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THE CHILD'S RIGHT TO LIVE: NAVIGATING THE ETHICAL AND LEGAL CROSSROADS OF PARENTAL CONSENT AND MEDICAL NECESSITY IN NIGERIA

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ABSTRACT

The doctrine of informed consent, a cornerstone of medical ethics, empowers competent individuals to steer their own healthcare journey. However, this principle faces a profound ethical crucible when applied to minors, whose autonomy is legally entrusted to parents or guardians. This delegation of authority becomes a matter of life and death when parental decisions, often rooted in sincere religious conviction, directly threaten a child's survival. This paper argues that Nigerian jurisprudence has decisively established a hierarchy of rights where the preservation of a child's life supersedes absolute parental autonomy. Through a comprehensive doctrinal analysis of statutory frameworks and pivotal case law, most notably the landmark Supreme Court decision in Esabunor & Anor. v. Dr. Tunde Faweya & Ors, this paper chronicles the legal evolution from parental absolutism to the state's protective parens patriae role. It explores the delicate balance between the constitutional rights to religious freedom and the inviolable right to life, particularly for society's most vulnerable. The paper concludes that the "best interests of the child" standard, with the right to life as its paramount component, must remain the unwavering compass guiding medical consent for minors in Nigeria. It recommends further legislative clarity and clinical guidelines to support healthcare providers navigating these agonizing dilemmas.

Keywords: *Informed consent, paediatric bioethics, parental refusal, religious freedom, child's best interests, parens patriae.*

1. INTRODUCTION

Imagine in a hospital where a physician explains to a distraught mother that her infant, pale and struggling to breathe, will almost certainly die without a blood transfusion. The medical solution is clear, simple, and effective. Yet, the mother, gripped by a faith that interprets the procedure as a violation of divine law, refuses to consent. This scenario presents a typical case where the child's fundamental human rights collide with the parent's sacred right to religious freedom in Nigeria, and it stands at the centre of a legal and ethical battle that has been waged in Nigerian courtrooms and hospitals, which defines the limits of parental authority and the state's duty to protect its youngest citizens.

The evolution of medical ethics from paternalistic models to patient-centred care has enshrined the principle of autonomy—the right of a competent individual to make informed

decisions about their own body (Maclean 2009:72; Foster, 2009). This concept, however, is inherently complex when the patient is a child. Law and custom vest decision-making power in parents, presuming they will act as benevolent guardians of their child's welfare (Remien and Kanchan 2022:17; Ibia 2013:179). But what happens when this presumption is shattered? When love and faith, however sincerely held, manifest as a refusal of life-saving care?

This paper examines how Nigerian law navigates this treacherous intersection of parental rights, religious conviction, and a child's right to survival. It posits that the Nigerian legal system has moved decisively away from viewing parental authority as absolute, instead establishing a framework where the state, acting as parens patriae (parent of the nation), can and must intervene to save a child's life. Through an analysis of key legislations and the seminal judgment in Esabunor v. Faweya (2019), we will explore the legal mechanisms that serve as a lifeline for children caught in this impossible conflict, affirming that the right to live is the ultimate right from which all others flow.

2. CONCEPTUAL FOUNDATIONS: DEFINING THE ACTORS AND THE COVENANT OF CARE

2.1 The 'Child' in the Nigerian Legal Consciousness

The law draws a bright line around childhood to denote a period of vulnerability and dependency requiring special protection (Arinze-Umobi, 2015:184). In Nigeria, this is codified in section 277 of the Child's Right Act (2003), which defines a child as a person under the age of 18 years. This definition harmonizes with Nigeria's international commitment under the United Nations Convention on the Rights of the Child (CRC), to which it is a signatory (Agbede & Agbede 2020). Article 1 of the CRC similarly defines a child as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier". This legal demarcation is crucial, as it establishes the population for whom the question of proxy consent—and its potential for conflict—is most relevant.

2.2 The Pillars of Informed Consent: Beyond a Signature

Informed consent is far more than a formality or a signature on a document; it is an ethical covenant between healthcare provider and patient, founded on the principle of

respect for persons (Aniaka, 2012). It represents a process of shared decision-making that empowers the patient (Berg, 2001). This process rests on three indispensable pillars:

a) *Voluntariness:* The decision must be made freely, without coercion, undue influence, or manipulation. The patient's choice must be their own.

b) *Capacity:* The individual must possess the mental and emotional ability to understand the nature of the proposed treatment, its potential benefits, its material risks, the alternatives (including no treatment), and the consequences of their decision.

c) *Knowledge:* The healthcare provider has a fiduciary duty to disclose all relevant information in a manner the patient can comprehend. This includes the diagnosis, the purpose of the treatment, the likely outcomes, and the risks involved (Borsellino, 2013:23).

For minors, the element of capacity is presumed to be absent or developing (Ajanwachuku & Faga 2016:585). Consequently, the law transfers the power to grant consent to parents or legal guardians, operating under the assumption that they will act in the child's best interests (Ross, 2002:6). This transfer is not a surrender of the child's rights but a delegation of their exercise (Selinger, 2009:50). The problem arises when the delegate's actions are diametrically opposed to the core interest they are meant to protect: survival itself.

3. THE NIGERIAN LEGAL ARCHITECTURE: FRAMING RIGHTS, DUTIES, AND INTERVENTIONS

The Nigerian legal system provides a multi-layered framework that shapes this issue, drawing from constitutional law, statutes, and the common law.

3.1 Constitutional Guarantees and Their Limits

The 1999 Constitution of the Federal Republic of Nigeria (as amended) forms the bedrock of fundamental rights. Two rights are particularly salient here:

a) *Right to Life (section 33):* This is the most fundamental of all rights, without which all other rights are meaningless.

b) *Right to Freedom of Thought, Conscience, and Religion (section.38):* This guarantees every person the freedom to manifest and practice their religion.

The conflict emerges when the manifestation of a parent's religion (e.g., refusing a blood transfusion) directly imperils the child's right to life. The Constitution itself implies that rights are not absolute; they can be justifiably limited in certain circumstances, particularly for the protection of public safety, order, health, or morals, or for the protection of the rights and freedoms of others (section 45). It is this last point—the protection of the rights of the *child*—that provides the constitutional gateway for state intervention against parental religious practice.

3.2 Statutory Obligations and the *Parens Patriae* Doctrine

Beyond the constitution, statutes impose clear duties on parents. The Criminal Code (s.300-301) and similar penal laws across Nigeria implicitly criminalize neglect, including the failure to provide the necessities of life, which unequivocally encompasses essential medical care (Adeyemo, 2017:279).

When parents abdicate this duty, the state's ancient parens patriae authority is activated. This Latin term, meaning "parent of the country", signifies the inherent power and duty of the sovereign (or its courts) to protect individuals who cannot protect themselves, such as children, the mentally ill, or the infirm (Ewuim, 2018:117). In the medical context, parens patriae allows the state, through a court order, to supersede parental decision-making when that decisions threatens the child's welfare or life (Anyamele, 2023:2). It is a safety net of last resort, embodying the principle that the well-being of a child is not merely a private family matter but a concern of the state and society as a whole.

3.3 The Doctrine of Necessity: Emergency Intervention

Distinct from, but related to, *parens patriae* is the doctrine of necessity. This common law principle allows a healthcare provider to act without consent in a genuine emergency where:

a) The patient is unable to give consent (e.g., is unconscious or a minor without a competent proxy present).

b) There is an immediate threat to life or long-term health.

c) The intervention is immediately necessary to avert that threat.

d) The action taken is what a reasonable person would do in the circumstances and is in the patient's best interests (Diekema, 2004:243).

This doctrine provides legal cover for doctors to act decisively to save a child's life when delay to obtain court override would be fatal (Nwabueze, 2012:1).

4. THE LANDMARK CLARION CALL: *ESABUNOR & ANOR. V. DR. TUNDE FAWEYA & ORS* (2019)

The theoretical framework established by statutes and doctrines found its definitive and most powerful expression in the Nigerian Supreme Court's judgment in *Esabunor v. Faweya (2019)*. This case is the cornerstone of modern Nigerian jurisprudence on this issue.

4.1 The Facts: A Race Against Time and Faith

The facts, as meticulously detailed by the court, present a classic and heart-wrenching scenario. A one-month-old infant was brought to the Chevron Clinic in Lagos by his mother. The child was diagnosed with severe sepsis and anaemia. The physician, Dr. Faweya, determined that an urgent blood transfusion was critical for the child's survival. The mother, a Jehovah's Witness, refused to consent, citing her religious beliefs which prohibit the receiving of blood.

As the child's condition deteriorated—he began convulsing and struggling to breathe—the hospital and police were forced to act. The police successfully obtained an order from the Lagos State Magistrate Court authorizing the blood transfusion. Acting on this court order, Dr. Faweya administered the transfusion. The child survived and made a full recovery. The mother, however, proceeded to sue the doctor and the hospital, leading to a legal journey that culminated at the Supreme Court.

4.2 The Judicial Reasoning: Life as the Paramount Consideration

The Supreme Court unanimously dismissed the mother's appeal. In a powerfully reasoned lead judgment, Okoro, JSC, articulated the court's philosophy with profound

clarity. He drew a sharp distinction between the rights of a competent adult and those of a child:

It is instructive to note that the law exists primarily to protect life and preserve the fundamental rights of its citizens inclusive of infants. The law would not override the decision of a competent mature adult who refuses medical treatment that may prolong his life but would readily intervene in the case of a child who lacks the competence to make decision for himself... I hold the view that it could have amounted to a great injustice to the child if the court had stood by and watched the child being denied of basic treatment to save his life on the basis of religious conviction of his parents.

This passage is monumental. It establishes a clear legal boundary:

a) *For Adults:* Self-determination is paramount. A competent adult has the right to refuse treatment, even life-saving treatment, for any reason, including religious belief. They may choose martyrdom for themselves.

b) *For Children:* Protection is paramount. The state will not allow parents to make martyrs of their children. The child's right to life and health outweighs the parent's right to religious manifestation in this critical context.

The court effectively held that allowing a child to die due to parental religious refusal constitutes a "great injustice" to the child, one which the law is duty-bound to prevent.

4.3 Implications and the Settling of a Legal Controversy

The *Esabunor* decision laid to rest years of legal uncertainty. It sent an unequivocal message to healthcare providers, parents, and lower courts: where a child's life is at stake, the courts will not hesitate to intervene to override parental refusal based on religion. It empowers doctors to seek judicial authority to treat and assures them that such actions, when backed by a court order, are legally sound. Most importantly, it places the child's best interests—and specifically their interest in staying alive—at the very apex of the legal hierarchy in medical consent cases.

5. BEYOND *ESABUNOR*: NUANCES, COMPARATIVE PERSPECTIVES, AND EVOLVING CAPACITIES

While *Esabunor* provides a clear rule for life-threatening scenarios involving young children, the landscape of paediatric consent is more nuanced.

5.1 The "Mature Minor" and Evolving Capacity

The law is not static in its view of childhood. It recognizes that as children grow older, they develop the capacity to understand and make decisions about their own healthcare. The concept of the "mature minor" acknowledges that some adolescents, while still legally under 18 years, may possess sufficient intelligence and understanding to appreciate the nature and consequences of a medical procedure (Afolabi, 2018:26). In such cases, it is ethically and legally prudent to seek their assent alongside parental consent. For certain sensitive treatments (e.g., for reproductive health, mental health, or substance abuse), some jurisdictions have laws that allow minors to consent independently. While Nigerian law is still developing in this specific area, the principle of evolving capacity is a growing part of global bioethical discourse and is likely to influence future legal revisions.

5.2 Non-Life-Threatening Treatment and the Scope of Parental Discretion

The Esabunor principle is most clear-cut in emergencies. But what about decisions for non-life-threatening care? For instance, parents might refuse certain vaccinations, opt for alternative therapies for a chronic condition, or decline a recommended surgery for a non-fatal ailment based on personal belief. In these "grey areas", the balance is more complex. Courts are generally more reluctant to interfere with parental discretion if the child is not in immediate danger (Chima, 2013:52). The threshold for state intervention is higher, requiring proof that the parental decision causes, or is likely to cause, significant harm to the child's health or development (Selinger, 2009:54; Nnebedum & Opawoye, 2019). This area remains a contested space where the 'best interests standard' must be carefully applied on a case-by-case basis.

5.3 A Global Consensus: Comparative Jurisprudence

The Nigerian position is not an outlier; it reflects a robust global consensus. From the United States to the United Kingdom, South Africa, and Canada, courts have consistently prioritized a child's life over parental religious objections (Pavlikova & van Dijk, 2021:387).

a) ***United States:*** In *Prince v. Massachusetts* (1944), the U.S. Supreme Court famously stated, "*Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children*". This dictum has been cited in countless cases involving medical neglect.

b) ***United Kingdom:*** English courts have frequently invoked their *parens patriae* jurisdiction to order medical treatment for children against parental wishes. In cases like *Re S (A Minor) (Medical Treatment)* [1993], courts have authorized treatments like blood transfusions for children of Jehovah's Witness parents, firmly establishing the principle that the welfare of the child is the paramount consideration.

c) ***South Africa:*** The South African Constitution also enshrines the best interests of the child as paramount (Anyamele, 2023:2). Courts have interpreted this to mean that the state has a positive duty to protect children from all forms of harm, including harm resulting from a denial of medical care for religious reasons (*Christian Education South Africa v. Minister of Education* 2000).

This comparative perspective underscores that Nigeria's approach in *Esabunor* is aligned with progressive international human rights norms and the global safeguarding of children's welfare.

6. CONCLUSION AND RECOMMENDATIONS: UPHOLDING THE SANCTITY OF THE CHILD'S LIFE

The journey of medical consent for minors is a profound narrative about the limits of private authority and the public duty to protect the vulnerable. The Nigerian legal system, through its constitutional provisions, statutory duties, and ultimately the courageous precedent set by the Supreme Court in Esabunor v. Faweya, has drawn a clear line in the sand: the life of a child is not negotiable.

While the rights to family autonomy and religious freedom are fundamental pillars of a democratic society, they are not absolute. They find their limit at the point where their exercise threatens the very existence of another human being, particularly one who is utterly dependent and unable to advocate for themselves. The state's parens patriae power

is not an instrument of oppression but one of compassion—a collective promise that no child will be allowed to perish because of the beliefs of their guardians.

Therefore, this paper concludes that the "best interests of the child" standard, as definitively interpreted to prioritize the right to life, must remain the immutable guiding principle for medical decision-making for minors in Nigeria. The Supreme Court's ruling in Esabunor should be celebrated as a landmark victory for child rights and should serve as the binding standard for all lower courts and medical practitioners.

To solidify this framework, the following recommendations are proposed:

1. *Legislative Codification:* while the judicial precedent is powerful, the National Assembly should consider amending the Child's Rights Act or the National Health Act to explicitly codify the *Esabunor* principle. This would provide even greater clarity and statutory force to the rule that life-saving treatment cannot be withheld from a child on the basis of parental religious belief.

2. *Development of Clinical Guidelines:* professional medical associations, such as the Nigerian Medical Association (NMA), should develop detailed clinical and ethical guidelines for healthcare providers on how to navigate parental refusal of consent. These guidelines should outline the steps for seeking emergency court orders, applying the doctrine of necessity, and engaging with resistant families in a respectful yet firm manner.

3. *Enhanced Judicial Awareness:* the National Judicial Institute should incorporate training on paediatric bioethics and the *Esabunor* precedent into its curriculum for magistrates and judges. This will ensure the consistent and swift application of the law across all jurisdictions in Nigeria.

4. *Counselling and Support Systems:* hospitals should establish or strengthen clinical ethics committees and ensure access to counselling services for families facing these traumatic decisions. The goal should not be adversarial but to explore all avenues for understanding and, if possible, reconciliation, while never compromising the child's safety.

In the final analysis, the law's primary function is to protect the weak from the strong, the vulnerable from harm. In the collision between faith and life, Nigerian law has rightly decided that a child's future must never be the casualty.

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