is inherent. As has already been held, the deceased met her death under circumstances of gross negligence. I also agree with the submissions of Counsel for the Plaintiff that the deceased was working as a nursing 20 aid, she



died at an early age of 35 years when she was fulfilling a natural duty of co-creation and giving birth to another life. As a nurse she had a bright and prosperous future. The 2nd and 3rd Defendants who would have saved the life of the deceased most especially a workmate acted in the most deplorable manner. The life of the deceased would have been saved and life is lived once and when it is lost, it cannot be compensated by any amount of 25 money. So since the life was permanently lost, the Plaintiff has prayed for general damages of UGX 3billion.

However, it is the finding and holding of this Court that UGX 3 billion is on a higher scale. In the circumstances, I am inclined to reduce it by half and so I award a sum of UGX 1.5 billion as general damages. All in all, and in view of what I have outlined above, I do hereby enter judgment in favour of the Plaintiff under the following terms;

i. An order that the 1st Defendant pays special damages of UGX 16,300,000/=.

ii. An order for the 1st Defendant to pay ordinary general damages of UGX 1.5 billion for the negligence of the 2nd and 3rd Defendants.

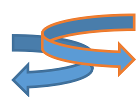
iii. Costs of the suit are awarded to the Plaintiff.

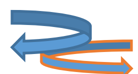
5 ....

WILSON MASALU MUSENE

JUDGE

03/10/2019

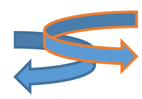




Appendix Four: Hippocratic Oath

"I swear before my gods, my ancestors, my teachers, my fellow healers and apprentices, and by all the arts and knowledge I was privileged to learn, that I will stand by these words:
I will love those who taught me these arts as I love my parents and I will offer my skills to the young with the same generosity that they were given to me. And I will never ask them for gold, but demand that they stand by this covenant in return. I also swear that if I earn fame and wealth, I will share it with my masters and my students.
I will soothe the pain of anyone who needs my art, and if I don't know how, I will seek the counsel of my teachers.
I will offer those who suffer all my attention, my science and my love. Never will I betray them or risk their wellbeing to satisfy my vanity. I will not hurt my fellow or put a knife to his flesh if I don't know how, or give him an herb to soothe his pain, even if he begs for it in anguish, if it might take away his breath.
I will never harm my suffering friend, because life is sacred, from the tender fruit that he once was in his mother's womb to that first sigh he gave out between her legs when he opened his eyes to the world.
I will try to understand his sorrows but his secrets will never leave my ears. Under no circumstance I will use his body to advance my knowledge or my fame, unless in his last moment, he or his widow give me his corpse, so that his death may help me understand how to soothe another's pain.
I pray that the attention I give to those who put themselves in my hands be rewarded with happiness. And in honor of the knowledge I've received from my teachers, I swear to care for anyone who suffers, prince or slave.

If I ever break this oath, let my gods take away my knowledge of this art and my own health.
Here speaks a citizen, a servant of people. May I be destroyed if I betray these words."



Appendix Five. Uganda Medical And Dental Practitioners Council (Umdpc) – Code of Professional Ethics

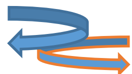
UGANDA MEDICAL AND DENTAL

PRACTITIONERS COUNCIL (UMDPC)

Centenary 1913 – 2013

CODE OF PROFESSIONAL ETHICS

Reprint 2013



FOREWORD

One of the cardinal statutory functions of the medical and Dental Practitioners Council is to take firm and fair disciplinary sanctions against practitioners who behave unethically in the course of their work.

In 2002, the council published “Guidelines with respect to complains against medical and dental practitioners” which outline the procedures through which complaints are handled by the council; provide a list of the different categories of offences and types of penalties that are handled out to errant practitioners. The guidelines do not however, spell out the does and don’ts in clinical practice. The publication of this ‘Code of Professional Ethics” endeavours to fill the gap.

It is significant to bring to the attention of practitioners that this code is a legal document which is derived from S 34 of the Medical and Dental Practitioners act, Cap of Laws of Uganda and it’s implementation will have a full legal force. It is, therefore, a must read for every practitioner is problem are to be averted in future.

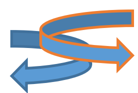
It is important to observe that the number of complaints received by the council is rising every year. Although this may be partly attributed to increased public awareness of patients’ rights are a result of improved information technology and world-wide travel for medical treatment, the increase in complaints may also mean deterioration in standards of health care delivery of the part of practitioners understand their responsibility in different situations in clinical practice. This code is not a blue print, but will undergo future reviews as new developments emerge, such as some aspects of HIV/AIDS, DNA testing, in vitro fertilization (IVF), organ donation, end-of-life care, etc.

It is noteworthy that some practitioners commit offences because they do not know that is unethical to do so. The code, therefore, provides an invaluable opportunity to increase practitioners’ awareness about the need to comply with the acceptable norms and standards of professional conduct, care and competence as well as respect for patients’ rights and human rights. He code is not substitute for the experience and integrity of individual practitioners, but it may serve as a reminder of the shared obligations and duties of the medical profession

The code is fully implemented, will contribute immensely to improvements in quality health care delivery. It will also help in revamping the reputation of the noble profession. I wish you good reading.

Dr. Sam Zaramba

Director General of Health Services



ARRANGEMENT OF RULES

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1. Preamble
2. Functions of medical practitioners in society
3. Nature of the code of professional ethics

PART II- ETHICAL OBLIGATIONS

4. Respect of human rights
5. Respect of persons
6. Protection of privacy
7. Integrity
8. Access to health care services

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12. Advertising
13. Canvassing and touting
14. Professional stationery
15. Practice names
16. Itinerant practice
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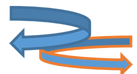
18. Partnerships and juristic persons
19. Covering



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29. Medicines
30. Financial interest in hospitals
31. Specialist
32. Impairment
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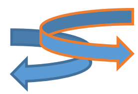
35. General obligation



PART I- INTRODUCTION

1. Preamble

This code of professional ethics is intended to be used as a guide to promote and maintain the highest standards of ethical behaviour by practitioners in Uganda. In order to maintain public confidence in the professional standards of practitioners, it is essential that high ethical standards be exhibited in carrying out their duties.

2. The function of a practitioner in society

In society founded on respect for human rights, a practitioner fulfils a special role. Patients are entitled to good standards on competence and conduct from practitioners. The duties of a practitioner do not begin and end with the faithful performance of his job but encompasses the necessity to serve the interests of the patients as well.

A practitioner's function therefore lays on him or her variety of ethical and moral obligation towards:-

(a) The patient

(b) The medical and dental professions in general and each follow member in particular;

3. The nature of the code of professional ethics

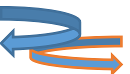
The code is designed through an obligation acceptance to those it applies to ensure proper performance. Failure of a practitioner to observe the code may result in a disciplinary sanction.

The rules herein therefore, require conduct that makes the care of the patient the practitioner's first concern, is ethical, does the patient no harm, and expects professional cooperation with other members of the health team and action against the practitioner if his or her practice places a patient at avoidable risk.

The acts or omissions set out in this code among others constitute acts or omissions in respect of which the council may take disciplinary steps against a practitioner. They however do not necessarily constitute an exhaustive list of unprofessional conduct and as such the council may inquire into and deal with any allegation that may be brought therefore it, based on generally accepted standards of conduct care and competence expected of a practitioner.

PART II- ETHICAL OBLIGATION

4. Respect for Human Rights



1) A practitioner shall not violate the human rights of a patient the patient's family or his or her caregiver.

2) A practitioner shall;-

(a) Not use his or her professional skills to participate I any actions that lead to violations of human rights

(b) Report to the Council if there has been a violation of human rights;

(c) Not carry out any specific actions that constitute a violation of bill of rights enshrined in the Constitution of Uganda and international human rights law.

5. Respect for persons

A practitioner shall not;-

(a) Discriminate in the management of patients basing on gender, race, religion, disability, HIV status or any other indication of vulnerability

(b) Act violently or indecently towards a patient, a professional colleague or the general public.

6. Protection of privacy

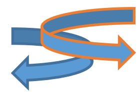
A practitioner shall observe the patient's confidentially and privacy and shall not disclose any information regarding the patient except-

(a) With the express consent of the patient; or in the case of a mirror with the consent of a patient or guardian; or in the case of a mentally disadvantaged or unconscious or deceased patient, with the consent of his or her authorized next of kin.

(b) To the extent that it is necessary to do so in order to protect the public or advance greater good of the community.

7. Integrity

A practitioner shall not-



(a) Aid in any form to inflict violence, torture, or degrading punishment or treatment to a person by the state or a private individual;

(b) Conduct any intervention or treatment without consent except where a bonafide emergency obtains.

8. Access to Health Care Services

(1) A practitioner shall not deny emergency treatment or health care to a patient.

(2) A practitioner shall at all times exercise due diligence and provide services of good quality of good quality especially where he or she ears responsibility for the resources that determine the quality of care.

PART III- STANDARDS OF PROFESSIONAL PRACTICE

9. Clinical Practice

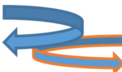
A practitioner shall-

(a) Regular update his or her skills and knowledge base to his or her scope of practice;

(b) Maintain adequate standards of equipment ad hygiene in all aspects of his or her service;

(c) Assess a patient's condition based on the history and clinical signs and where necessary carry out appropriate investigations;

(d) Refer a patient to another practitioner, where it is deemed necessary;



(e) Keep clear, accurate and current records of the relevant clinical findings the decisions made advice given and treatment prescribed to a patient;

(f) Meet the standards of professional practice that are generally regarded as appropriate nationally and internationally;

(g) Not perform a professional act for which he or she is inadequately qualified or insufficiently experienced;

(h) Not perform a professional act under improper conditions or in an appropriate surroundings;

(i) Not over-service a patient for his or her own personal gain;

(j) Not issue a false medical reports;

10. Participation in Biomedical Research

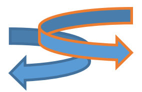
A practitioner shall-

(a) Subject his or her research proposal to authorized institution ethical review;

(b) Ensure the protection of human rights of all study participants;

(c) Conform to recognized norms and guidelines for acceptable ethical practice in research.

11. Developing and Implementing Health Policies



A practitioner shall-

(a) Not promote or implement policies related to health and health care that violate the human rights of a patient or a community,

(b) Not promote or implement policies related to health and health care that lead to poor quality;

(c) Observe, at all times, ethical and human rights implementation of health policies.

12. Advertising

A particular shall not advertise his or her services in an unprofessional manner

13. Canvassing and touting

A practitioner shall not canvass or tout for patients in any manner whatsoever.

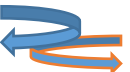
14. Professional stationary

1. A practitioner shall not print on any professional stationary such as letterheads and account forms any information other than his or her name, profession, registered category, specialty (If any), registered professional qualifications or other academic qualifications and honorary degrees in abbreviated form, addresses, telephone numbers and hours of consultation.

2. A group of practitioners as a juristic person may indicate such fact on their professional stationery.

3. A practitioner shall not use prescription forms or envelopes bearing the name and address of a pharmacist.

15. Practice names



A practitioner shall not for private practice, use a name or any other expression that creates the impression that such a practice is in association with or affiliated to an existing hospital or clinic.

16. Itinerant practice.

A practitioner shall not carry out itinerant practice at a place where another practitioner is established unless he or she renders the same service at the same cost, as in the place where he or she is resident.

17. Fees and commissions

A practitioner shall not do the followimg;

(a) Accept a commission from a person or another practitioner in return for substances or materials used by him or her in the conduct of his or her practice;

(b) Pay a commission to any person for recommending a patient;

(c) Share fees with any person or practitioner who has not taken a part in the service for which those fees are charged;

(d) Charge or receive fees for services not personally rendered, except for services rendered by another practitioner with whom he or she is associated as a partner, shareholder in a juristic person;

(e) Receive any consideration from or on behalf of a particular facility or institution in return for carrying out any professional activities for such facility or institution.

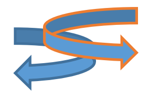
18. Partnerships and juristic persons.

A practitioner shall not-

(a) Practice in partnership or association with a person not accredited or registered with the council as a health professional;

(b) Practice in partnership, association or as a juristic person outside the scope of the profession in respect of which the practitioner is registered.

19. Covering



A practitioner may not-

(a) Employ as a professional assistant or locum tenens, a person not registered as a practitioner;

(b) Help or support a person registered in respect of a profession in any illegal practice or conduct;

(c) Employ any person who is suspended from practicing.

20. Taking over a patient

A practitioner shall not take over patient from another practitioner without taking reasonable steps to inform the practitioner who was originally in charge of the case.

21. Impeding

A practitioner may not impede a patient, or someone acting on behalf of a patient, from obtaining the opinion of another practitioner or from being treated by another practitioner.

22. Professional reputation of colleagues

A practitioner shall not unjustifiably cast doubt on the probity or professional reputation or skills of another practitioner.

23. Certificates and Reports

(1) A certificates of illness granted by a practitioner shall contain the following information;

(i) The name, address and qualification of the practitioner;

(ii) The name of the patient;

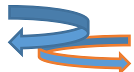
(iii) The employment number of the patient (if applicable);

(iv) The date and time of the examination;

(v) Whether the certificate is being issued as a result of personal observation by the practitioner during an examination, or as the result of information received the patient and which is based on acceptable medical grounds;

(vi) A description of the illness, disorder or malady in layman's terminology (with the consent of the patient);

(vii) Whether the patient is totally indisposed for duty or whether the patient will be able to perform less strenuous duties in the work situation;



(viii) The exact period of recommended sick leave;

(ix) The date of issuing the certificate of illness; and

(x) A clear indication of the identity of the practitioner who issued the certificate.

(2) Where the practitioner uses pre-printed stationery he or she shall delete words that are irrelevant.

(3) A practitioner shall issue a brief factual report where a patient requires information concerning him or herself.

24. Professional Appointment

A practitioner shall not accept any professional appointment, except in accordance with a written contract of appointment that is not drawn up on a basis, which is detrimental to the interests of the public or the profession.

25. Secret remedies

A practitioner shall not in the conduct of his or her practice use

(a) Any form of treatment, apparatus or technical process which is secret or is claimed to be secret;

(b) Any apparatus, which has been prove upon investigation to be incapable of fulfilling the claims, made in regard to it.

26. Consulting rooms.

A practitioner shall not share a consulting or waiting room with a person not registered with the Council as a practitioner; or has an entrance to or a nameplate at the entrance of such person's consulting or waiting room or business.

27. Statutory duties of the council

A practitioner shall not-

(a) Perform any act, which prevents the Council or the registrar from carrying out duty mandated by legislation.

(b) Communicate with a person whom he or she knows to be a witness at an inquiry into his or her professional conduct on any aspect of the evidence to be given by such witness at the inquiry.

28. Exploitation

A practitioner shall not permit himself to be exploited in a manner that is detrimental to the public or professional interest.

29. Medicines

(1) Subject to legislation relating to medicines control, a practitioner shall not;

Participate in the manufacture (for commercial purposes), sale, advertising or promotion of any medicine, or in any other activity that amounts to trading in medicines;

Advocate the preferential use or prescription of any medicine, if any valuable consideration is derived from such preferential use or prescription.

(2) Without prejudice to sub-rule (1), a practitioner shall not be prohibited from owning shares in a registered company manufacturing or marketing medicines, from being an owner or part owner of a pharmacy, or while being employed by a pharmaceutical concern, from performing duties as are normally performed in accordance with such employment.

(3) A Practitioner shall not prescribe or supply any substance listed in legislation relating to medicines control as habit-forming or potentially so, unless he or she has ascertained through a personal examination, or by virtue of a report by another practitioner under whose treatment the specific patient has been, that such a prescription or supply is necessary for the treatment of the patient, except in the case of a repeat prescription for a patient with a chronic illness.

30. Financial Interests in Hospitals

A practitioner, who has a financial interest in a private clinic or hospital, shall not refer a patient to such a clinic or hospital without disclosing that he or she has a financial interest in such a clinic or hospital.

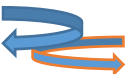
31. Specialists

A practitioner shall not contravene the conditions of practicing as a specialist.

32. Impairment.

A practitioner shall-

a) Report impairment in another practitioner to the Council if he or she is convinced that such other practitioner is impaired.



b) Report his or her own impairment to the Council if he or she is aware of his or her impairment or has been advised to obtain help in view of impairment.

PART V- LEGAL AND GENERAL OBLIGATIONS

33. Conviction in a court of law.

Where a practitioner has been convicted in a court of law or a legal tribunal has made an adverse finding against him or her, the Council shall deal with him or her in accordance with the Act

34. Delegation of care.

1) Where a practitioner believes it is appropriate, he or she may delegate medical care of a patient to a Nurse or other health care staff who are not registered practitioners; he or she shall ensure that the person to whom he or she delegates is competent to undertake the procedure or therapy involved, and to ensure that enough information about the patient and the treatment needed is passed on.

2) Where the practitioner has delegated care, he or she shall still be legally responsible for management of the patient.

35. General obligations

In addition to the specific rules set out above, a practitioner shall at all times comply with the norms and standards of professional conduct, car and competence generally accepted by the profession.

36. Interpretations

In this code, unless the context otherwise requires-

“Act” means the Medical and Dental Practitioners Act, Cap. 272 of the laws of

Uganda;

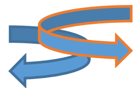
“Council” means the Medical and Dental Practitioners Council established under the Act;

“Juristic person” means any legal entity duly constituted or otherwise organized under the Laws of Uganda (including any corporation, partnership, joint venture, trust or association)

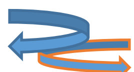
“Practitioner” means a person registered under the Act to practice medicine, surgery or dentistry;

“Registrar” means the Registrar of the Council;

“Specialist” means a practitioner who has trained full time for not less than three years in an institution or in different institutions under guidance of a consultant or consultants or senior



professionals in the relevant field of medical or dental practice and has obtained a post graduate qualification.



Appendix six: THE TRADITIONAL AND COMPLEMENTARY MEDICINE ACT, 2019.

THE REPUBLIC OF UGANDA

THE TRADITIONAL AND COMPLEMENTARY MEDICINE ACT, 2019.

THE REPUBLIC OF UGANDA

I SIGNIFY my assent to the bill.

Date of assent:-... (7 (QĐO

Act Traditional and Complementary Medicine Act 2019

THE TRADITIONAL AND COMPLEMENTARY MEDICINE ACT, 2019.

ARRANGEMENT OF SECTIONS

Section

PAIU I—PRELIMINARY.

l . Commencement

2. Objectives of Act

3. Interpretation

PART Il—ESTABLISHMENT, OBJECT AND FUNCTIONS OF THE NATIONAL COUNCIL OF TRADITIONAL AND COMPLEMENTARY MEDICINE PRACTITIONERS.

4. The Council

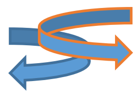
5. Composition of Council

6. Associations of traditional and complementary medicine practices

7. Object and functions of the Council

8. Tenure of office of members

9. Termination of office 10. Meetings of the Council l l . Committees of the Council



12. Disciplinary Committee of the Council

13. Intellectual Property Rights Committee

14. Allowances of members of the Council

15. Collaboration with other agencies

PART Ill—SECRETARIAT AND STAFF OF COUNCIL.

16. Secretariat

17. Management of traditional and complementary medicine at local government level

18. The Registrar

19. Functions of the Registrar

20. Other staff of Council

PAKr IV—REGISTRÆION OF PRACTITIONERS.

21. Registration of practitioners

22. Qualification for registration

23. Registration of non-citizens and foreign trained practitioners

24. Duration and renewal of certificate of registration.

25. Titles of practitioners

26. Suspension of registration

27. Cancellation of registration

28. Restoration of name on register

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30. Licensing of Practices

31. Application and conditions of licence

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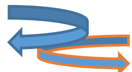
33. Display of licence

34. Application by non-citizen



35. Revocation, suspension or refusal to renew licence

36. Notice of revocation, suspension or refusal to licence

37. Refusal to grant a licence

38. Effect of suspension or revocation of licence

39. Representation of the Council

40. Power of entry and inspection

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Traditional and Complementary Medicine Act 2019

THE REPUBLIC OF UGANDA

THE TRADITIONAL AND COMPLEMENTARY MEDICINE ACT, 2019.

An Act to define traditional and complementary medicine in relation to modern medicine, to establish a Council to control and regulate the practice of traditional and complementary medicine, to register and license practitioners and to provide for related matters.

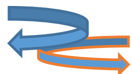
DÆE OF AssENT:

Date of Commencement:

BE IT ENACTED by Parliament as follows:

PARr I—PRELIMINARY.

1. Commencement.



This Act shall come into force on a date the Minister may by statutory instrument appoint; but the Minister may appoint different dates for the commencement of different provisions of this Act.

Act Traditional and Complementary Medicine Act 2019

2. Objectives of Act.

The Objectives of this Act are to—

(a) define and standardise the concept of traditional and complementary medicine practice;

(b) provide for registration and categorisation of traditional and complementary medicine practitioners;

(c) define the acceptable scope and standard of traditional and complementary medicine practice as well as unacceptable malpractices;

(d) institute appropriate rewards for good Practice and sanctions against malpractices in traditional and complementary medicine practice;

(e) protect and promote the profession of traditional and complementary medicine practice;

(f) promote the sustainable production of agro-business medicinal plants; promote the use of authentic and quality traditional and complementary medicine products;

(h) promote the rational use of traditional and complementary medicine through the provision of scientific evidence; promote collaboration and integration of traditional and complimentary medicine with conventional medicine;

(j) provide for the regulation of herbal medicine and herbal practice;

(k) provide for quality assurance in the delivery of traditional and complementary medicine services; create a Council responsible for the regulation oftraditional and complementary medicine practitioners and define their roles; and

(m) ensure professional discipline and good conduct among traditional and complementary medicine practitioners.

Act Traditional and Complementary Medicine Act 2019

3. Interpretation.

In this Act, except where the context otherwise requires—

"advertisement" includes any notice, circular, label, wrapper or a document, and an announcement made orally or by means of producing or transmitting light or sound;

"association" means an association or body of associations of traditional or complementary medicine practitioners registered under the laws of Uganda and recognized by the Council;

"bio—diversity" means living things of varied nature;

"complementary medicine" refers to health care practices that are not part of the traditional or conventional medicine of Uganda and can be used alone or along with conventional medicine including aromatherapy, homeopathy, naturopathy, reflexology and Ayurveda;

'complementary medicine practitioner" means a person registered under this Act to practice complementary medicine;

"conventional medicine" means a system in which medical doctors and other healthcare professionals such as nurses, pharmacists, and therapists treat symptoms and diseases using drugs, radiation or surgery;

"Council" means the National Council of Traditional and Complementary Medicine Practitioners established under section 4;

"currency point" has the value assigned to it in the Schedule

1 to this Act;

"herbal medicine" means any finished labeled medicinal product that contains active ingredients of aerial or underground

Act Traditional and Complementary Medicine Act 2019

parts of plants or other plant material or a combination of them, whether in a crude state or as a plant preparation and for the purpose of this definition—

(a) herbal medicine may contain inactive substances in plant material in addition to the active ingredients and in exceptional cases may also contain natural organic active ingredients, that are not of plant origin; and

(b) plant material includes extracts, gums, fatty oils and any other substance of that nature;

"inspector" means a person empowered under Part V of this Act to enter any premises;

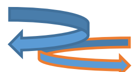
"Minister" means the Minister responsible for health; "Ministry" means the Ministry responsible for health;

"Practice" means traditional and complementary medicine practice;

"practitioner" means a person registered and licensed under this Act to practice traditional or complementary medicine;

"traditional medicine" means the sum total of knowledge, skills, and practices based on theories and experiences indigenous to the different cultures in Uganda, whether explicable or not, used to maintain health and also to prevent, diagnose, improve or treat physical or mental illness;

"traditional medicine practitioner" means a person registered under this Act who uses a recognised aspect of traditional medicine for the prevention, promotion and maintenance of health, diagnosis and treatment of diseases."



PARr Il—ESTABLISHMENr, OBJECT AND FUNCTIONS OF THE

NÆIONAL COUNCIL OF TRADITIONAL AND COMPLEMENTARY MEDICINE PRACTITIONERS.

4. The Council.

(1) There is established a Council to be known as the National Council of Traditional and Complementary Medicine Practitioners.

(2) The Council shall be a body corporate with perpetual succession and a common seal.

(3) The Council shall in its own name be capable of—

(a) entering into any contract, acquiring, holding or disposing of property movable or immovable, necessary for the attainment of the objectives of the Council and the performance of the functions of the Council under this Act;

(b) suing or being sued; and

(c) doing or suffering all acts and things a body corporate may lawfully do or suffer.

5. Composition of the Council.

(l) The Council shall consist ofthe following members— (a) two representatives of the association of traditional medicine practitioners, one of whom shall be a herbalist;

(b) two representatives of the association of complementary medicine practitioners;

(c) a representative from the National Drug Authority;

(d) the commissioner for clinical services in the Ministry or his or her nominee;

(e) the director of research at the Natural Chemotherapeutical Research Institute or his or her nominee.

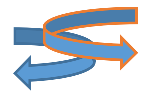
(2) The Registrar appointed under section 18 of this Act shall be secretary to the Council and an ex-officio member of the Council.

(3) The Minister shall appoint the chairperson of the Council from the members of the Council.

(4) The Minister shall appoint the members referred to in subsection (l) (a) and (b).

(5) At least one third of the members of the Council shall be women.

6. Associations of Traditional and Complementary medicine practitioners.



(l) The Minister shall supervise the formation of associations for traditional and complementary medicine practitioners.

(2) Where the Council is formed before the associations referred to in sub-section (l) are in existence, the Minister shall appoint interim representatives for traditional and complementary medicine practitioners.

7. Functions of the Council.

(l) The functions of the Council shall be to—

(a) register, license and monitor the activities of traditional and complementary medical practitioners;

(b) oversee the enforcement of this Act;

institute disciplinary action against traditional and complementary medicine practitioners for professional misconduct and unethical behavior;

(d) set standards and quality control measures and assurances for traditional and complementary medicine practitioners;

(e) promote continuous training and skilling for traditional and complementary medicine practitioner;

(f) approve, in consultation with the education and research institutions the curricula for training in traditional and complementary medicine in the institutions;

serve as a link between the conventional medicine practice fraternity and traditional and complementary medicine practitioners;

(h) protect and promote the legitimate and professional interests of traditional and complementary medicine practitioners;

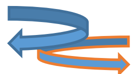
support the continuous growth and development of traditional and complementary medicine sector;

(j) promote continuous training and skills development for traditional and complementary medicine practitioners;

(k) receive complaints, investigate and discipline errant traditional and complementary medicine practitioners;

(l) maintain records relating to traditional and complementary medicine including research on traditional medicine;

(m) ensure the establishment of conservation areas and banks for medicinal plants; and



(n) do anything incidental or conducive to the attainment of its object and functions under this section.

8. Tenure of office of members.

A member of the Council other than a member appointed by virtue of his or her office shall hold office for three years and shall be eligible for re-appointment for only one more term.

9. Termination of office.

(1) Where a member of the Council other than the ex-officio member resigns, dies, is removed from office or is for any reason and Complementary

unable to act as a member of the Council, the appointing authority shall appoint another person to hold office for the unexpired term ofthe member's term of office.

(2) A member of the Council other than the ex-officio member may at any time resign from the Council.

(3) A member of the Council other than the ex-officio member that is absent for three or more consecutive meetings of the Council without sufficient cause shall cease to be a member of the Council.

(4) The Minister may in public interest terminate the term of office of a member of the Council.

10. Meetings of the Council.

The provisions of Schedule 2 to this Act shall have effect with regard to the meetings of the Council.

11. Committees of the Council.

(l) The Council may appoint committees composed of members of the Council and non members of the Council, to exercise any of the functions under this Act.

(2) Every committee of the Council shall be chaired by a member of the Council-

(3) The Council shall determine the functions and procedures of the committees of the Council.

12. Disciplinary Committee of the Council.

The Council shall appoint a disciplinary committee to deal with matters of professional misconduct, unethical behaviour and malpractices among the practitioners.

13. Intellectual Property Rights Committee.

The Council shall appoint a committee to ensure protection of the intellectual property rights of the practitioners.

14. Allowances of members of the Council.

There shall be paid to the members of the Council, members of a committee of the Council and any other person as the Council may deem fit such allowances as may be approved by the Minister in consultation with the ministers responsible for finance and public service.

15. Collaboration with other agencies.

In carrying out its functions, the Council shall collaborate with relevant agencies and institutions including the National Drug Authority, Uganda National Council for Science and Technology, Uganda National Research Health Organization and Uganda Communications Commission.

PART Ill—SECRETARIÃr AND STAFF OF COUNCIL.

16. Secretariat.

(l) The Secretariat of the Council shall be the Ministry of Health.

(2) For purposes of subsection (1), a unit shall be formed by the Permanent Secretary ofthe Ministry in consultation with the ministry responsible for public service to serve the Council.

(3) The unit shall comprise public officers determined by the Minister in consultation with the ministry responsible for public service.

17. Management of traditional and complementary medicine at the local government level.

The Council shall be represented in the district local government health management structures.

18. The Registrar.

(1) The Minister shall, in consultation with the ministry responsible for public service and the Council, appoint a Registrar of the Council.

(2) The Registrar shall hold office upon such terms and conditions as shall be specified in his or her letter of appointment.

(3) The Registrar shall be a practitioner with administrative and managerial experience.

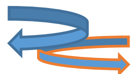
19. Functions of the Registrar-

(l) Subject to the directions of the Council, the Registrar shall be responsible for the day-to-day administration of the Council and shall be answerable to the Council in the performance of his or her functions under this Act.

(2) The Registrar shall keep up to date records of registered practitioners and licensed Practices under this Act.

(3) The Registrar shall as approved by the Council, issue and renew the registration certificates of practitioners and the licenses of Practices.

(4) The Registrar shall perform such other functions as the Council may determine.



(5) The Registrar may delegate any of his or her functions to a staff of the secretariat of the Council.

20. Other staff of the Council.

(l) The Council shall have such other officers and staff as may be necessary for the proper and effective performance of its functions.

(2) The Minister shall in accordance with the advice of the Council and in consultation with the ministry responsible for public service and on such terms and conditions as he or she may determine appoint other staff of the Council.

(3) The Council may engage the services of such consultants and advisers as it may determine upon the recommendation of the Registrar.

(4) Other public officers may be transferred or seconded to the Council or may otherwise give assistance to it.

PARr IV—REGISTRÆION OF PRACTITIONERS.

21. Registration of practitioners.

(l) A person shall not operate, own or use premises as a practitioner, producer, manufacturer, supplier or seller of traditional, herbal or complementary medicine unless that person is registered as a traditional or complementary medicine practitioner in accordance with this Act.

(2) A person seeking registration shall apply to the Registrar in such manner, as the Council shall determine.

22. Qualification for registration.

(l) A person is not qualified to practice as a traditional or complementary medicine practitioner unless—

(a) in the case of traditional medicine practice the person—

(i) has training, knowledge or skill in the practice of traditional medicine recognised by the Council; and

(ii) is recommended by; the district health office;

(B) a representative of the Council at the district local government; and

(C) a responsible officer from the cell or village council.

(b) in the case of complementary medicine practice, the person—

(i) holds a valid qualification in the field ofspecialisation of complementary medicine from an institute recognised by the Council;

(ii) has completed internship in complementary medicine for a period determined by the council; and

(iii) is recommended by; the district health office;

(B) a representative of the Council at the district local government;

(C) a responsible officer of the local council of the community; and

(D) an association of complementary medicine practitioners.

(2) Upon satisfaction by the Council that an applicant has fulfilled all the conditions for registration under this Act and has paid the prescribed fee, the Council shall direct the Registrar to enter the applicant's name in the register of practitioners and issue the applicant with a certificate of registration.

(3) A person issued with a certificate under subsection (2) shall be known as a practitioner for the purposes of this Act.

(4) Registration under this Act shall be in addition to registration required under any other law for the time being in force in respect of the Practice.

(5) The Council shall on an annual basis publish a list of all registered practitioners.

Act and Complementary

23. Registration ofnon-citizens and foreign-trained practitioners. A person who is not a citizen ofUganda or a foreign trained practitioner may be registered as a practitioner where that person—

(a) is the holder of a work permit or is otherwise entitled to engage in gainful employment in Uganda;

(b) has undergone internship training in an institution approved by the Council for a period determined by the Council;

(c) has a good working knowledge of the official language of

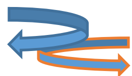
Uganda or an indigenous language of Uganda;

(d) has proof of qualification and registration to practice in his or her country of origin or where he or she was trained; and

(e) has paid the prescribed fee.

24. Duration and renewal of certificate of registration. The certificate of registration shall expire after twelve calendar months from the date of issue.

25. Titles of practitioners.



The Minister may on the recommendation of the Council, prescribe by regulations the titles to be used by practitioners based on the type of service rendered and the qualifications of the practitioners.

26. Suspension of a practitioner.

The Council may suspend a practitioner for a period determined by the Council where—

(a) the pratitioner is being investigated for an offence committed in relation to the Practice;

(b) allegations of misconduct have been made against the practitioner;

Traditional and Complementary Medicine Act 2019

(c) a false declaration has been made in an application for a certificate or licence issued to him or her; or

(d) the practitioner has contravened any provision of this Act.

27. Cancellation of registration.

(l) A certificate of a practitioner may be cancelled by the Council on the recommendation of a committee of the Council where the practitioner—

(a) has been convicted of an offence under this Act or regulations made under it;

(b) has breached any of the terms of the licence for the Practice;

(c) has lost the qualification on the basis of which the registration was made; or

(d) has appeared before the disciplinary Committee of the council and the Committee had recommended that the certificate be cancelled.

(2) A certificate of a practitioner shall be cancelled where the Council considers it necessary in the interest of public health.

(3) The Council shall within two weeks after cancellation of a certificate of a practitioner notify the general public of the cancellation and give reasons for the cancellation.

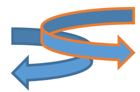
28. Restoration of name on register.

(l) A practitioner whose registration is suspended may apply to the Council for restoration of his or her name on the register where the period of suspension has elapsed and the reasons for the suspension have been rectified.

(2) Subject to subsection (1), the Council may direct the Registrar to restore the name of a practitioner on the register.

Act Traditional and Complementary Medicine Act 2019

29. Rioht of a practitioner to be heard by the Council.



(l) The Council shall give a practitioner at least notice of fourteen days of the intention of the Council to suspend or cancel registration of the practitioner.

(2) The Council shall give the practitioner an opportunity to be heard before a decision is made by the council.

PARF OF PRACTICES.

30. Licensing of Practices.

A person shall not own or operate a Practice unless he or she holds a licence in respect of the Practice issued under this Act and holds a licence issued under the National Drug Policy and Authority Act Cap. 206 in respect of the medicine.

31. Application and conditions of licence.

(l) A person may apply to the Council for a licence through the representative of the Council at the district local government within the area in which the Pactice is to be operated and in such form as the Council shall determine.

(2) There shall be attached to the application—

(a) the block plan of the premises for the Practice, where applicable;

(b) approval from the physical planning office or relevant authority on land use, where applicable;

(c) evidence of ability ofthe applicant to carry out the Practice and proof of applicant's registration;

(d) testimonials of the applicant and recommendation from the association of either traditional or complementary medicine as the case may be;

(e) two passport size photographs of the applicant;

Act Traditional and Complementary Medicine Act 2019

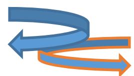
(f) a list of the types of services to be rendered by the practitioner; the prescribed licence fee; and

(h) any other additional information, as shall be determined by the Council;

(3) A licence shall not be issued to an applicant unless the Council is satisfied that the applicant—

(a) is registered as a practitioner under this Act;

(b) has the experience and competence to manage the Practice in accordance with this Act; and



(c) has complied with any other requirement specified by the Council, the provisions of the National Drug Policy and Authority Act and any other relevant law.

(4) Where applicable the Council may request from the applicant—

(a) clearance or an appropriate permit from the National

Environmental Management Authority; and

(b) evidence of financial viability for the ownership and operation of the Practice.

32. Issue and renewal of licence.

(l) Where the Council is satisfied that an applicant has fulfilled all conditions required under this Act for licensing of a Practice, it shall approve the application and issue the applicant with a licence.

(2) The licence shall expire after twelve calendar months from the date of issue.

(3) There shall be paid by the applicant in respect of the licence and renewal of the licence such fee as may be prescribed and a licence or renewal shall not be issued or made unless the prescribed fee is paid.

Act Traditional and Complementary Medicine Act 2019

33. Display of licence.

The licence shall be displayed in a conspicuous place in the premises of the practitioner which is accessible to the public.

34. Application by non-citizen.

(I) A non-citizen may apply for a licence to the Council through the representative ofthe Council at the district local government within the area in which he or she intends to practice.

(2) The applicant shall indicate that he or she—

(a) has a valid work permit issued by the responsible authority;

(b) has evidence of being trained in the Practice of traditional medicine in his or her country of origin, if he or she was not trained in Uganda, and has been registered or licensed as a practitioner;

(c) has at least five years post qualification experience in a recognized institution relevant to traditional and complementary medicine; and

(d) has passed—

(i) an English language proficiency test where the applicant is not trained in English; and

(ii) any professional test set by the Council, where applicable;

(iii) has registered with the Uganda Investment Authority, where applicable; and

(iv) has fulfilled the conditions set out in section 3 1 (2) as the Council may determine and any other conditions set by the Council.

Act Traditional and Complementary Medicine Act 2019

35. Revocation, suspension and refusal to renew licence.

(1) The Council may revoke, suspend or refuse to renew a licence of a Practice where the Council is satisfied that—

(a) the provisions ofthis Act are not being complied with;

(b) the continued operation of the Practice creates risk to public health, safety or is immoral;

(c) the services provided in the Practice have deteriorated below the required standard;

(d) qualified practitioners have not been employed by the owner or operator of the Practice;

(e) a practitioner in the Practice is not a fit or qualified person to be so employed;

(f) there is a breach of quality control requirements in the preparation of the herbal medicine dispensed by the Practice; and

any other reasonable requirement the Council deems fit has not been complied with.

(2) Where the Council revokes, suspends or refuses to renew a licence of a Practice, the Council shall notify the general public in a newspaper of wide circulation of the area or in case of a local authority, the notification shall be displayed at the sub-county headquarters.

36. Notice of suspension, revocation of licence and refusal to renew licence.

(l) Where the Council intends to suspend or revoke or refuse to renew a licence of a Practice, the Registrar shall give the licensee—

(a) notice of intention to suspend, revoke or refuse renewal;

(b) reasons for the intention to suspend, revoke or refuse; and

Act Traditional and Complementary Medicine Act 2019 (c) an opportunity to be heard.

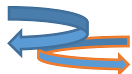
(2) Subject to sub-section (l)(a), the notice shall be given at least fourteen days before the decision to suspend, revoke or refuse to renew is made.

37. Refusal to grant a licence.

(l) Where the Council intends to refuse to issue a licence, the

Registrar shall give the applicant— (a) reasons for refusal; and

(b) an opportunity to be heard.



(2) Subject to sub-section (l) the applicant shall be given an opportunity to be heard within fourteen days before a decision to refuse is made.

38. Effect of suspension or revocation of licence.

Where the licence of a Practice is suspended or revoked under this Act, the premises shall be closed down and such practitioner shall be barred from carrying out a related Practice from any other place or location.

39. Right to be heard.

(1) A licensee who receives a notice under sections 36 may appear in person or by representation before the Council within fourteen days from the date of receipt of the notice.

(2) Where a representation is not made under subsection (1 the Council may revoke a licence or temporarily close the Practice after the time specified under subsection (l) has expired.

(3) Where representation is made under this section the affected Practice shall subject to subsection (2) not operate until the Council determines the case.

Act Traditional and Complementary Medicine Act 2019

(4) The Council shall within three months after the receipt of a representation under subsection (l), take a decision and inform the licensee of its decision within fourteen days.

40. Power of entry and inspection.

(1) An inspector authorized by the Council may at any reasonable time enter a Practice or a place suspected to be used as a Practice or a place for the production of herbal medicines for sale, to investigate activities there and make a report to the Council.

(2) Where an inspector enters any premises by virtue of subsection (l) he or she shall inspect—

(a) the licence, registers, books and equipment of the Practice;

(b) the registration certificate of any practitioner;

(c) the premises;

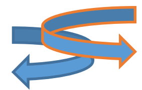
(d) any herbal medicines and may conduct random sampling of the herbal medicines to determine compliance with the quality control requirements; and

(e) any other thing, which is relevant to the investigation.

(3) The inspector shall produce his or her authorization.

(4) The Council shall cause each Practice to be inspected at least once a year.

(5) The Council may order the temporary closure of a Practice in the presence of a police officer if it considers it in the public interest to do so.



(6) Nothing in this section shall be construed as authorising the inspection of any medical record of a patient found in premises of a Practice except where such patient has given written authorization to the Council to inspect the medical record.

Act Traditional and Complementary Medicine Act 2019

41. Obstruction of inspector.

A person shall not obstruct an authorised inspector in the conduct of his or her duty under this Act.

42. Notification of chairperson of the local council.

A practitioner shall notify the chairperson of the local council in that area within twenty-four hours of any death, which occurs on the premises of the Practice.

PARF VI—FINANCIAL PROVISIONS.

43. Funds of the Council.

The funds of the Council shall consist of—

(a) monies appropriated by Parliament for the purposes of the Council;

(b) revenue derived from the sale of property, movable or immovable, by or on behalf of the Council.

fees derived from services offered, fines and penalties instituted by the Council.

44. Power to open and operate bank accounts.

(l) The Council may, with the approval of the Accountant General open and maintain such accounts as are necessary for the performance of the functions of the Council.

45. Estimates.

The Registrar shall, within three months before the end of each financial year, cause to be prepared and submitted to the Council for its approval, estimates of the income and expenditure of the Council.

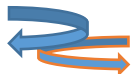
46. Financial year of the Council.

The financial year of the Council shall be the same as the financial year for the Government.

Act Traditional and Complementary Medicine Act 2019

47. Accounts.

(1) The Registrar shall cause to be kept, proper books of accounts and records of the transactions of the Council in accordance with accepted accounting principles.



(2) Subject to any direction given by the Council, the Registrar shall cause to be prepared an annual financial statement stating the basis of accounting and shall identify any significant departure from it and the reasons for departure.

(3) The statements of account shall include—

(a) a balance sheet, an income and expenditure account and a source and application of Council's statement; and

(b) any other information in respect of the financial affairs of the Council as the Auditor General or auditor appointed by the Auditor General may, in writing require.

48. Audit.

(l) The Auditor General or an auditor appointed by the Auditor shall, in each financial year, audit the accounts of the Council in accordance with National Audit Act, 2008.

(2) The Registrar shall ensure that three months after the end of each financial year, a statement of accounts is submitted to the Auditor General or to an auditor appointed by the Auditor General for auditing.

49. Annual report.

(1) The Council shall submit to the Minister, as soon as practicable and in any case not later than six months after the end of each financial year, a report dealing generally with the activities

and operations of the Council during the year to which the report relates.

(2) The report referred to in subsection (l) shall contain—

(a) the audited accounts of the Council and the Auditor General's report on the accounts of the Authority; and

(b) such other information as the Council may consider necessary.

(3) The Minister shall, within two months after the receipt of the annual report, submit the report to Parliament with any statement which he or she considers necessary.

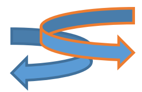
50. Compliance with Public Finance Management Act, 2015. The Council shall at all times comply with the Public Finance Management Act, 2015.

PARr VII—GENERAL.

Minimum standards to be maintained in the practice oftraditional and complementary medicine.

51. Application of Part VII.

The provisions of this Part shall apply with regard to the minimum standards to be maintained in the practice of traditional and complementary medicine.



52. Code of conduct.

The following shall be followed as a code of conduct of practitioners of traditional and complementary medicine— (a) respect for patients;

(b) non exploitation of patients;

(c) respect for community values and acceptable moral and societal norms;

Act Traditional and Complementary Medicine Act 2019

(d) promotion of beneficial aspects of traditional medicine;

(e) elimination of harmful Practices;

(f) promotion of social justice through safe, acceptable and cost effective traditional medicines and Practice; and (g) the informed consent of the patient.

53. Ethical principles.

In the practice of traditional and complementary medicine the following ethical principles shall be maintained— (a) protection of the individual or patient;

(b) confidentiality and privacy of patients;

(c) informed consent of patients;

(d) prevention ofprejudice and discrimination against patients;

(e) respect for the dead;

(f) respect of intellectual property rights; and adequate compensation for services rendered and for injuries, damages or losses arising from malpractice.

Relationship between traditional and complementary medicine practice and conventional medicine practice.

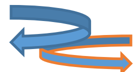
54. Dual Practice.

(l) A person who desires to carry on dual Practice is authorized to do so upon fulfillment ofthe requirements stipulated in this Act.

(2) A conventional medicine practitioner who wishes to practice traditional or complementary medicine shall obtain a certificate of registration for the Practice and a license in accordance with this Act.

55. Non-use of conventional medical titles.

(1) A person who practices traditional or complementary medicine shall not use or refer to himself or herself a title belonging to the practice of conventional medicine for which the person is not qualified, such as doctor, nurse or professor.



(2) The Minister may on the recommendation by the Council, by statutory order declare titles to be used by practitioners of traditional and complementary medicine based on their qualifications and quality of service rendered.

56. Regulations for Part VIl.

The Minister may by regulations made under section 64 prescribe any details required to give full effect to this Part and may by the regulations prescribe penalties in respect of contravention of the regulations including disciplinary penalties; and may provide for appeals from disciplinary proceedings.

PART VIII—MISCELLANEOUS.

57. Form of seal.

The common seal of the Council shall be in a form approved by the Council.

58. Protection from liability.

A member of the Council or any employee of the Council or other person engaged by the Council shall not be liable for any act done by him or her in good faith on behalf of the Council or under the instructions of the Council.

59. Ministerial responsibility and directives.

The Minister shall have ministerial responsibility for the council and may give to the Council directives of a general nature on the policy to be followed by the Council in the performance of its functions.

60. Register of traditional and complementary medicine practitioners.

The Registrar shall record in a register to be known as the Register of traditional and complementary medicine practitioners the names of registered practitioners and premises licensed for that Practice under this Act.

61. Patent rights in relation to traditional and complementary medicine.

This Act does not prohibit the right of any person to claim patent rights in respect of any invention relating to traditional and complementary medicine under any law relating to patents.

62. Offences.

(l) A person who—

(a) owns or operates a Practice without having been registered as a practitioner under this Act;

(b) uses a Practice for services other than those for which it is licensed;

(c) makes a false declaration in an application for registration or for licence;

(d) provides the Council with false information concerning a Practice;

(e) obstructs the entry for inspection of an authorised inspector;

(f) prevents an authorised person from closing down the Pactice;

(g) disregards safety regulations made under this Act;

(h) pollutes the environment in the course of his or her operations under this Act;

(i) works in a Practice without the appropriate qualification or registration; uses a title for which he or she is not qualified;

(k) fails to keep the required register or records prescribed by regulations;

(1) fails to notify a local council authority of death in his or her Practice; or

(m) breaches the ethical principles and code of conduct;

commits an offence and is liable on conviction to a fine not exceeding three hundred currency point or imprisonment not exceeding two years or both.

Act Traditional and Complementary Medicine Act 2019

(4) The trial court may where necessary order the closure of the premises of the Practice on such conditions as it deems fit.

63. Appealing the decision of the Council.

(l) A practitioner who is dissatisfied with a decision of the Council regarding registration, cancellation or suspension of a certificate or licence or closure of premises of Practice, may apply to High Court for review of the decision of the Council.

(2) A person who is dissatisfied with the decision of the Council regarding the issuance of licence may apply to High Court for review of the decision of the Council.

64. Regulations.

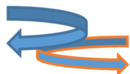
(1) The Minister may on advice of the Council by statutory instrument, make regulations for the better carrying into effect of the provisions of this Act.

(2) Without prejudice to the general effect of subsection (l), the Minister may prescribe—

(a) the standards of safety and sanitary conditions of a Practice;

(b) a code of ethics for practitioners and for disciplinary matters;

(c) how to regulate the arrangements for sterilisation and disinfection of a Practice and the prevention of spread of infections from a Practice;



(d) how the register and records are to be kept in respect of a Practice;

(e) the fees to be paid for registration of practitioners and licensing of a Practice;

(f) regulations of the preparation and storage of herbal medicines; and

(g) acts which constitute exploitation of patients.

Act Traditional and Complementary Medicine Act 2019

(3) Regulations made under subsection (l) may—

(a) prescribe fees in respect of anything to be done under this Act;

(b) prescribe penalties for the contravention of the regulations not exceeding a fine of one hundred and twenty currency points or imprisonment not exceeding five years or both;

(c) prescribe a higher penalty for repeated or continued offences; and

(d) require the court to confiscate anything used in the contravention.

65. Power to amend Schedules.

The Minister may amend the Schedules to this Act.

Act Traditional and Complementary Medicine Act 2019

SCHEDULE 1

Sections 3.

CURRENCY POINT.

One currency point is equivalent to twenty thousand Uganda shillings.

Act Traditional and Complementary Medicine Act 2019

SCHEDULE 2

Sections 10 1. Meetings of the Council.

(l)) The Council shall meet for the transaction of business at such times and at such places as the Chairperson may determine but shall meet at least once in every three months.

(2) The Chairperson shall at the request in writing of not less than onethird of the membership of the Council convene an extraordinary meeting of the Council at such a place and time as he or she may determine.

(3) Five members of the Council shall constitute a quorum.

(4) A meeting of the Council shall be presided over by the Chairperson and in his or her absence by a member of the Council elected by the members present from among their members.

(5) A matter before the Council shall be decided by a simple majority of the members present and voting and where there is an equality of votes, the Chairperson shall have a second or casting vote.

(6) The Council may co-opt any person to attend a Council meeting but that person shall not vote any matter for decision by the Council.

(7) Proceedings of the Council shall not be invalidated by reason of any vacancy in the membership of the Council or by reason of any defect in the appointment of any member or by reason that a person not entitled to be present or vote at any meeting of the Council was present or voted at the meeting.

(8) The Council may where it considers appropriate determine any matter by circulation of papers and indication of views by members except that a member may request that a specific matter should be dealt with formality by the Council.

2. Disclosure of interest.

(l) A member of the Council who has a direct or indirect pecuniary interest in a matter being considered or about to be considered by the Council

Act Traditional and Complementary Medicine Act 2019

shall, as soon as possible after the relevant facts have come to his or her knowledge, disclose to the Council the nature of his or her interest.

(2) A disclosure under sub paragraph (l) shall be recorded in the minutes of the meeting of the Council and the member making the disclosure shall not, unless the Council otherwise directs in respect of the matter—

(a) be present during any deliberation on the matter by the Council; or

(b) take part in any decision of the Council on the matter.

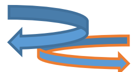
(3) A member who contravenes this paragraph is liable to be removed from the Council.

3. Minutes of meetings of the Council.

The Council shall cause the minutes of the proceedings of its meetings to be recorded and kept and the minutes shall be confirmed by the Council at the next meeting and signed by the Chairman or other person presiding at the next meeting.

4. Council to regulate its proceedings.

Subject to this Schedule, the Council may regulate its own proceedings and the proceedings of committees appointed by the Council.



Act Traditional and Complementary Medicine Act 2019

Cross References

1. National Drug Policy and Authority Act, Cap. 206.
2. Public Finance Management Act, 2015
3. National Audit Act, No. 7 of 2008.
4. Uganda Communications Commission Act, 2013
5. Uganda National Health Research Organisation Act, 2011
6. Uganda National Council for Science and Technology Act, 1990
7. National Environment Act, 1995

THE REPUBLIC OF UGANDA

This printed impression has been carefully compared by me with the bill which was passed by Parliament and found by me to be a true copy of the bill.

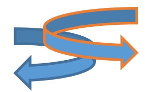
Clerk to Parliament

Date of authentication: .. . .

Appendix seven: Building Control Act, 2013

ACTS

SUPPLEMENT No. 511th October, 2013.



ACTS SUPPLEMENT

to The Uganda Gazette No. 51 Volume CVI dated 11th October, 2013.

Printed by UPPC, Entebbe, by Order of the Government.

Act 10 Building Control Act 2013

THE BUILDING CONTROL ACT, 2013

ARRANGEMENT OF SECTIONS

PART I—PRELIMINARY

Section

1. Commencement

2. Interpretation

PART II—NATIONAL BUILDING REVIEW BOARD

3. Establishment of the Board

4. Composition of the Board

5. Disqualification from appointment as member

6. Tenure of office of Board members

7. Remuneration of Board Members

8. Filling of vacancies of the Board

9. Functions of the Board

10. Official seal of the Board

11. Board's power to co-opt persons

12. Meetings of the Board

13. Committees of the Board

PART III—SECRETARIAT AND STAFF OF THE BOARD

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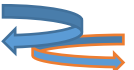
15. Executive Secretary

16. Functions of Executive Secretary



17. Other officers and staff of the Board

18. Experts and consultants

19. Protection of members and employees

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23. Financial year of the Board

24. Accounts

Section

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SCHEDULES

Schedule 1 - currency point.

Schedule 2 - Meetings and Procedure of the Board.

Schedule 3 - Meetings and procedure of Building Committees.

THE BUILDING CONTROL ACT, 2013

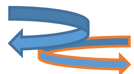
An Act to consolidate, harmonise and amend the law relating to the erection of buildings; to provide for building standards; to establish a National Building Review Board and Building Committees; to promote and ensure planned, decent and safe building structures that are developed in harmony with the environment; and for other related matters.

DATE OF ASSENT: 2nd October, 2013.

Date of Commencement: See section 1.

BE IT ENACTED by Parliament as follows—

PART I—PRELIMINARY



1. Commencement

This Act shall come into force on a date appointed by the Minister, by statutory instrument.

2. Interpretation

In this Act, unless the context otherwise requires—

“access’’ means the possibility for any person to reach a place, maneuver within it, use a service, participate in activities provided in a public place; with dignity, independence and safety on an equal basis with others;

“accessibility standards” refers to a practical guide to create a barrier-free physical environment in Uganda for all persons including persons with disabilities;

“application” means an application for a building permit made under section 35;

“architect” means a professional architect registered under the Architects Registration Act, and who is a member of the Uganda Society of Architects;

“authorised agent” means a person authorised by a Building Committee to act on its behalf;

“Board” means the National Building Review Board established by section 3;

“building” means—

(a) any structure, whether of a temporary or permanent nature, and, irrespective of the materials used in its erection, erected or used for or in connection with—

(i) the accommodation or convenience of human beings or animals;

(ii) the manufacture, processing, storage or sale of any goods;

(iii) the rendering of any service;

(iv) the destruction or treatment of refuse or otherwaste material; or

(v) the cultivation or growing of any plant or crop;

(b) a swimming pool, dam, bridge, tower or other structure connected with it;

(c) a fuel pump or tank used in connection with a pump;

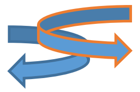
(d) an electrical installation or other installation connected with it;

(e) a gas supply installation or other installationconnected with it;

(f) any other part of a building or of an installation connected to the building;

“Building Committee” means a committee established under section 28;

“Building Control Officer” means a person appointed by the District Service Commission under section 32, and includes an assistant building control officer and an authorised agent; “building operation” means any act done in relation to—



(a) the erection of a building;

(b) the demolition of a building;

(c) any temporary work on a permanent building;

(d) plumbing;

(e) drainage;

(f) repairs, renovations, alterations and extensions of abuilding;

(g) erosion control works; or

(h) the installation of utilities, including electricity and gas;

"building plan" means architectural or engineering drawings required by a Building Committee in respect of a building operation;

"Chairperson" means the Chairperson of the Board appointed by the Minister under section 4(3);

"Code" means the National Building Code made under section 46;

"currency point" means the value assigned to it in Schedule 1;

"demolish" means any act relating to the removal of a building or any part of a building;

"earthwork" means—

(a) an excavation below natural ground level;

(b) a fill above natural ground level; or

(c) a support that is required to maintain the sides of anexcavation or a fill;

"engineer" means an engineer registered under the Engineers Registration Act;

"erection" in relation to a building, means its—

(a) construction;

(b) alteration;

(c) restoration;

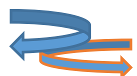
(d) conservation;

(e) extension;

(f) re-building;

(g) repair; or

(h) subdivision.



“Executive Secretary” means the Executive Secretary appointed by the Board under section 15;

“Minister” means the Minister responsible for building works;

“minor building works”—

(a) means a building operation of—

(i) a single storey dwelling constructed of temporary, semi-permanent or permanent materials such as mud and wattle, mud bricks, burnt bricks, concrete blocks or timber boards, and not more than thirty square metres in floor area;

(ii) a unit for poultry or livestock constructed of temporary semi-permanent or permanent material, not exceeding thirty square metres in floor area;

(iii) a tool shed, external kitchen or store, notexceeding thirty square metres in floor area;

(iv) a commercial structure such as a food kiosk,carpentry shed or blacksmith’s shed, constructed in temporary, semi-permanent or permanent materials, and not more than thirty square metres in floor area, whether as a free standing structure or as an addition to an existing building;

(b) does not include additions or alterations to existingbuildings relating to changes in plan or structure of the building such as painting, redecoration, replacing window or door shutters, floor finishes, wall fittings or damaged roof covering;

“physical planner” means a physical planner possessing the relevant qualifications from a recognised institute;

“regulations” means regulations made under section 52;

“standard” means any standard relating to—

(a) quality of goods and materials;

(b) methods of design;

(c) specifications;

(d) workmanship; or

(e) any other matter relevant to buildings as specified by the Uganda National Bureau of Standards established under the Uganda National Bureau of Standards Act;

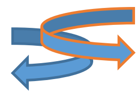
“surveyor” means a surveyor registered under the Surveyor’s Registration Act.

PART II—NATIONAL BUILDING REVIEW BOARD

3. Establishment of the Board

(1) There is established a National Building Review Board.

(2) The Board shall be a body corporate with an official seal andmay, for the discharge of its functions under this Act—



(a) acquire, hold and dispose of moveable and immoveable property;

(b) sue and be sued; and

(c) do all acts and things as a body corporate may lawfully do.

4. Composition of the Board

(1) The Board shall consist of—

(a) one representative of the department responsible for building works;

(b) one representative of the department responsible for physical planning;

(c) one representative of the ministry responsible for water and environment;

(d) one representative of the department responsible for housing;

(e) a representative of the Ministry responsible for persons with disabilities;

(f) one representative of each of the following professions, nominated for appointment by the relevant professional body or association—

(i) engineers;

(ii) architects;

(iii) physical planners;

(iv) surveyors;

(v) lawyers;

(g) a public health officer from the Ministry responsible for health;

(h) a representative of persons with disabilities nominated forappointment by the National Council for Disability;

(i) a representative of workers nominated for appointment by the national trade union centres;

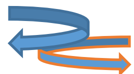
(j) a representative of Uganda Local Authorities Association of Uganda nominated for appointment by the Uganda Local Governments Association;

(k) a representative of Urban Authorities Association of Uganda nominated for appointment by the Association of Urban Authorities;

(l) one person from the private sector nominated for appointment by the Private Sector Foundation.

(2) At least one-third of the board members shall be women.

(3) The Minister shall appoint the members of the Board andshall designate as Chairperson of the Board, one of the members.



(4) The members of the board shall be eminent persons of goodrepute and standing in society, who are qualified and experienced or who possess specialized knowledge in matters relating to their respective fields.

(5) A member of the Board shall hold office on terms andconditions specified in his or her instrument of appointment.

5. Disqualification from appointment as member

A person shall not be appointed to the Board who is an undischarged bankrupt or who has made any assignment or arrangement with his or her creditors.

6. Tenure of office of Board members

(1) A member of the Board shall hold office for three years andis eligible for reappointment for one more term.

(2) The Minister shall appoint the first members of the Boardwithin six months after the coming into force of this Act.

(3) A member of the Board may, at any time, resign his or heroffice by letter addressed to the Minister.

(4) A member of the Board may be removed from office by theMinister at any time if the member— (a) is inefficient or incompetent;

(b) is incapacitated by mental or physical illness that renders him or her incapable of performing the functions of member of the Board;

(c) has been absent for more than four consecutive meetings of the Board, or is absent from Uganda for more than twelve months without reasonable cause;

(d) is declared bankrupt; or

(e) where a member ceases to be a member of the body which nominated him or her.

(5) The Minister may terminate or suspend the Board— (a) for misappropriation of the funds of the Board; and

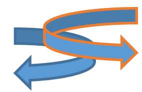
(b) for failure to implement the functions of the Board under this Act.

7. Remuneration of Board members

The Chairperson and other members of the Board shall be paid such remuneration as the Minister may determine in consultation with the Minister responsible for finance and Minister responsible for public service.

8. Filling of vacancies of the Board

(1) Where a vacancy occurs in the membership of the Board, theMinister may appoint another person qualified in terms of section 4 to fill that vacancy.



(2) Where a person is appointed to fill a vacancy undersubsection (1), that person shall hold office for the remainder of the term of the previous member and, subject to this Act, is eligible for re-appointment.

9. Functions of the Board

The functions of the Board are—

(a) to monitor building developments;

(b) to ensure that the design and construction of buildings and utilities to which the public is to have access cater for persons with disabilities;

(c) to oversee, inspect and monitor the operations of Building Committees;

(d) to prepare and submit to the Minister, reports relating to any matter under this Act, as the Minister may require;

(e) to hear and determine appeals from persons dissatisfied with the decisions of a Building Committee;

(f) to determine the fees to be charged by urban and district building committees for approval of plans, issue of building permits and occupation permits; and

(g) to perform any other function conferred on it by this Act.

10. Official seal of the Board

(1) The official seal of the Board shall be in a form determinedby the Board and shall be kept in the custody of the Secretary.

(2) The official seal shall, when affixed to any document, beauthenticated by the signatures of the Chairperson and the Secretary.

(3) In the absence of the Chairperson, one other member of theBoard appointed by the Minister for the purpose shall sign in the place of the Chairperson.

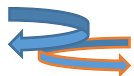
(4) A person performing the functions of the Secretary shall signin the absence of the Secretary.

(5) A contract or instrument which if entered into or executed bya person not being a body corporate would not be required to be under seal, may be entered into or executed without seal on behalf of the Board by the Secretary or any other person authorised for that purpose by the Board.

(6) Every document purporting to be—

(a) an instrument issued by the Board and sealed with the official seal of the Board and authenticated in the manner prescribed by this section; or

(b) a contract or instrument entered into or executed under subsection (5);



shall be received in evidence as such an instrument without further proof, unless the contrary is proved.

11. Board's power to co-opt persons

(1) The Board may co-opt any person who, in the opinion of theBoard, has expert knowledge concerning the functions of the Board and who is likely to be of assistance to the Board, to attend and take part in the proceedings of the Board.

(2) A person attending a meeting of the Board under subsection (1) may take part in any discussion at the meeting on which his or her advice is required, but shall not have a right to vote at that meeting.

12. Meetings of the Board

Schedule 2 has effect with respect to the meetings and procedure of the Board and other matters provided for in that Schedule.

13. Committees of the Board

(1) The Board may appoint committees to advise it on any matterconcerning the functions of the Board as the Board may determine.

(2) A committee appointed under subsection (1) shall consist ofa Chairperson who shall be a member of the Board and such other persons, whether members of the Board or not, as the Board may determine.

(3) The Board may delegate any of its functions under this Actto a committee appointed under this section, subject to any limitations imposed by the Board.

(4) The Board may require any committee appointed under thissection to act jointly or in co-operation with any other committee.

(5) Subject to any direction given by the Board, a committeeappointed under this section may regulate its own procedure.

(6) Members of a committee appointed under this section maybe paid such allowances as the Board may, with the approval of the Minister, determine.

PART III—SECRETARIAT AND STAFF OF THE BOARD

14. Secretariat

The Board shall have a Secretariat consisting of an Executive Secretary and other staff.

15. Executive Secretary

(1) The Executive Secretary of the Board shall be appointed bythe Board on terms and conditions specified in the instrument of appointment.

(2) The Executive Secretary shall be a person with professionalqualifications and experience in law, management or public administration.

(3) The Executive Secretary shall hold office for four years andis eligible for re- appointment for two consecutive terms only.

16. Functions of Executive Secretary

(1) The Executive Secretary shall be the chief executive officerof the Board and is responsible for the day-to-day operations and administration of the Board.

(2) Subject to this Act and to the general supervision and controlof the Board, the Executive Secretary is responsible for—

(a) the implementation of the policies and programmes of the Board;

(b) the funds and property of the Board;

(c) the organisation and control of the staff of the Board; and

(d) performing any other duty that may be assigned to him or her by the Board.

(3) The Executive Secretary shall, in addition to his or her functions, be the secretary to the Board and shall—

(a) take the minutes of meetings of the Board and keep a record of all the transactions of the Board;

(b) have custody of the seal of the Board; and

(c) carry out such other functions as the Board may assign to him or her.

(4) The Executive Secretary is, in the performance of his or herfunctions, answerable to the Board.

(5) The Executive Secretary shall cease to hold office if—(a) he or she resigns;

(b) he or she is removed from office by the Board for—

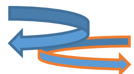
(i) inability to discharge the functions of his or her office arising out of physical or mental illness;

(ii) misbehaviour or misconduct;

(iii) incompetence; or(iv) bankruptcy.

17. Other officers and staff of the Board

(1) The Board may appoint other officers and staff of the Boardas may be necessary for the effective performance of the functions of the Board.



(2) The employees appointed under subsection (1) shall holdoffice on such terms and conditions as may be specified in their instruments of appointment.

18. Experts and consultants

(1) The Board may, on the advice of the Executive Secretary,engage the services of experts and consultants in respect of any functions of the Board with which they are considered to have special competence.

(2) Experts and consultants engaged under subsection (1) maybe paid such fees and allowances, and may be afforded such facilities as the Board may determine.

19. Protection of members and employees

A member or an employee of the Board, or a person acting on the directions of the Board is not personally liable for any act or omission done or omitted to be done in good faith in the exercise of the functions of the Board.

PART IV—FINANCES

20. Funds of the Board

(1) The funds of the Board shall consist of—

(a) money appropriated by Parliament for the purposes of the Board;

(b) fees charged for services rendered by the Board under this Act; and

(c) grants, gifts or donations from the Government or other sources made with the approval of the Minister responsible for finance.

(2) Any fees received by the Board from the services rendered by the Board and other activities under this Act shall be retained by the Board in a fund established for the purpose, in accordance with the Public Finance and Accountability Act, for purposes of defraying the expenses of the Board and for the effective implementation of this Act.

21. Power to open and operate bank accounts

(1) The Board shall open and operate such bank accounts as arenecessary for the performance of its functions.

(2) The Board shall ensure that all money received by or onbehalf of the Board is deposited in the bank as soon as practicable after being received.

(3) The Board shall ensure that no money is withdrawn from orpaid out of any of the Board’s bank accounts without the authority of the Board.

22. Estimates

(1) The Executive Secretary shall, within three months beforethe end of each financial year, cause to be prepared and submitted to the Board for its approval, estimates of the expenditure of the Board for the next financial year.

(2) The Board shall, within two months after receipt of theestimates referred to in subsection (1) cause to be submitted to the Minister for his or her approval, the estimates of income and expenditure as approved by the Board.

23. Financial year of the Board

The financial year of the Board is the period of twelve months beginning on the 1st July in each year and ending on the 30th June in the next calendar year.

24. Accounts

(1) The Executive Secretary shall cause to be kept, proper booksof accounts and records of the transactions of the Board.

(2) Subject to any direction given by the Minister, the Boardshall cause to be prepared and submitted to the Minister responsible for finance in respect of each financial year, and not later than three months after the end of the financial year, a statement of accounts, which shall include—

(a) a balance sheet, a statement of income and expenditure and a statement of surplus or deficit; and

(b) any other information in respect of the financial affairs of the Board as the Minister responsible for finance may, in writing require.

25. Audit

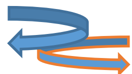
(1) The Auditor General or an auditor appointed by the AuditorGeneral shall, in each financial year, audit the accounts of the Board.

(2) The Board shall ensure that within four months after the endof each financial year, a statement of accounts described in section 24 is submitted for auditing to the Auditor-General or an auditor appointed by the Auditor General.

(3) The Auditor General and any auditor appointed by theAuditor General shall have access to all books of accounts, vouchers and other financial records of the Board, and is entitled to any information and explanation required in relation to those records.

(4) The Auditor General and any auditor appointed by theAuditor General shall, within four months after receipt of the statement of accounts under subsection (2), deliver to the Board a copy of the audited accounts together with a report on the accounts.

26. Investment of surplus funds

Any funds of the Board not immediately required for any purpose under this Act may be invested in a manner, which the Board may, after consultation with the Minister and the Minister responsible for finance, determine.

27. Annual report

The Board shall, within three months after the end of each financial year, submit to the Minister an annual report on the activities of the Board.

PART V—BUILDING COMMITTEES

28. Establishment of Building Committees

(1) There is established for each District and for each UrbanAuthority, a Building Committee which shall be a committee of the District or the Urban Council respectively.

(2) A Building Committee established under subsection (1) shall, in the case of a District Council, consist of—

(a) the Chief Administrative Officer;

(b) the Town Clerk;

(c) the Chairperson of the Planning and Development

Committee of the District Council;

(d) the officer responsible for physical planning;

(e) the officer responsible for health;

(f) the officer responsible for engineering;

(g) the officer responsible for land management;

(h) the officer responsible for environment management;

(i) an officer responsible for architecture;

(j) a representative of the persons with disabilities nominated by the National Council for Disability at the district level;

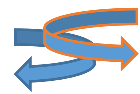
(k) an officer from the police department responsible for fire prevention; and

(l) a member of the district executive committee.

(3) The Chairperson of the Planning and DevelopmentCommittee of the District Council shall be the Chairperson of the District Building Committee.

(4) A Building Committee established under subsection (1) shall, in the case of an Urban Authority consist of—

(a) the Chairperson of the Urban Planning and Development Committee;



(b) a category of officers in the Urban Service similar to the category of officers in the District Council referred to in paragraphsn (b) to (i) of subsection (2);

(c) a representative of the persons with disabilities nominated by the National Council for Disability;

(5) The Chairperson of the Urban Planning and Development Committee of the Urban Council shall be the Chairperson of the Urban Building Committee.

29. Functions of Building Committees

(1) The functions of Building Committees are— (a) to scrutinise and approve building plans; (b) to issue building permits and occupation permits;

(c) to ensure that the design and construction of buildings and utilities to which the public is to have access cater for persons with disabilities;

(d) to review decisions on applications for permits for minor building works submitted to a building control officer under section 39;

(e) to ensure that this Act is complied with; and

(f) perform any other function assigned to it by the Board.

(2) A Building Committee may, in writing, delegate to a competent person, any function conferred upon it by or under this Act, other than the functions referred to in sections 29 (1)(b) and 41.

30. Building Committee's power to co-opt persons

(1) A Building Committee may co-opt any person who, in theopinion of the Committee, has expert knowledge concerning the functions of the Committee, which is likely to be of assistance to the Committee, to attend and take part in the proceedings of the Committee.

(2) A person attending a meeting of the Building Committeeunder subsection (1) may take part in any discussion at the meeting on which his or her advice is required, but shall not have a right to vote at that meeting.

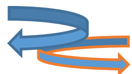
31. Meetings of Building Committees

Schedule 3 has effect with respect to the meetings and procedure of Building Committees and other matters provided for in that Schedule.

32. Building Control Officer

The District Service Commission shall, for each District Council and for each Urban Authority, appoint—

(a) a District Building Control Officer and an Urban Building Control Officer, respectively; and



(b) such number of Assistant Building Control Officers as are necessary to enable the Building Committee to carry out its functions under this Act.

33. Functions of Building Control Officer

The functions of a Building Control Officer are—

(a) to make recommendations to a Building Committee in relation to— (i) building plans;

(ii) specifications of materials and workmanship;

(iii) any document submitted to a Building Committeeunder section 35;

(b) to forward to the Building Committee for review, copies of all applications for minor building works submitted to the Building Control Officer under section 39, and his or her decision on the application;

(c) to ensure that any instructions given by a Building Committee in accordance with this Act are complied with;

(d) to inspect—

(i) the erection of any building;

(ii) the demolition of any building;

(iii) any activity, in respect of which a permit has been issued in accordance with sections 35 and 39, and to ensure that any condition upon which the permit is issued is complied with;

(e) to carry out regular inspection of completed buildings; and

(f) to carry out any other duty assigned to it by the Building Committee.

PART VI—CONTROL OF BUILDING OPERATIONS

34. Building operations without permit prohibited

(1) A person shall not carry out a building operation unless he or she has a valid building permit issued by a Building Committee.

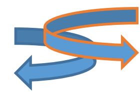
(2) A person who contravenes subsection (1) commits anoffence and is liable, on conviction to a fine not exceeding fifty currency points or imprisonment not exceeding two years, or both.

35. Application for building permit

(1) A person who intends to carry out a building operation shallapply to the Building Committee in the area in which he or she intends to carry out the building operation, for a building permit.

(2) An application for a building permit shall be in a formprescribed by the Board, and shall—

(a) contain the name and physical and postal address of the applicant;



(b) be accompanied by the land title or other proof of ownership of the land;

(c) where the applicant is not the owner of the land on which the building operation is to be carried out, contain the name of the landowner, the land title or other proof of ownership of the land and a statement of the legal relationship between the applicant and the landowner;

(d) contain the name, registration number and a copy of the practising certificate of the architect and his or her signature, and official stamp of the Uganda Society of Architects and in the case of an engineer, a certificate of good structural practice;

(e) be accompanied by such number of copies of building plans and other documents as may be required by regulations; and

(f) contain a letter from the Chairperson of the Village Council of the area in which the building operation is to be carried out.

(3) Where the building is a multi-storied structure or building, the application shall include—

(a) a structural design and plans, stamped by a registered structural engineer including the name, registration number and his or her signature, a copy of the registration certificate and a copy of the structural design calculations;

(b) a geotechnical report made by a geotechnical laboratoryaccredited by the ministry responsible for works and endorsed by a registered geotechnical engineer;

(c) where there are any excavations, a design of the soil supportsystem and protection of the adjacent structures, endorsed by a registered geotechnical or structural engineer.

(4) A Building Control Officer may, if he or she is of the opinion that an application made to a Building Committee under subsection (1) does not comply with the requirements of this Act, reject the application, giving reasons in writing for the rejection.

36. Procedure for issuing building permit

(1) A Building Committee may, upon receipt of an applicationfor a permit under section 35, issue a building permit to the applicant within thirty days after the date of receipt of the application.

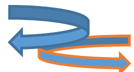
(2) A Building Committee may refuse to issue a permit wherethe building operation in respect of which the permit is applied for— (a) may constitute a change in land use different from that for which the land is designated;

(b) may result in degradation of the environment in the area inwhich the building operation is to be carried out;

(c) may cause the depreciation in value of adjoining orneighbouring properties;

(d) may result in a building which is unsightly or objectionableto the public;

(e) may result in a building which is a nuisance to occupiers ofadjoining or neighbouring properties;



(f) may be dangerous to life or property;

(g) may be located on a site which is filled up or covered with refuse or matter liable to decomposition; or

(h) does not comply with the requirements of this Act.

(3) Where the Building Committee rejects an application for apermit under subsection (2) the Committee shall, within thirty days after receipt of the application, notify the applicant, giving reasons, in writing, for the refusal.

(4) A person whose application is rejected under subsection (3) may, after amending it as may be required by the Building Committee, submit it to the Building Committee for reconsideration.

(5) Where the Building Committee is unable to reach a decisionwithin thirty days as required by subsection (1), it shall, notify the applicant in writing of that fact, within fourteen days after the date of the meeting of the Committee, and shall indicate in the notice, a reasonable period within which it will be able to reach a decision, but in any case not later than sixty days from the date of the receipt of the application.

(6) The Building Committee shall, where it issues a permit undersubsection (1), endorse its approval on the building plan and other documents, and shall return one endorsed copy each of the building plan and other documents to the applicant.

(7) A building permit issued under this section may be issued uponsuch terms and conditions as the Building Committee may determine.

37. Appeals from decisions of Building Committee

(1) A person aggrieved by a decision of a Building Committeemay appeal to the Board within thirty days after the date on which he or she receives notice of the decision of the Building Committee.

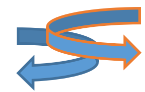
(2) An appeal under subsection (1) shall be in writing by theapplicant or by the agent of the applicant.

(3) Where a Building Committee fails to issue a building permitwithin the period specified in section 36, the applicant may appeal to the Board.

(4) The right of appeal to the Board under this section does nottake away the right of an applicant to appeal to a court of law and the court may confirm, reverse or modify the decision of the Board.

38. Building operation subject to time limit

(1) A building operation in respect of which a building permit isissued under section 36 shall commence within twelve months of the date on which the building permit is issued and shall be completed within a period of sixty months of the date on which the building operation was commenced.



(2) Notwithstanding subsection (1), where a person, due tounforeseen circumstances, is unable to comply with the period of time specified in subsection (1), he or she shall apply to the Building Committee for extension of the time within which to complete the building operation and the Building Committee shall not unreasonably withhold the grant of extension.

(3) A person who carries on a building operation incontravention of this section commits an offence and is liable, on conviction, to a fine not exceeding twenty five currency points or imprisonment not exceeding thirteen months or both, and after the notice is given, to a further fine not exceeding five currency points for each day on which the offence continues.

39. Permits for minor building works

(1) A person intending to carry out minor building works shallapply, in writing, to a Building Control Officer for a building permit.

(2) An application under subsection (1) shall be accompanied bya sketch plan with dimensions.

(3) A Building Control Officer shall forward to the BuildingCommittee for review, a copy of each application for a permit made under this section, and his or her decision on that application within five working days after his or her decision.

(4) A permit for minor building works under this section—

(a) may be issued upon such terms and conditions as may be prescribed by regulations; and

(b) is valid for six months, within which time the building operation shall commence; except that the Building Control Officer may, on the application of the permit holder, for good cause, extend the period for six further months.

(5) Where a Building Control Officer refuses to issue a permit or an extension permit under this section, the applicant may appeal to the Building Committee against the refusal.

40. Order to stop building operation

(1) A Building Committee may, by notice in writing, order any person to stop a building operation—

(a) where the building operation is carried out in a manner which—

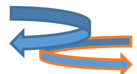
(i) is contrary to the provisions of this Act and the Code; and

(ii) does not comply with health and sanitationrequirements prescribed by regulations.

(b) where the building is one to which the public is to have access but does not provide access for persons with disabilities as provided for in the Accessibility Standards.

(c) if it is discovered, during the building operation, that the site is—

(i) predisposed to flooding; or



(ii) has a poor drainage system.

(2) Where a Building Committee issues a notice to a personunder subsection (1), the Committee may order that person to take remedial measures to the satisfaction of the Building Committee before continuing with the building operation.

(3) A person who fails, without good cause, to comply with anotice issued under subsection (1) or an order given under subsection (2) commits an offence and is liable, on conviction, to a fine not exceeding seventy five currency points or imprisonment not exceeding three years or both.

41. Remedial action on defective building

(1) A Building Committee may, where a building—

(a) is in a state of disrepair;

(b) is dilapidated; or

(c) is showing signs of disrepair or dilapidation,

by notice in writing, order the owner of the building to demolish the building or take remedial action on the building, as the case may be, to a standard determined by the Building Committee.

(2) A Building Committee may, where—

(a) a building; or

(b) earthwork on which a building operation is carried out or is to be carried out, is dangerous or shows signs of becoming dangerous to life or property, by written notice, order the holder of the permit to ensure that the building or earthwork, as the case may be, ceases to be in a state that is dangerous to life or property.

(3) A notice issued under subsection (1) or (2) shall contain suchconditions as the Building Committee may determine and the person upon whom the notice is served shall comply with the conditions stated in the notice.

(4) A person who fails to comply with a notice issued undersubsection (1) or (2) commits an offence and is liable, on conviction, to a fine not exceeding twenty four currency points or imprisonment not exceeding one year, or both.

42. Prohibition of building methods and materials

(1) The Minister may, after consultation with the Board, andupon being satisfied that any method or material used in a building operation is not safe, by notice published in the Gazette, prohibit the use of that method or material in the building operation.

(2) A person aggrieved by the decision of the Minister madeunder this section may appeal to the High Court.

(3) A person who uses a prohibited method or material contraryto a notice issued under subsection (1), commits an offence and is liable, on conviction, to a fine of not exceeding forty eight currency points or imprisonment not exceeding two years, or both.

43. Right of entry by Building Control Officer

(1) For the purposes of this Act, a Building Control Officer shall,at all reasonable times, have the right of entry onto any land or site where a building operation is being carried out, for the purpose of determining whether this Act is being complied with.

(2) A Building Control Officer may conduct tests on or carry outan inspection on any land or site on which a building operation is being carried out.

(3) A Building Control Officer shall, upon request by the ownerof the building or person in charge of a building operation whose site is entered by the Building Control Officer or authorised agent, produce his or her official identification card.

(4) A person who hinders or obstructs a Building Control Officerin the exercise of his or her functions under this section, commits an offence and is liable, on conviction, to a fine not exceeding twenty five currency points or imprisonment not exceeding thirteen months or both.

44. Occupation permit

(1) Upon the completion of a building, the owner of the building shall—

(a) notify the Building Committee of the practical completion of the building in accordance with the approved plans and the regulations; and

(b) apply to the Building Committee for an occupation permit.

(2) The Building Committee shall, within fourteen days after receipt of notification of completion of a building and receipt of an application for an occupation permit, examine the building, and may—

(a) if satisfied that the building has been erected in conformity with the approved plans and regulations, issue an occupation permit; or

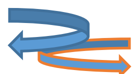
(b) if the building has not been erected in accordance with this Act, refuse to issue an occupation permit, and give reasons in writing for its refusal.

(3) Any person who occupies or uses a building—

(a) before an occupation permit is issued, except where the occupation or use is essential for the erection of the building;

(b) in any period not being the period in respect of which the occupation permit was issued;

(c) in contravention of any condition on which an occupation permit was issued; or



(d) otherwise than in such circumstances and conditions as may be prescribed by the Code, commits an offence and is liable, on conviction, to a fine not exceeding twenty four currency points.

(4) Notwithstanding subsection (3) the Building Committee mayissue an occupation permit in respect of a partially completed building, where it determines that the building is safe and adequate for human habitation.

(5) An occupation permit issued under subsection (4) shall bevalid for a period not exceeding twenty-four months and may be renewed upon application to the Building Committee.

45. Liability for causing accidents on building construction site

(1) Any person whose negligence, commission or omissioncauses or leads to the occurrence of an accident on a building construction site, which results in the injury or death of another person, or the destruction of property, commits an offence and is liable on conviction to a fine not exceeding two hundred eighty eight currency points or to imprisonment not exceeding twelve years or both.

(2) For the avoidance of doubt, the activities referred to insubsection (1) include— (a) breach of contract;

(b) failure to comply with stipulated building procedures andstandards;

(c) professional negligence;

(d) failure to take out insurance for the workers; and

(e) failure to comply with this Act and regulations made under this Act.

PART VII—MISCELLANEOUS

46. National Building Code

(1) The Minister may, after consultation with the Board,establish a Code to be known as the National Building Code.

(2) The National Building Code shall include matters relating

to—

(a) building standards;

(b) structural design;

(c) plumbing;

(d) electrical installations;

(e) mechanical installations;

(f) fire and safety;

(g) geotechnical report; (h) accessibility standards; and

(i) postal code numbering.

(3)) For the avoidance of doubt, the Minister shall establish the building code under this section not later than six months after the commencement of this Act.

47. Reports

(1) The Minister may request a Building Committee to furnish him or her with a report on—

(a) the adequacy of measures in connection with any buildingwithin its area of jurisdiction against fire, floods, earthquakes or other disasters; and

(b) a particular building operation in its area of jurisdiction.

(2) Where the Minister is not satisfied with the report of a Building Committee submitted under subsection (1), the Minister may request the Board to furnish a report on that subject.

48. Power of Minister to give directions

The Minister may give directions of a policy nature in writing to the Board and the Board shall comply with the Minister's directions.

49. Delegation of Minister's powers

The Minister may, in writing, delegate to the Chairperson of the Board any power conferred upon the Minister by or under this Act, other than the powers referred to in sections 42, 46, 52 and 53 and upon such conditions as the Minister may specify.

50. Employees of former building authorities

A person who, immediately before the coming into force of this Act, is employed by a building control authority or other related body, to exercise any or all of the functions of a Building Control Officer under this Act, shall continue to exercise those functions until Building Control Officers are appointed under this Act.

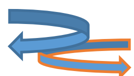
51. Service of notices

Where, in this Act, there is reference to the service of any notice, that notice shall be served by post or delivered by hand to the addressee or his or her agent, as the case may be, or to the person in charge of a building operation, at the site.

52. Regulations

(1) The Minister may, on the advice of the Board, by statutoryinstrument, make regulations generally for the better carrying into effect of the provisions of this Act.

(2) Without prejudice to the general effect of subsection (1),regulations made under this section may—



(a) prescribe the remuneration and allowances that may be paid to members of the Board or to persons co-opted to meetings of the Board;

(b) prescribe the remuneration and allowances that may be paid to members of a Building Committee or to persons coopted to meetings of a Building Committee;

(c) prescribe the procedure and the costs to be paid in respect of any appeal lodged with the Board;

(d) impose penalties in respect of any contravention of the regulations, not exceeding a fine of forty eight currency points or imprisonment not exceeding two years or both, and in the case of a continuing contravention, an additional fine not exceeding five currency points for each day during which the contravention continues;

(e) prescribe the content of building plans and other documents required to be submitted under this Act;

(f) prescribe the fees for permits and for services rendered by the Board or by a Building Committee under this Act;

(g) prescribe the forms and procedure for application for building permits, occupation permits and other permits issued under this Act; and

(h) prescribe anything that is required or authorised to be prescribed under this Act.

53. Amendment of Schedules

(1) The Minister may, by statutory instrument, with the approvalof Cabinet, amend Schedule 1.

(2) The Minister may, by statutory instrument, amend Schedules2 and 3.

54. Transition

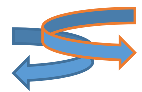
(1) A building which is completed, or in respect of which anybuilding operation is commenced before the coming into force of this Act and which does not conform to the standards prescribed by this Act shall, within a period prescribed by the Minister on the advice of the Board be adjusted so as to bring it in conformity with this Act.

(2) An occupation permit in respect of adjustments to be madeunder subsection (1) shall be obtained within a period prescribed by the Building Committee.

(3) An application for a permit made to a building authoritybefore the commencement of this Act shall, on the commencement of this Act, be considered as an application made to a Building Committee established by this Act.

(4) Subject to this Act, a building permit issued by a buildingauthority before the coming into force of this Act shall be deemed to have been issued under this Act.

55. Effect on existing law



(1) This Act shall take precedence over any other Act orinstrument in existence, relating to building operations, before the coming into force of this Act and any such Act or instrument shall, to the extent to which it is inconsistent with this Act or an instrument made under this Act be deemed to be modified to accord with this Act.

(2) For the avoidance of doubt, where a provision of anyenactment referred to in subsection (1) conflicts with a provision of this Act, this Act shall prevail.

SCHEDULE 1

Section 2

CURRENCY POINT

One currency point is equivalent to twenty thousand shillings.

SCHEDULE 2

Section 12

MEETINGS AND PROCEDURE OF BOARD

1. Meetings of Board

(1) The Chairperson shall convene every meeting of the Board at atime and place as the Board may determine and the Board shall meet for the discharge of business at least once in every two months.

(2) The Chairperson may, at any time, convene a special meeting ofthe Board and shall call a meeting within fourteen days, if requested to do so in writing by at least five members of the Board.

(3) The Chairperson shall preside at every meeting of the Board and inthe absence of the Chairperson, the members present shall elect one of their number to preside at that meeting.

2. Quorum and decisions

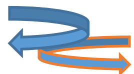
(1) The quorum for a meeting of the Board is two-thirds of themembers.

(2) All questions proposed at a meeting of the Board shall be decidedby a majority of the votes of the members present and voting and in case of an equality of votes, the person presiding at the meeting shall have a casting vote in addition to his or her deliberative vote.

3. Minutes of meetings

(1) The Secretary shall keep the minutes of all the meetings of theBoard in a form approved by the Board.

(2) The minutes recorded under this paragraph shall be submitted tothe Board at its next meeting following that to which the minutes relate and when confirmed, shall be signed by the Chairperson and the Secretary in the presence of the members present at the latter meeting.



4. Validity of proceedings not affected by vacancy

The validity of any proceedings of the Board shall not be affected by a vacancy in its membership or by any defect in the appointment or qualification of a member or by reason that a person not entitled, took part in its proceedings.

5. Disclosure of interest of members

(1) A member of the Board who is in any way directly or indirectlyinterested in a contract made or proposed to be made by the Board, or in any other matter which falls to be considered by the Board, shall disclose the nature of his or her interest at a meeting of the Board.

(2) A disclosure made under subparagraph (1) shall be recorded in theminutes of that meeting.

(3) A member who makes a disclosure under subparagraph (1) shallnot, unless the Board decides otherwise—

(a) be present during any deliberation of the Board with respect to thatmatter; or

(b) take part in any decision of the Board with respect to that matter.

(4) For purposes of determining whether there is a quorum, a member withdrawing from a meeting or who is not taking part in a meeting under paragraph (3)(b) shall be treated as being present.

6. Board may regulate its procedure

Subject to this Act, the Board may regulate its own procedure or any other matter relating to its meetings.

SCHEDULE 3

Section 31

MEETINGS AND PROCEDURE OF BUILDING COMMITTEE

1. Meetings of Building Committee

(1) The Chairperson of a Building Committee shall convene everymeeting of a Building Committee at times and places as the Building Committee may determine and the Building Committee shall meet for the discharge of business at least once in every two months.

(2) The Chairperson may, at any time, convene a special meeting ofthe Building Committee and shall also call a meeting within fourteen days, if requested to do so in writing by at least six members of the Building Committee.

(3) The Chairperson shall preside at every meeting of the BuildingCommittee and in the absence of the Chairperson, the members present shall elect one of their number to preside at that meeting

2. Quorum and decisions

(1) The quorum for a meeting of a Building Committee is two-thirdsof the members including at least one member of the District Executive Committee in the case of a District Building Committee or one executive member of the Urban Planning and Development Committee in the case of an Urban Building Committee.

(2) All questions proposed at a meeting of the Building Committeeshall be decided by a majority of the votes of the members present and voting and in case of an equality of votes, the person presiding at the meeting shall have a casting vote in addition to his or her deliberative vote.

3. Minutes of meetings

(1) The Building Committee shall cause to be kept minutes of all themeetings of the Building Committee in a form approved by the Building Committee.

(2) The minutes recorded under this paragraph shall be submitted to theBuilding Committee at its next meeting following that to which the minutes relate and when confirmed, shall be signed by the Chairperson and the Secretary at that meeting in the presence of the members present at the latter meeting.

4. Validity of proceedings not affected by vacancy

The validity of any proceedings of a Building Committee shall not be affected by a vacancy in its membership or by any defect in the appointment or qualification of a member or by reason that a person not entitled, took part in its proceedings.

5. Disclosure of interest of members

(1) A member of a Building Committee who is in any way directly orindirectly interested in a contract made or proposed to be made by a Building Committee, or in any other matter which falls to be considered by the Building Committee, shall disclose the nature of his or her interest at the meeting of the Building Committee.

(2) A disclosure made under subparagraph (1) shall be recorded in theminutes of that meeting.

(3) A member who makes a disclosure under subparagraph (1) shallnot, unless the Building Committee decides otherwise—

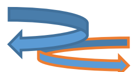
(a) be present during any deliberation of the Building Committee withrespect to that matter; or

(b) take part in any decision of the Building Committee with respectto that matter.

(4) For purposes of determining whether there is a quorum, a member withdrawing from a meeting or who is not taking part in a meeting under paragraph (3)(b) shall be treated as being present.

6. Building Committee may regulate its procedure

Subject to this Act, the Building Committee may regulate its own procedure or any other matter relating to its meetings.



Cross References

1. Architects Registration Act, Cap. 269
2. Engineers Registration Act, Cap. 271
3. Public Finance and Accountability Act, 2003
4. Surveyors Registration Act, Cap. 275
5. Uganda National Bureau of Standards Act, Cap. 327

Appendix Eight: Advocates (Professional Conduct) Regulations

THE ADVOCATES ACT.

Statutory Instrument 267—2.

The Advocates (Professional Conduct) Regulations.

Arrangement of Regulations.

Regulation

1. Citation.

2. Manner of acting on behalf of clients.

3. Withdrawal from cases.

4. Advocate not to prejudice former client.

5. Duty to appear in court, etc.

6. Advocate to be personally responsible for client's work.

7. Nondisclosure of client's information.

8. Advocate to account for money of a client.

9. Personal involvement in a client's case.

10. Advocate's fiduciary relationship with clients.

11. Advocate not to exploit client's shortcomings.

12. Advocate to advise clients diligently.

13. Unlawful arrangements with public officers, etc.

14. Undertakings by an advocate.

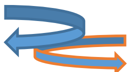
15. Affidavits to contain truth.

16. Advocate to inform the court of his or her client's false evidence.

17. Duty of an advocate to advise the court on matters within his or her special knowledge.

18. Coaching of clients.

19. Advocate not to hinder witness, etc.



20. Res sub judice.

21. Advocate may act for client of other advocate.

22. Touting.

23. Publications by advocates.

24. Advocate's nameplate or signboard.

25. Advocate not to advertise his or her name.

26. Contingent fees.

27. Advocate to advance money only for disbursements.

28. Excessive fees, etc.

29. Advocate to account promptly and correctly.

30. Advocate not to engage in unbefitting trade, etc.

31. Offences under the Advocates Act, etc.

THE ADVOCATES ACT.

Statutory Instrument 267—2.

The Advocates (Professional Conduct) Regulations.

(Under section 77(1)(a) of the Act.)

1. Citation.

These Regulations may be cited as the Advocates (Professional Conduct) Regulations.

2. Manner of acting on behalf of clients.

(1) No advocate shall act for any person unless he or she has received instructions from that person or his or her duly authorised agent.

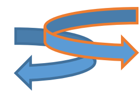
(2) An advocate shall not unreasonably delay the carrying out of instructions received from his or her clients and shall conduct business on behalf of clients with due diligence, including, in particular, the answering of correspondence dealing with the affairs of his or her clients.

3. Withdrawal from cases.

(1) An advocate may withdraw from the conduct of a case on behalf of a client where—

(a) the client withdraws instructions from the advocate;

(b) the client instructs the advocate to take any action that may involve the advocate in proceedings for professional misconduct or require him or her to act contrary to his or her advice to the client;



(c) the advocate is duly permitted by the court to withdraw;

(d) the client disregards an agreement or obligation as to the payment of the advocate's fees and disbursements.

(2) Whenever an advocate intends to withdraw from the conduct of a case, the advocate shall—

(a) give his or her client, the court and the opposite party sufficient notice of his or her intention to withdraw; and

(b) refund to his or her former client such proportionate professional

fees as have not been earned by him or her in the circumstances of the case.

4. Advocate not to prejudice former client.

An advocate shall not accept instructions from any person in respect of a contentious or noncontentious matter if the matter involves a former client and the advocate as a result of acting for the former client is aware of any facts which may be prejudicial to the client in that matter.

5. Duty to appear in court, etc.

(1) Every advocate shall, in all contentious matters, either appear in court personally or brief a partner or a professional assistant employed by his or her firm to appear on behalf of his or her client.

(2) Where it is not possible for the advocate so to appear personally or to brief a partner or professional assistant employed by his or her firm, he or she shall brief another advocate acceptable to the client so to appear; except that where the advocate considers the proceedings in question to be of minor decisive value to the final outcome of the case, he or she shall not be required to obtain the client's acceptance of such other advocate.

6. Advocate to be personally responsible for client's work.

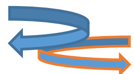
An advocate shall be personally responsible for work undertaken on behalf of a client and shall supervise or make arrangements for supervision by another advocate who is a member of the same firm of all work undertaken by nonprofessional employees.

7. Nondisclosure of client's information.

An advocate shall not disclose or divulge any information obtained or acquired as a result of his or her acting on behalf of a client except where this becomes necessary in the conduct of the affairs of that client, or otherwise required by law.

8. Advocate to account for money of a client.

(1) An advocate shall not use money held on behalf of a client either for the benefit of himself or herself or of any other person.



(2) An advocate shall make full disclosure to his or her client of the amounts and nature of all payments made to the advocate on behalf of that client and, when making any payments to the client, shall set out in writing the sums received on behalf of the client and any deductions made by the advocate from those receipts.

(3) An advocate shall return any sum or part of the sum paid to the advocate by a client as a retainer if the amount paid exceeds the value of the work done and disbursements made on behalf of the client.

9. Personal involvement in a client's case.

No advocate may appear before any court or tribunal in any matter in which he or she has reason to believe that he or she will be required as a witness to give evidence, whether verbally or by affidavit; and if, while appearing in any matter, it becomes apparent that he or she will be required as a witness to give evidence whether verbally or by affidavit, he or she shall not continue to appear; except that this regulation shall not prevent an advocate from giving evidence whether verbally or by declaration or affidavit on a formal or noncontentious matter or fact in any matter in which he or she acts or appears.

10. Advocate's fiduciary relationship with clients.

An advocate shall not use his or her fiduciary relationship with his or her clients to his or her own personal advantage and shall disclose to those clients any personal interest that he or she may have in transactions being conducted on behalf of those clients.

11. Advocate not to exploit client's shortcomings.

An advocate shall not exploit the inexperience, lack of understanding, illiteracy or other personal shortcoming of a client for his or her personal benefit or for the benefit of any other person.

12. Advocate to advise clients diligently.

Every advocate shall advise his or her clients in their best interest, and no advocate shall knowingly or recklessly encourage a client to enter into, oppose or continue any litigation, matter or other transaction in respect of which a reasonable advocate would advise that to do so would not be in the best interests of the client or would be an abuse of court process.

13. Unlawful arrangement with public officers, etc.

An advocate shall not enter into any arrangement with any person employed in the public service whereby that person is to secure either the acquittal of the advocate's client, the bringing of a lesser criminal charge against that client or the varying of the evidence to be adduced by or for the prosecution except where any such arrangement is deemed to be proper practice.

14. Undertakings by an advocate.

An advocate shall not—

(a) give any undertaking to another advocate or any other person knowing that he or she has no authority or means of satisfying the undertaking; and

(b) knowingly breach the terms of an undertaking.

15. Affidavits to contain truth.

An advocate shall not include in any affidavit any matter which he or she knows or has reason to believe is false.

16. Advocate to inform the court of his or her client's false evidence.

If any advocate becomes aware that any person has, before the court, sworn a false affidavit or given false evidence, he or she shall inform the court of his or her discovery.

17. Duty of an advocate to advise the court on matters within his or her special knowledge.

(1) An advocate conducting a case or matter shall not allow a court to be misled by remaining silent about a matter within his or her knowledge which a reasonable person would realise, if made known to the court, would affect its proceedings, decision or judgment.

(2) If an irregularity comes to the knowledge of an advocate during or after the hearing of a case but before a verdict or judgment has been given, the advocate shall inform the court of the irregularity without delay.

18. Coaching of clients.

An advocate shall not coach or permit a person to be coached who is being called by him or her to give evidence in court nor shall he or she call a person to give evidence whom he or she knows or has a reasonable suspicion has been coached.

19. Advocate not to hinder witness, etc.

An advocate shall not, in order to benefit his or her client's case in any way, intimidate or otherwise induce a witness who he or she knows has been or is likely to be called by the opposite party or cause such a witness to be so intimidated or induced from departing from the truth or abstaining from giving evidence.

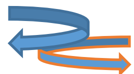
20. Res sub judice.

An advocate shall not make announcements or comments to newspapers or any other news media, including radio and television, concerning any pending, anticipated or current litigation in which he or she is or is not involved, whether in a professional or personal capacity.

21. Advocate may act for client of other advocate.

(1) An advocate may act for a client in a matter in which he or she knows or has reason to believe that another advocate is then acting for that client only with the consent of that other advocate.

(2) An advocate may act for a client in a matter in which he or she knows or has reason to believe that another advocate has been acting for that client, if either—



(a) that other advocate has refused to act further; or

(b) the client has withdrawn instructions from that other advocate upon proper notice to him or her.

22. Touting.

No advocate may directly or indirectly apply or seek instructions for professional business, or do or permit in the carrying on of his or her practice any act or thing which can be reasonably regarded as touting or advertising or as calculated to attract business unfairly, and in particular, but not derogating from the generality of this regulation—

(a) by approaching persons involved in accidents, or the employment of others to approach such persons;

(b) by influencing persons, whether by reward or not, who by reason of their employment are in a position to advise persons to consult an advocate; and

(c) by accepting work through any person, organisation or body that solicits or receives payment or any other benefit for pursuing claims in respect of accidents.

23. Publications by advocates.

(1) Subject to subregulations (2) and (3) of this regulation, an advocate shall not knowingly allow articles (including photographs) to be published in any news media concerning himself or herself, nor shall he or she give any press conference or any press statements which are likely to make known or publicise the fact that he or she is an advocate.

(2) An advocate may answer questions or write articles that may be published in the press or in news media concerning legal topics but shall not disclose his or her name except in circumstances where the Law Council has permitted him or her so to do.

(3) Where the Law Council cannot readily convene, the chairperson of the Law Council may grant the permission referred to in subregulation (2) of this regulation to the advocate.

(4) This regulation shall not apply to professional journals or publications or to any publications of an educational nature.

24. Advocate’s nameplate or signboard.

(1) An advocate may erect a plate or signboard of not more than 36 centimetres by 25.5 centimetres in size containing the word “advocate”, indicating his or her name, place of business, professional qualifications, including degrees, and where applicable, the fact that he or she is a notary public or commissioner for oaths.

(2) Notwithstanding subregulation (1) of this regulation, a nameplate or signboard shall, in the opinion of the Law Council, be sober in design.

(3) No advocate shall carry on any practice under a firm name consisting solely or partly of the name of a partner who has ceased to practise as an advocate.

(4) An advocate or a firm of advocates affected by subregulation (3) of this regulation shall be allowed five years from the date of the change in the composition of the firm, in which to effect the required change in the firm name.

(5) Notwithstanding subregulation (1) of this regulation, no advocate shall include on his or her nameplate, signboard or letterhead any nonlegal professional qualifications or appointments in any public body whether the appointments are present or past.

25. Advocate not to advertise his or her name, etc.

(1) An advocate shall not allow his or her name or the fact that he or she is an advocate to be used in any commercial advertisement.

(2) An advocate shall not cause his or her name or the name of his or her firm or the fact that he or she is an advocate to be inserted in heavy or distinctive type, in any directory or guide and, in particular, a telephone directory.

(3) An advocate shall not cause or allow his or her name to be inserted in any classified or trade directory or section of such directory.

26. Contingent fees.

An advocate shall not enter into any agreement for the sharing of a proportion of the proceeds of a judgment whether by way of percentage or otherwise either as—

(a) part of or the entire amount of his or her professional fees; or (b) in consideration of advancing to a client funds for disbursements. 27. Advocate to advance money only for disbursements.

An advocate representing a client shall not advance any money to the client except only for disbursements connected with the case on the matter in which he or she is instructed.

28. Excessive fees, etc.

(1) No advocate shall charge a fee which is below the specified fee under the Advocates (Remuneration and Taxation of Costs) Rules.

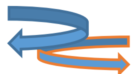
(2) Where fees are not specified, the advocate shall charge such fees as in the opinion of the Disciplinary Committee are not excessive or extortionate.

29. Advocate to account promptly and correctly.

Every advocate shall account to his or her clients promptly and correctly for all monies held in respect of clients and in accordance with the Advocates Accounts Rules set out in the First Schedule to the Act.

30. Advocate not to engage in unbefitting trade, etc.

An advocate shall not engage in a trade or profession, either solely or with any other person, which in the opinion of the Law Council is unbecoming of the dignity of the legal profession.



31. Offences under the Advocates Act, etc.

(1) Any act or omission of the advocate, which is an offence under the Advocates Act, shall be professional misconduct for the purposes of these Regulations.

(2) Any conduct of an advocate, which in the opinion of the Disciplinary Committee, whether the conduct occurs in the practice of the advocate's profession or otherwise, is unbecoming of an advocate shall be a professional misconduct for the purposes of these Regulations.

History: S.I. 79/1977.

Cross Reference

Advocates (Remuneration and Taxation of Costs) Rules, S.I. 267-4.

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ABOUT THE BOOK

This book unveils the answer on the *how, what and who* to sue and of course *when* to sue my lawyer, personal doctor, engineer, pastor or priest, sheikh, To err is human of course but certain errors though forgivable, the effect therefrom can be unbearable, regrettable and nothing could make good the resultant harm. This book does not instruct you to claim against every harm, or give "a tooth for a tooth" but it makes known to you the legalis operandi of knowing and claiming what is yours. Thence forth, you learn how and when to sue your professional for the bad they do. Trite it is that various authors and case law talk about professional negligence which is well quoted for it's "duty of care" but: There are instances where the duty of care is non existent but the ethics of being humane, demand particular action or omission. Whereas the present day professional malpractice has been so bended and litigated mostly on tortious negligence which demands a duty of care, a continuous operation under this synthesis of law has left so many an issue unsolved in addition to a bulging impunity by professionals, a thing which has occasioned a lacuna not only in law but also a profound want in ethical conduct. The acts and omissions of a "neighbor" in the words of lord Atkin have in the present time faded between and betwixt the arguments of "no duty of care" and as a result, professionals escape being held liable for the bad acts they do or omit amidst a professional-client relationship. For the fact that I don't know *if I can sue, how to sue, who to sue and when or why can I sue* occasions a handicapped situation to one who so being naive and yet dealing with a another so qualified, experienced and hyper positioned to influence the quality and reasonableness of a weakling's actions.

This book unveils the answer on the *how, what and who* to sue and of course *when* to sue my lawyer, personal doctor, engineer, pastor or priest, sheikh, traditional healers etc... regarding their bad actions both in exercise of their profession and when not. In discussing Professional malpractice let's not just bubble about negligence, rather on misdeeds by many professionals, such as doctors, dentists, chiropractors, optometrists, nurses, lawyers, architects, accountants, engineers and so forth. When you have faith in a pastor, lawyer or traditional healer, you expect them to exhibit the highest professionalism when so performing, but what if they don't perform up to standard?

This book is traced on a background that every profession has a professional code of conduct which in my opinion is the first safeguard to any client and in absence of such, then human ethics would demand a particular way of conduct from such a professional whereby in an event of failure to so conduct oneself, this book provides you with how to proceed on suing your lawyer, pastor, witch-doctor, sheikh, priest or doctor, etc...
If today you learn your rights, then harden not your attitudes or fears of what happens when I sue. Africans today have mild oblivions and court phobia in preserve of their "humility" , good relations and keeping a good talk about them in people, and this has left us aggrieved numerously, yet fearing to sue somebody as of right.
Be blessed to find your rights and the agitation procedure therefore in this book.

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