LEGAL ASPECTS OF MEDICAL CONSENT FOR MINORS: PARENTAL RIGHTS AND CHILD AUTONOMY

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Abstract

Today, a well-known and a core tenet of medical law and ethics is that a medical professional must get an informed consent from a competent patient before giving any sort of therapy to that patient. This is consistent with the notion of autonomy (self-determination as a fundament right), which is inherent in every individual except in cases where observance of this value might be lawfully departed. In the therapeutic context, for instance, 'autonomy' refers to a patient's 'right to refuse and participate in every decision involving medical treatment'. While children as minors may have limitations as to the exercise of this right, parents are in the best position to oversee to its applicable situations. The question now is, what is the nuances existing between parents rights and child autonomy? This issue is a legal tussle. This paper examined the legal aspects of medical consent for minors within the ambits of parental rights and child autonomy. The paper discovered that finding a balance between the competing interests may be challenging because patients' rights as well as child's autonomy vary depending on the circumstances of each case, and a variety of legal factors influence the medical space and occasionally change the standard, making it nearly impossible to apply the same standard everywhere. According to the study, there are situations in which a patient is incapable of giving such agreement to a medical expert; as a result, the patient must have such consent obtained on his or her behalf and for the patient's welfare. The paper recommends that current regulatory framework be reviewed and repealed in view of finding a lasting solution to the problem of conflict between parents' right and child's autonomy.

Introduction

In modern medical ethics, the position of the law is that patient autonomy is regarded as a major principle in making decisions about an individual's health, and individuals receiving healthcare need to possess the entitlement to exercise their autonomy in a conscious and unrestricted manner. Conversely, healthcare providers and medical professionals have a duty to uphold this right and let patients to exercise their autonomy during their treatment[1]. In circumstances when a patient is unable to exercise this right owing to a limited ability to make medical decisions (known as lack of capacity), as the patient's surrogate, a suitably qualified individual will act in that person's best interests[2]. The position of Momen-Ghomi on this issue is that an individual's autonomy in lawful concerns is a logical concept recognised by both local and international enactments, provided that it doesn't endanger the value of human life[3]. As a result, according to Paragraph 2 of Article 59 of Iran's Islamic Penal Code, for instance, all medical and surgical procedures must be performed with the consent of the patients, their parents, guardians, or legal representatives, as well as in accordance with technical, scientific, and government regulations.

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1 Beauchamp TL, and Childress JF, *Principles of Biomedical Ethics*, (5th ed. Oxford: Oxford University Press, 2001): 57-104.

2 Parsapoor A, Bagheri A and Larijani B, 'Patient Rights in Iran,' *Med Ethics Hist*, 27, (2009): 39-47.

3 Momen-Ghomi M, *Kalematon Sadidah Fee Masayelen Jadidah* (1st ed. Ghom: Moassesat-onashre-l-eslami Pub., 1994): 163.

At the other hand, physicians in paediatrics face a wide range of intellectual and cognitive difficulties on the patient's side in terms of his or her right of participation in the medical decision-making; this, combined with the presence of parents, who have the right and responsibility to maintain their children under the law, exposes the doctor to ethical challenges at the crossroad of making this delicate medical decisions. To MacDonald and Walto, these difficulties go beyond just treatment as they specifically affect paediatric research.[4] Matutina while writing on 'Ethical Issues in Research with Children and Young People,'[5] stated that the same problem is evidence in the research paradigm as it poses a conundrum for researchers.

In light of the existing legal regime on child's right to medical consent and autonomy, the decision-making capacity required to exercise child's autonomy, issues bordering on a child's capacity to give medical consent, child's age and the right to consent: in light of medical ethics and concerns arising from parental decision-making on behalf of a child (in a medical setting), the current study aimed to explore the limits of children's autonomy and the extent of parental authority when it comes to making medical decisions for their children. To make things more concrete, we have offered helpful insights based on the existing legal regime.

Overview of Existing Legal Regime on Child's Right to Medical Consent and Autonomy

In line with the Nigeria's legal arena, the Federal Republic of Nigeria's Constitution is the fundamental document from which all other laws are derived, that is, it is the grundnorm.[6] Fundamental rights are covered in Chapter IV of the constitution and are unalienable until they are granted by the law.[7] The right to life,[8] the right to human dignity,[9] the right to personal liberty[10], the right to private and family life[11], and the right to freedom of thought, conscience[12], and religion are among the constitutional provisions that recognise the autonomy rights of all persons within the Nigerian space.[13] Obidimma and Obidimma are not mistaken in this issue. To them, in most jurisdictions of the world, the preservation of human life is the primary objective of governance.[14] In accordance with this governmental obligation, the people's security and welfare should be the government's primary purpose, under the Federal Republic of Nigeria Constitution's section 33 and section 14(2)(b), which ensures the right to life. In their interpretations, the state's interest in protecting the lives of its citizens is widely seen as the most important. In this regard, while fully recognising a competent adult's right to refuse medical treatment, the court may, if necessary, issue an order overriding the patient's autonomy to decide what happens to his body, such as when the health and safety of society are at stake.[15]

It goes without saying that these rights include the freedom to keep one's personal space free from unwarranted interference from others or from authorities. The individual's autonomy is constituted by this private area. For instance, the individual must not be subjected to

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4 MacDonald C and Walton N., *Research Involving Children and Youth*, Available at: http://www.researchethics.ca /children-andyouths.htm. Accessed on September 3, 2024.
5 Matutina RE, 'Ethical Issues in Research with Children and Young People,' *Pediatric Nurse*, 21(8), (2009):38-44.
6 CFRN, 1999 (as amended)
7 *Ibid, Section 45 CFRN.*
8 *Ibid, Section 33 CFRN.*
9 *Ibid, Section 34 CFRN.*
10 *Ibid, Section 35 CFRN.*
11 *Ibid, Section 37 CFRN.*
12 *Ibid, Section 38 CFRN.*
13 *Ibid* at note 7.
14 Obidimma EOC and Obidimma AE, p. 160
15 See *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* [2001] 7 NWLR (pt. 711) 206 at 244.

torture or any other cruel, inhuman, or degrading treatment as guaranteed by their right to human dignity.[16] A person who undergoes surgery without giving informed consent may file a battery lawsuit, which is based on this legal right. In the *Uzoukwu v. Ezeonu*[17] case, I hold that the court is right in defining "torture" as a mental abuse in addition to physical brutality, "inhuman treatment" as any act that shows no empathy for the suffering of the other person, and "degrading treatment" as any action that diminishes a person's standing in society or their character.[18] Similarly, since it provides the most fundamental foundation for a patient's ability to refuse a treatment because it conflicts with their faith, the constitutional right to freedom of thought, conscience, and religion is essential to autonomy. *The Medical and Dental Practitioners' Disciplinary Tribunal v. Okonkwo* case was effective in the expression of this point.[19] Additionally, the autonomy arguments claimed in favour of stifling a mentally ill patient for the sake of therapy are supported by the constitutional right to freedom of movement.[20] From the preceding, it is evident that autonomy is recognised within the parameters of the Nigerian Constitution, which serves as the foundational document of the nation. It can be acknowledged that Nigeria's constitutional law is on par with the highest international standard in terms of autonomy because these fundamental human rights, as outlined in the Constitution, are an adaption of the United Nations Universal Declaration of Human Rights of 1948.

The African Charter on Human and People's Rights, which was adopted in 1986,[21] guarantees each person's right to the "integrity of his person,"[22] their dignity, and freedom from exploitation and degradation, including torture, harsh, inhuman, or humiliating punishment and treatment. Nigeria has ratified this charter as well.[23] These internationally inspired legal instruments have now been adopted and domesticated into Nigerian law, where they have the same level of legal force as any other law passed by the country's legislative arm.[24] The Child's Rights Act and the Nigerian Code of Medical Ethics, a supplementary law created under the Medical and Dental Practitioners Act[25], are also two more laws that are pertinent to medical autonomy in Nigeria.

In furtherance to the above, the general tort system in Nigerian law is a crucial element of medical autonomy. When it comes to autonomy claims in a therapeutic context, tort law elements including battery, negligence, and false imprisonment are pertinent. According to McHale, Fox and Murphy, consent to medical treatment is also rooted in the common law tort of trespass to the person, but it has evolved into an independent doctrine in some jurisdictions that runs through the specialised field of medical law[26]. Nigeria is not one of the countries that have experienced these developments, as our understanding of our rights and obligations in the medical domain is still in its development stage. For example, if a patient undergoes surgery without giving their consent, they may file a battery lawsuit. Similarly, if a mentally ill patient's movement is restricted in order to provide therapy that is outside the

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16 *Ibid,* at note 13, Section 34 CFRN.
17 [1991] Part 200, 6 NWLR 708 at 764-778.
18 Prince-Oparaku U, 'Reproductive Health and the Right to Contraception in Nigeria: The Way Forward,' *NIALS Journal of Health Law and Policy,* (Maiden Edn): 128-129.
19 *Ibid.*
20 *Ibid,* at note 16, Section 41.
21 Domesticated by CAP A9 LFN, 2004.
22 Article 4.
23 Article 5.
24 See *Abacha v. Fawehinmi* [2000] 6. N.W.L.R (Pt 660) 221.
25 CAP M8 LFN 2004.
26 McHale J, Fox M and Murphy J, *Health Care Law, Text and Materials* (London: Sweet & Maxwell, 1997) 317.

bounds of legal permissibility, the aggrieved party may be successful in bringing a false imprisonment claim. Additionally, clinical situations may be covered by general tort law. The two most notable ones are negligence and assault. In situations where a surgical procedure is performed without the patient's express agreement; there is always a potential legal liability arising therefrom. Conversely, medical procedures inherently give rise to instances of duty of care, the violation of which may constitute a tortuous negligence.

Overall, it is evident that the domain of patient autonomy within the Nigerian legal system is comprised of the constitution, international law, statutory enactments, and common law tort and the principles of equity. Put another way, autonomy is recognised as relevant domestically by statutory law, common law, and international instruments, all of which draw their foundation from the fundamental human rights provisions of the 1999 Constitution FRN (as amended).

The Decision-Making Capacity Required to Exercise Patient Autonomy

While regurgitating on this issue, Sessums, Zembrzuska and Jackson were of the view that for patients to maintain their integrity and exercise their autonomy during a certain treatment plan, they must have the necessary capability and decision-making ability as required by law[27]. This implies that the ethical approach views decision-making ability as a relative concept rather than a binary one. To Kaushik, Narang and Agarwal, only a patient's unique situation, including the kind and extent of any dangers, can be taken into consideration when evaluating their capacity for making decisions[28]. The conflict between a parent's right to give consent on behalf of a minor, minor's right to autonomy and a doctor's duty of care and beneficence has an impact on the evaluation of a patient's capacity for decision-making[29]. To be able to resolve this, Sugarman advised it is recommendable to seek advice from hospital ethics committees or professionals or psychiatrists in situations where there is dispute or the patient is not complying appropriately during the evaluation of their ability for decision-making.[30] Schneider and Bramstedt, went ahead to advise that the law should take prominent in all situations[31].

It is still the physician's responsibility to provide the patient with the opportunity to participate in the process in a way that is appropriate for their capacity, even if the patient is a child and not entirely autonomous in making medical decisions[32]. Regarding the matter of paediatric patients' involvement in medical decision-making, many recommendations have been made in various nations [33], such as the Canadian Law of Consent to Treatment as reviewed by Rozovsky[34].

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27 Sessums LL, Zembrzuska H and Jackson JL, 'Does this Patient have Medical Decision-Making Capacity?' *JAMA*, 306(4), (2011): 420-427.

28 Kaushik JS, Narang M and Agarwal N, 'Informed Consent in Pediatric Practice,' *Indian Pediatr*, 17(47), (2010): 1039-1046.

29 Larkin GL, Marco CA and Abbott JT, 'Emergency Determination of Decision-Making Capacity: Balancing Autonomy and Beneficence in the Emergency Department,' *Acad Emerg Med*, 8(3), (2001):282-284.

30 Sugarman J, *Ethics in Primary Care* (New York: McGrow Hill, 2000): 234-235.

31 Schneider PL and Bramstedt KA, 'When Psychiatry and Bioethics Disagree About Patient Decision Making Capacity,' *Journal of Medical Ethics*, 2(2), (2006):90-93.

32 American Academy of Pediatrics Committee on Bioethics, 'Informed Consent, Parental Permission, and Assent in Pediatric Practice,' *Pediatrics*, 95(2), (1995):314-317.

33 British Medical Association, *Consent, Rights and Choices in Health Care for Children and Young People* (London: BMJ Books, 2001): 25-26.

34 Rozovsky LE, Children, Adolescents and Consent, In *The Canadian Law of Consent to Treatment* (2nd ed. Toronto: Butterworths, 1997): 61-75.

Be that as it may, it seems only reasonable to give the parents the authority to make medical decisions in cases where a paediatric patient lacks the mental capacity necessary to make a specific medical decision. The rationale behind the above stipulation is that, they are the ones responsible for raising and caring for their children, which includes having the authority to make decisions on their behalf. However, parents are the best proxies for determining what is in the best interests of paediatric patients because of their love for them, their sense of responsibility for their lives and futures, and their sensitivity to those needs[35].

Issues Bordering on a Child's Capacity to give Medical Consent

The ability to freely and knowingly consent to medical treatment and intervention is one of a patient's most fundamental rights. Such a right is based on a fundamental premise of medical ethics, and in this case, autonomy. However, to Goold and Herring, it is also an acknowledged precept of medical ethics that autonomy does not demand acceptance for every choice, but just those made by competent patients[36]. This is why children, who are not fully competent, are still treated paternally in health care, despite the fact that during the past 40 years, an autonomy paradigm (patient self-determination) has largely supplanted a paternalistic model (doctors making decisions on behalf of patients)[37]. This approach to children has been referred to as "dynamic self-determinism" or "gentle paternalism" in child rights studies. Eekelaar[38] and Fortin are prominent scholars who can be referenced to such researches[39].

Depending on the regulatory framework of each country, children may or may not have the ability to independently agree to medical treatment. Notwithstanding national consent laws, however, all nations that have joined the UN Convention on the Rights of the Child (CRC) are required to provide children given the chance to voice their thoughts and take part in decisions pertaining to their health[40]. The right to be heard helps a youngster understand their own independence. As a result, involvement in decision-making is a broader concept than consent[41], and it is therefore more appropriate for examining the exercise of a child's autonomy in the triadic relationship that this article centres on.

The argument of Liefaard and colleagues is that European and international standards do not sufficiently recognise the principle of children's evolving capacities and their right to be heard and participate in decision-making linked to their health and welfare, and place excessive highlight the child's right to protection[42].

Apart from the constraints imposed by the legal system and a lack of knowledge regarding children's rights, adults' attitudes also impede children from participating and achieving their own autonomy. According to Martenson and Agerski[43], parents' and healthcare

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35 Cummings CL and Mercurio MR, 'Ethics for the Pediatrician: Autonomy, Beneficence, and Rights,' *Pediatr Review,* 31(6), (2010):252-255.

36 Goold I and Herring J, *Great Debates in Medical Law and Ethics* (London, UK: Bloomsbury Publishing, 2018): 26.

37 *Ibid*, page 11.

38 Eekelaar J, 'The Interests of the Child and the Child's Wishes: The Role of Dynamic Selfdeterminism,' *International Journal of Law, Policy and the Family,* 8(1), (1994): 42-61.

39 Fortin J, 'Children's Rights: Are the Courts now Taking Them More Seriously?' *King's Law Journal*, 15(2), (2004): 253-272.

40 See *Article 12 of CRC*

41 Participation and consent are conceptually different, a distinction that is frequently and unfairly overlooked.

42 Liefaard T, Hendriks AC and Zlotnik D, *From Law to Practice: Towards a Roadmap to Strengthen Children's Rights in the Era of Biomedicine Report* (Leiden, Netherlands: Leiden University, 2017): 5.

43 Martenson EK and Agerski F, 'Old AM: A Review of Children's Decision-Making Competence in Health Care,' *Journal of Clinical Nursing*, 17, (2008): 3131–3141.

providers' views have a greater influence on children's ability to make decisions than their own abilities permit. A research conducted in Estonia (Praxis)[44], forty percent of adults either don't know if a kid has the right to participate in health-related decisions or the right to be informed about those decisions, or they even think that a child doesn't have those rights.

Previous researches on children's health-related decision-making, such as those of Grootens-Wiegers, Hein, and van den Broek[45], Paron[46], Ruhe, Wangmo and Badarau[47], Weller, Levin and Rose[48], has mostly focused on evaluating children's decision-making competence and ability, which has led to an emphasis on criteria for evaluating competence. When it comes to the support or limitation of a child's autonomy when health decisions are made in a child-doctor-parent triadic interaction, there is a knowledge gap. This research reveals how doctors see the realisation of a child's autonomy in an effort to expand this area of study.

Nonetheless, according on their age, psychological state, and level of maturity, youngsters exhibit a wide range of developmental capacities. Hence, clinicians should help them understand their medical conditions as much as possible. Even though the legal right to give consent for children lies with those of parental responsibility, the clinicians should as well involve the minors in all aspects of medical decision making wherever the possibility exists.

However, it is important that minors and children should not have beneficial medical treatment delayed unnecessarily while waiting for parents to consent. While the consent of any one person with legal parental responsibility is valid and sufficient, this decision must be in the best interests of the child. In an emergency, the treating physician is required to proceed with treatment even if consent is declined, as long as it is clearly in the child's best interests. If urgency is not of the essence, the clinician can seek a court order for treatment if attempts to convince the parents prove futile[49].

Child’s Age and the Right of Consent: The Perspective of Medical Ethics

When assessing a pediatric patient's capacity for making decisions, it is important to take into account their ability to evaluate their own condition, the consequences of their choices, and their capacity to make exact and reasonable deductions[50]. However, if patients could be grouped based on age so that each group's capacity is comparable, it would help paediatricians make moral decisions when evaluating the capacity of their patients. Naturally, this kind of categorisation would be predicated on the accepted evaluation of the decision-making ability of every age group; hence, unless demonstrated differently, a particular degree of capacity can be presumed in each group. According to the Canadian Paediatric Society, early childhood, middle childhood, and adolescent are the three periods

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[44] Praxis, Lapse Õiguste Ja Vanemluse Uuring. *Study on Children’s Rights and Parenting*, (2018). Available at: http://www.praxis.ee/tood/lapse-oigused-ja-vanemlus-2018/. Accessed on September 3, 2024).

[45] Grootens-Wiegers P, Hein IM, van den Broek JM, et al., ‘Medical Decision-Making in Children and Adolescents: Developmental and Neuroscientific Aspects,’ *BMC Pediatrics,* 17(1), (2017): 1-10

[46] Paron K, (2020) ‘The Child’s Autonomy in Decision-Making on Medical Treatment: Theoretical Considerations,’ *Juridical International,* 29, (2017)): 124-132.

[47] Ruhe KM, Wangmo T, Badarau DO, et al., ‘Decision-Making Capacity of Children and Adolescents—Suggestions for Advancing the Concept’s Implementation in Pediatric Healthcare,’ *European Journal of Pediatrics,* 174(6), (2015): 775-782.

[48] Weller JA, Levin IP, Rose JP, et al., ‘Assessment of Decision-Making Competence in Preadolescence,’ *Journal of Behavioral Decision Making,* 25(4), (2012): 414-426.

[49] Dr Thirumoorthy T and Dr Peter Loke, ‘Consent in Medical Practice 3: Dealing with Persons Lacking Capacity,’ *SMA Centre for Medical Ethics & Professionalism News*, (2013): 16-19.

[50] Parsapoor A, Parsapoor MB and Larijani B, ‘Informed Consent, Contents, Conditions and Practical Methods,’ *Iran J Diab Lipid Disord,* 5(1), (2005): 1-15.

of childhood that are frequently recognised by ethical guidelines[51]. In the first category, children are not permitted to participate in the decision-making process and parents are essentially the only ones who make decisions. In contrast, the second group believes that parents should make all final decisions, even while it is morally right to appease a child by giving them goodies and, when appropriate, to take a child's severe and ongoing resistance seriously. In this category, the child's assent is plainly sufficient; informed consent is not necessary[52].

The most challenging scenario is adolescents' autonomy prior to reaching their maximum potential. Adolescents' ability to make medical decisions appears to be very varied, ranging from total incapacity to perfect capacity. It is common practice in this age group to evaluate the patient's capacity and base all decisions on it. Additionally, clinicians have an ethical duty to include adolescent patients in medical decision-making to the extent that it is appropriate given their capacity[53].

The Position of the Law in Regard to Decisions Made by a Parent on Behalf of a Child (In the Medical Context)

The English Law Position

The general rule of law is that patients have the right to choose the course of therapy that will be given to them.[54] Thus, in the case of *Chester V Afshar*,[55] Lord Steyn proposed that a regulation compelling a physician to refrain from doing an operation without a patient's informed consent serves two purposes. It usually prevents the specific physical injury from happening, a risk that the patient is not ready to take on. Additionally, it guarantees that every patient's autonomy and dignity be respected appropriately.[56]

Once more, Mason and Laurie stated that the common law has long acknowledged each person's right to self-determination, stating that "every person has the right to have his or her bodily integrity protected against invasion by others."[57] However, these writers believe that the first fundamental point to note is that, at this point in its development, English law (pertaining to decision making regarding those who lack capacity) is based on the idea that, while a person who lacks capacity should have the right to autonomy, that right should not be absolute[58]. When examining the topic of autonomy, the contention of Selinger is that "the principle of total autonomy contradicts itself when applied to society on a philosophical basis." An absolute right to consent is impossible since autonomy serves as the primary ethical foundation for informed consent.[59] Selinger goes on to state that the argument over whether a principle or a right is unquestionable encompasses more than just moral and legal considerations. It also discusses the absoluteness philosophical argument. For instance, freedom cannot be an absolute ideal since it would significantly restrict the freedom of another person if it were granted to one. The right of Person A to possess any good will affect Person B's right to own property. The similar issue occurs when these concepts are applied

51 Canadian Paediatric Society. 'Treatment Decisions Regarding Infants, Children and Adolescents,' *Paediatric Child Health,* 9(2), (2004): 99-114.
52 *Ibid* at note 49.
53 No authors, 'Informed Consent, Parental Permission, and Assent in Pediatric Practice,' *Pediatrics*, 95(2), (1995): 314-317.
54 Herring J, *Medical Law and Ethics* (4th Ed., Oxford University Press, 2012): 149.
55 [2004] UKHL 41, para 18
56 See also the earlier case of *Schloendorff V New York Hospital* [1914] 211 NY 125, 126.
57 Mason JK and Laurie GT, *Law and Medical Ethics* (9th Ed, Oxford University Press, 2013): 70-71.
58 *Ibid*
59 Selinger CP, 'The Right to Consent: Is it Absolute?' *BJMP*, 2 (2009): 54

to autonomy as one person's complete autonomy negatively impacts the autonomy of other people. In order to provide an equitable way of life, the modern democratic society has created laws and regulations. This limits autonomy on the one hand, but it also ensures that every member of this community has the same level of autonomy on the other[60]

Thus, the English legal system accepts the challenge of attempting to find an "acceptable balance" between all of these interests, acknowledging the necessity to protect human autonomy without sacrificing other interests. Nonetheless, the possible ambiguity and fluidity of the issues involved in making decisions about persons who lack capacity present the task's immediate challenge. As Michael Gunn[61] rightly points out, capacity and incapacity are not concepts with distinct boundaries. From full capacity at one end to full incapacity at the other, they are seen on a continuum. There are, therefore, degrees of capacity. The challenge is to determine the right level to set as the entrance to decision-making and respect for persons.

This paper makes the case, to the credit of the English legal system, that the laws pertaining to this topic have chosen to define and develop the category of "lack of capacity" as an inability to handle this challenge in the present circumstances. This method may be used to control the degree to which someone is judged to be incapable in any particular situation. As a result, the term "lacking capacity" has acquired topical and temporal significance. Topical in that a person cannot be ruled incapable on one medical decision-making topic simply because he was found incapable on another and temporal in that a person cannot be proclaimed incapable today simply because he was deemed incapable yesterday[62].

However, a decision can only be taken on behalf of a patient in their "best interests" if the patient has been declared legally incapable of making decisions after considering all pertinent information. However, in keeping with its context-specific methodology, English law anticipates that broad assumptions regarding the patient's "best interests" should be eliminated as much as possible. Instead, the patient's "specific circumstances"—rather than the general consensus about what is in a man's best interests—should be taken into account.[63]

The moral category of permission serves as the foundation for the entire debate about autonomy in making decisions about medical treatment. In the US case of *Canterbury v Spence*,[64] which established the doctrine of informed consent, the court concluded that the patient's right to self-decision sets the boundaries of the duty to reveal in the. Only in situations when the patient has access to sufficient information to make an informed decision can that right be used effectively. Therefore, the patient's need—which is the knowledge necessary to make a decision—must be used to gauge the extent of the doctor's discussions with the patient.

According to English law, in order to maintain a patient's autonomy, their consent must be "informed consent."[65] In addition, to Jackson, it must be demonstrated that the patient is

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60 *Ibid*

61 British Medical Association, 'Ethical Kits for Students' (2011). Accessed 3 September, 2024.

62 The Mental Capacity Act, 2005, c. 9, s. 2(1) provides that "… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (emphasis mine). Therefore, in concluding one as lacking capacity, what counts is the material time of decision making and not time in absolute terms.

63 Medical Protection Society, 2013. Also, the Mental Capacity Act, 2005 provides that "Exactly what is in someone's best interests will depend upon his/her specific circumstances and is not confined to purely medical considerations" and that "all factors, including religious beliefs or values expressed by the patient when competent be taken into consideration."

64 [1972] 464 F (2nd) 772.

65 *Ibid* at note 58.

capable of giving consent and that they did so willingly after being informed about the nature of the treatment in order for it to be considered legitimate.[66] Jackson nevertheless believes that this is consistent with the English law's contextualisation of "incapacity." By emphasising that one's consent must be "informed," the patient is treated as a distinct soul among all humans; circumstances specific to his cognitive space as an individual are now a key factor; the patient's educational background, experience, and overall exposure in life are thus brought into the picture in determining his capacity for informed consent. Thus, depending on the complexity of the medical concerns involved, "consent" may be interpreted differently when given by someone with a medical background against his counterpart without such a background.[67]

The Position of the Nigerian Law

The National Health Act[68] provides the framework under Nigerian law for the management, development, and regulation of a national health system as well as the establishment of requirements for providing healthcare services. The Act makes no mention of how capacity is to be assessed in cases when a person lacks capacity. Nonetheless, the "rights and obligations of users and health care personnel" are covered in Part III of the Act. According to Section 23,[69] the user must be fully informed about his health status and any related treatments that are required. The details ought to include:

(a) the user's health status, unless there is strong evidence that disclosing the status would not be in the user's best interests;

(b) the variety of diagnostic tests and treatment options that the user typically has access to;

(c) the advantages, disadvantages, costs, and consequences that are typically associated with each option; and

(d) the user's right to refuse health services and to be informed of the implications, risks, and obligations of doing so[70].

The clause favours patient liberty over medical paternalism in terms of protection and preservation. Furthermore, the Nigerian patient is granted this right to autonomy under the joint application of Sections 35, 37, and 38 of the Federal Republic of Nigeria Constitution[71]. Therefore, for reasons that may be reasonable, obviously irrational, or unfounded, the Nigerian patient has the freedom to choose whether or not to follow the doctor's recommended course of treatment.[72] Thus, the Supreme Court of Nigeria in the case of *Medical and Dental Practitioners Disciplinary Tribunal V Dr. John E.N. Okonkwo*, upheld the Court of Appeal's ruling that a physician who respected the autonomy of the patient is not liable. The Supreme Court of Nigeria held that a patient may lawfully refuse medical

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66 Jackson E, *Medical Law Text, Cases, and Materials* (2nd Ed., Oxford University Press, 2006): 181.

67 From the same principle arises the fact that for consent to be valid, a doctor ought to provide the patient with all relevant information to be able to make a balanced judgment. But that the physician has provided this information will not in itself be enough, he ought to as well determine the patient's "ability to understand, retain, believe, evaluate, weigh and use information that is relevant to a medical intervention or its withdrawal". These tests are reflected in the Mental Capacity Act and have been affirmed by the courts in cases such as Re MB (an adult: medical treatment) [1997] 2 FLR 426, Re C (adult refusal of treatment) [1994] 1WLR 290, and Re B (consent to treatment: capacity) [2002] EWCH 429).

68 2014, SB. 215.

69 *Ibid*.

70 *Ibid*.

71 1999 (as amended)

72 Toki A., 'Patient's Right to Refuse Treatment in Nigeria', *World Association for Medical Lawyers Newsletter*, Issue 27, (2015): 4-5.

treatment or procedures recommended by the physician.[73] Nonetheless, a legitimate lawsuit for assault and invasion of privacy may be brought against the healthcare provider if they disregard the patient's right to decline treatment[74].

It is important to note that the patient whose autonomy is to be respected must be of "full age" and capacity in light of the aforementioned circumstances. By way of definition or determinant of "full age" we take into consideration "the age of eighteen years and above"[75]. Therefore, it could be assumed from the Constitutional requirement that once an individual reaches full age (18 years and above), they are presumed to have the requisite capacity and autonomy to give consent.

The Position of the Nigerian Law on the Parents Right of Consent

The best interests of the kid must come first when making decisions on their behalf under the Nigerian legal system. Article 4 (1) of the African Charter on the Rights and Welfare of a Child,[76] which is ingrained in the Child's Right Act, makes provisions for this. It declared that the best interests of the child must always come first in every decision involving a child, whether of whether it is made by a private or public entity, an individual, a court of law, an institution of service, or an administrative or legislative body.[77] According to the Children and Young Persons Act, a "child" is defined as anyone under the age of fourteen, and a "young person" is anyone over the age of fourteen but under the age of seventeen.[78] But the pertinent hassle is how to measure the certainty of decisions made on behalf of a child and ensure they are made for their best interest.

Consequently, it is crucial to clarify that issues pertaining to children fall under the residuary legislative list and are therefore state-specific.[79] Although the kid's Right Act[80] has been enacted by the majority of states, some have modified the definition of "a child." In several states, a "child" is defined as "a young person under the age of thirteen".[81] Numerous interpretations of the term exist. Akwa Ibom state, for instance, gave a definition of "a child" to be a young person who is under the age of sixteen.[82] Conclusively, it is worthy to expresses dissatisfaction at the absence of a thorough definition of a child that is broadly relevant to all states in Nigeria and, however, we may find the arguments of Iguh and Nosike to be plausible in Nigeria. To them, the perception of age as a defining characteristic of a kid differs by cultural background. Furthermore, the lack of a broad definition that is applicable throughout the nation is an all-encompassing handicap in terms of the just application of the provisions of the law.[83]

Conclusion and Recommendations

In conclusion, it is reiterated that the issues surrounding the autonomy of children who lack (or are suspected of lacking) capacity are delicate, dynamic, and occasionally ambiguous; as a result, English law is largely well-positioned to meet the needs of contemporary society by

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73 *Ibid*, p. 4.
74 *Ibid*, p. 5.
75 CFRN, 1999 (as amended), s. 29 (4) (a).
76 ACRWC, July 1999.
77 Child's Right Act, Cap 2003.
78 S. 2, Cap. 22, Laws of the Federation of Nigeria, 2004.
79 Iguh NA and Nosike O, 'An Examination of the Child Rights Protection and Corporal Punishment in Nigeria', *Nnamdi Azikiwe University Journal of International Law and Jurisprudence*, 2, (2011): 108.
80 *Ibid*, p. 108 – Some of the states are Anambra, Abia, Bayelsa, Rivers, Ebonyi, Edo, Ekiti, Imo, Jigawa, Kwara, Lagos, Nassarawa, Ogun, Ondo, Taraba, etc.
81 *Ibid*.
82 *Ibid*.
83 *Ibid*.

prohibiting absoluteness in resolving these issues. The British Medical Association[84] said that "there is no straightforward answer in determining when a person lacks capacity," which encapsulates the nature of English law. Additionally, it is praiseworthy that English legislation has established external balances against abuses by including the court, especially when it has to do with minors. Furthermore, the law has precisely drawn the line at the point when the public interest is most at risk, as is the case with communicable diseases, by guaranteeing that the complete abolition of an individual's autonomy will only occur in those circumstances.

However, it must be noted that the English legal system is unable to resolve certain issues pertaining to the autonomy of individuals who are incapable of making their own decisions. Even with all the benefits mentioned above, there is still a great deal of subjectivity in the interpretation of the text of the law, just as in any issue involving human rights and the public interest. Against this backdrop, this paper proposes that, in order to reduce the impact of subjectivity in the process of implementing the current law, relevant regulatory bodies optimise the practice of producing guidelines in the form of practice manuals that break down the provisions of the law into categorical, unambiguous specifics. These rules should also be updated on a regular basis, taking into account fresh insights gained from practitioners' and other concerned individuals' daily field experience.

When comparing the circumstances in Nigeria with the United Kingdom, for instance, it is inevitable to acknowledge that a complex legal and administrative framework for identifying individuals who lack ability is still in its early stages of development and therefore rife with discrepancies. Put another way, despite all of its flaws, Nigeria may still learn a lot from the British system as a useful case study while she develops her own internal organisation. Irehobhude Iyioha correctly noted that "health law and policy in Nigeria is a novel field." In this usage, "novel" denotes developing and unexplored.[85] In addition, a large portion of the nation's current health legislation was imported from Britain, her former colonial overlord; nevertheless, this may not accurately reflect the political and cultural reality on the ground.[86]

Given the aforementioned, Nigeria must pass a law that would apply generally to determine a person's capacity and to define what constitutes a child. Nigeria's laws should be based on the English legal system when suitable, considering the majority of them were imported from Britain, our former colonial overlord. In Nigeria, a patient's right to autonomy should always come first and be respected in all doctor-patient interactions, unless it is not feasible. To promote positive behaviours in the doctor-patient interaction, medical personnel should be taught of the legal stance on "informed consent." Medical personnel should be educated on patients' rights through a module that is added to undergraduate programs in Nigerian universities. A monitoring task force should be established to ensure compliance, and various medical association bodies in Nigeria should provide medical practitioners with an updated code of conduct and good medical standards to be followed by all medical practitioners.

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84 *Ibid* at note 34.

85 Iyioha IO, 'Pathologies, Transplants and Indigenous Norms: An Introduction to Nigerian Health Law and Policy' (2015).

86 *Ibid*.