



A REVIEW OF THE LEGAL FRAMEWORK ON CHILDREN'S CONSENT TO HEALTHCARE IN NIGERIA AND THE UNITED KINGDOM: LESSONS FOR NIGERIA

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Abstract

Children's right to healthcare is an important aspect of human rights and their ability to provide consent is essential for their well-being. However, children in Nigeria cannot provide consent to medical treatment and child participation does not extend to medical decision making. In the United Kingdom, children's right to healthcare is extended to include the right to consent to specific forms of medical treatment under certain circumstances. The laws establish an age threshold for medical consent and the types of treatment they may consent to only if the child is found competent to do so. In Nigeria, there is a gap in addressing the issue of medical consent for mature minors through formal legal frameworks. The medical practitioner is expected to rely on the consent of parents to administer treatment to mature minors. This paper reviews the legal framework on children's consent to healthcare in Nigeria and the United Kingdom. It adopts the doctrinal method of legal research. The findings are that the laws as they are do not offer minors medical autonomy. It concludes that the United Kingdom's approach provides a suitable model to follow; particularly the competency test set out in its law and recommends legislative reforms that align with social and cultural realities to establish clearer standards.

Keywords: *Child Rights, Healthcare, Informed Consent, Mental Capacity, Autonomy*

1.0 Introduction

One of the rights that children are entitled to is the right to healthcare. International covenant and regional treaties recognise this right to enjoy the highest attainable standard of physical and mental health conducive to living a life in dignity. They mandates States to take steps to achieve its full realization and protect the health of its population.¹ In Nigeria, domestic legislation such as the 1999 Constitution of the Federal Republic of Nigeria (as amended) (CFRN), the Child Rights Act 2003 (CRA) recognise the right to health and health services for children.² Considering that all children have

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¹ International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR), art 12(1); UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art 12)* E/C.12/2000/4; ICESCR, art 12(1); African Charter on Human and Peoples' Rights 1981 (ACHPR), art 16; ACHPR, art 14; Aisha Haruna, 'Realization of the Right to Health-Care in Nigeria: Need for a Paradigm Shift' [2020] (4)(1) *African Journal of Law and Human Rights*, 1-10.

² CFRN, s17(3)(c); pt III, Fourth Schedule, s2(c); Child Rights Act 2003 (CRA), s17(1).



the right to healthcare, the issue of consent to medical treatment is a concern. Children generally lack the capacity to give consent. This lack of capacity extends to their competence to give consent to some forms of medical treatment either independently or with the involvement of both the child and the parent, guardian or caregiver.

In jurisdictions like the United Kingdom, the landmark case of *Gillick v. West Norfolk and Wisbech Area Health Authority*³ provided the criteria for the medical competence of children under the age of 18 years. The House of Lords as per Lord Scarman, in a very detailed judgement, propounded the Gillick Competency test in this regard. The test demands that the child understands the type, purpose, broad nature and effect of treatment and possesses the capacity to choose whether to accept treatment or refuse it. The test also demands an assessment of the ability of the minor to appreciate the reasonably foreseeable consequences of both accepting and refusing the treatment.⁴ After the *Gillick case*, subsequent cases have given clarity to the Gillick principle as to whom a competent minor is to consent to or refuse medical treatment. The English Courts have gone ahead to rule that the Gillick principle for competency is not strict as certain factors can override the minor's choice, particularly as it pertains to the competency of the child to reject medical treatment.⁵ Thus, the application of this test is not strict and may vary based on the circumstances of the child in question. By law, children can give consent to selected forms of medical treatment and advice if they fulfil certain conditions. The laws also provide the age threshold for consent.⁶ Factors such as age, maturity, intelligence and nature of the risk involved in the treatment is taken into consideration in the circumstance.⁷

Thus, the objective of this paper is to review the legal framework for children's healthcare in Nigeria and the United Kingdom with primary focus on the area of medical consent to healthcare to draw lessons for Nigeria. The paper adopts the doctrinal legal research methodology. The significance of this analysis is to highlight the gaps in Nigeria's legal framework that may hinder children's access to healthcare, particularly with regard to consent to medical treatment. The paper sets out by discussing the conceptual and legal basis for consent in healthcare, the legal framework for children's consent to healthcare in Nigeria and the United Kingdom, a review of the United Kingdom's approach, impact of cultural and social context of the United Kingdom's model in Nigeria. Finally, it highlights the lessons for Nigeria and concludes by recommending amendment to existing laws.

³ *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 112; [1985] 3 All ER 402.

⁴ *Ibid*; Priscilla Alderson and Jonathan Montgomery, *Health Care Choices: Making Decisions with Children* (Institute for Public Policy Research London, 1996) 54, 56.

⁵ *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1992] 4 ALL ER 627; *Re R (A minor: wardship and consent to treatment)* [1992] Fam. 11; [1991] 3 W.L.R. 592; [1991] 4 All E.R. 177, C.A; *Re Ernestine Gregory* 133 Ill 2d 98, 549 N.E.2d 322 [1989].

⁶ Eduardo Osuna, 'Legal Protection of Informed Consent of Minors' [2010] (29)(2) *Medicine and Law*, 218; Lawrence Schlam and Joseph P. Wood, 'Informed Consent to the Medical Treatment of Minors: Law and Practice' [2000] (10)(2) *Health Matrix: Journal of Law-Medicine*, 142.

⁷ Schlam and Wood (n6), 143.



2.0 The Conceptual and Legal Basis for Consent to Healthcare

Before defining what informed consent means, it is best to define the meaning of consent. Kleinig⁸ draws an analogy that will be useful in describing this term. He describes consent as a proprietary gate that one opens to allow another access that would be impermissible, absent the act of voluntarily opening the gate of access. Thus, a person can consent to the performance of a medical procedure or the sharing of confidential information. Kleinig⁹ placed the meaning of consent within a moral context, as a communicative act that serves to alter moral relations between two individuals or a group of persons and that for such moral relation to have been altered, a communicative act must have ensued. A process of enquiry must be initiated to which consent is obtained as a response to such enquiry. Suppose a person is desirous to have a medical procedure carried out, such a person approaches a physician, after due consultation where the medical practitioner presents the terms of treatment, the person in need of treatment is expected to provide consent to the medical practitioner to go ahead with the treatment. Informed consent for medical treatment means, obtaining approval which must be signified by a conventional communication after relevant information about the medical condition, treatment options, potential risks and benefits, and alternative courses of action have been communicated to the individual in need of medical care.

Consent must be expressive, it must be signified, and it must take the form of conventional communication, only then can it be said that a moral relationship is created.¹⁰ Thus, consent must follow a recognised procedure for signifying consent. This is what he describes as signification and will be dependent on the purpose for which it is needed. For purposes of obtaining treatment, a medical consent form is usually signed as the conventional means of communicating consent. For validity, it must be voluntarily given by a person who is competent to consent, it must be appropriately informed and it must be intentional. Consent must be sought and obtained before treatment is administered. Obtaining the consent of a patient is important because failure to seek and obtain consent can render the health provider or the hospital liable in tort. This may stimulate action in negligence resulting from non-consensual administration of treatment.¹¹ Consent serves both legal and clinical functions as identified by Lord Donaldson in *Re W*.¹² The legal function is to justify the treatment. The clinical function is to secure the patient's trust and care. Without consent, the crime of battery would be committed and the healthcare professional would also be liable in tort for trespass to a person.¹³

⁸ John Kleinig, 'The Nature of Consent' in Franklin G. Miller and Alan Wertheimer (eds), *The Ethics of Consent: Theory and Practice* (Oxford University Press, 2010) 4.

⁹ *Ibid*, 6.

¹⁰ *Ibid*, 10.

¹¹ Festus O Emiri, *Medical Law and Ethics in Nigeria* (Malthouse Press Limited, 2012) 268; M. O Izzi, 'Tortious Liability in the Practice of Medicine in Nigeria' *Port Harcourt Law Journal*, 47 <https://www.researchgate.net/publication/332291010_TORTIOUS LIABILITY_IN_THE_PRACTICE_OF_MEDICINE_IN_NIGERIA> accessed 25 November 2023.

¹² *Re W* [1992] 4 All ER 627.

¹³ JA Dada, *Legal Aspects of Medical Practice in Nigeria* (Optimist Publishers Calabar, 2002) 79-84; Peter de Cruz, *Comparative Healthcare Law* (Cavendish Publishing Limited, 2001) 118.

When consent is needed for medical purposes, the term ‘informed consent’ is commonly heard and used. Beauchamp and Childress¹⁴ highlight the concept of informed consent as a central aspect of autonomy in healthcare. Informed consent requires healthcare providers to provide patients with relevant information about their condition, treatment options, potential risks and benefits, and alternative courses of action. Patients are then able to make decisions based on this information, giving them control over their own healthcare choices. According to Kirby,¹⁵ the principle of informed consent requires health professionals to explain to patients what is involved before performing any diagnostic or therapeutic procedure that may have a reasonable possibility of causing harm to the patient. Informed consent is assent acquired after the patient has been fully informed concerning the procedure’s risk-to-benefit ratio in comparison to alternative procedures or receiving no medical care at all.

As Kruger¹⁶ notes, informed consent or informed decision-making as it applies to medical decision-making entails knowledge, appreciation and consent. The patient must be fully aware of the type and scope of the risk or harm; the patient must have appreciated and understood the nature and extent of the harm or risk; and the patient must have consented to the harm or risk, which consent must have been comprehensive.¹⁷ Iyioha and Akorede¹⁸ have defined informed consent in healthcare law as a doctrine that requires healthcare practitioners to obtain the consent of their patients upon whom treatment is to be administered or surgery performed before embarking on the treatment or surgical procedure. It is an ethical and legal doctrine that is founded on the principles of patient autonomy.

The doctrine of *volenti non-fit injuria* is based on informed consent – if a patient has given informed consent, such consent is justification for conduct that would otherwise constitute a wrongful act.¹⁹ Ogundiran and Adebamowo²⁰ note that the supply of relevant, sufficient, and understandable information for the patient to make an educated decision regarding a surgical intervention is central to the concept of informed consent. To accomplish this, the surgeon must have the appropriate abilities to assess his or her patient’s ability to receive and apply supplied information. He or she must also be forthcoming in presenting honest clinical information in a non-threatening or coercive manner. In addition, The Code of Medical Ethics in Nigeria (CMEN) describes the importance of informed consent. It provides that ‘practitioners involved in procedures requiring the consent ... must ensure that the appropriate consent is obtained before such procedures, either for surgery or diagnostic purposes, are

¹⁴ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn Oxford University Press Oxford, 2019), 117.

¹⁵ Michael D Kirby, ‘Informed Consent: What Does it Mean?’ [1983] (9)(2) *Journal of Medical Ethics*, 69; John Kleinig, ‘The Nature of Consent’ in Franklin G. Miller and Alan Wertheimer (eds), *The Ethics of Consent: Theory and Practice* (Oxford University Press, 2010) 17.

¹⁶ Hanneretha Kruger, ‘Allowing Competent Children in South Africa to Refuse Medical Treatment: Lessons From England’ [2021] (32) *Stellenbosch Law Review*, 411.

¹⁷ *Ibid.*

¹⁸ Ireh Iyioha and Yusuff AO Akorede, ‘You Give Me Welfare but Take My Freedom: Understanding the Mature Minor’s Autonomy in the Face of the Court’s *Parrens Patriae* Jurisdiction’ [2010] (13)(2) *Quinnipiac University Health Law Journal*, 283.

¹⁹ Kruger (n16).

²⁰ Temidayo O Ogundiran and Clement A Adebamowo, ‘Surgeons’ Opinions and Practice of Informed Consent in Nigeria’ [2010] (36)(12) *Journal of Medical Ethics*, 742.



done, be they invasive or non-invasive'.²¹ Explanations to patients from whom consent is being sought should be simple, concise and unambiguous about expectations. Proper counselling should precede the signing of the consent form.²²

The easing of the restrictions on children's capacity in this regard has been attributed to several factors such as the changing order of the parent-child relationship universally. This is combined with the recognition of children as potentially independent persons, depending on the task at hand and the child's age and level of maturity.²³ Competence in decision-making is judged by the ability to make a particular decision, at a specific time and under specified conditions. This will include the capacity to understand and communicate, the capacity for reasoning and deliberation and a consistent set of values of what is good.²⁴ Other factors are the rise in the children's rights movement and the result of the widespread research on children's level of maturity that emphasizes nurturing and protection in childhood to claim autonomy as they advance in age.²⁵ As children become older, their capacity to make decisions becomes glaring, parental authority also evolves from total control to an advisory role and eventually comes to an end when the child acquires the capacity to make decisions.²⁶

3.0 The Legal Framework on Children's Consent to Healthcare in Nigeria

This section reviews the Child Rights Act 2003, the National Health Act 2014, the Code of Medical Ethics 2008. The aim is to evaluate the extent to which these laws guarantee access to healthcare for children by allowing them give consent to medical treatment and advice.

3.1 Child Rights Act 2003

The Child Rights Act 2003 (CRA) sets out to provide a legal framework for children and further protect their rights. In line with international and regional standards, the CRA emphasizes the best interest of the child to be a paramount consideration in all actions affecting children.²⁷ The best interest concept was developed because young children depend on trustworthy adults to stand up for their rights and interests when choices are made that affect their ability to function both individually and collectively.²⁸ A child is to be given the protection and care necessary for his/her well-being. This will take into account the parental rights and obligations, legal guardianship, and individuals or institutions accountable for the care and protection of the child.²⁹

²¹ Code of Medical Ethics in Nigeria 2008 (CMEN), rule 19.

²² *Ibid.*

²³ Charles Ngwena, 'Health Care Decision-making and the Competent Minor: The Limits of Self-Determination' [1996] *Acta Juridica*, 132.

²⁴ Michael Freeman, 'Deciding for the Intellectually Impaired' [1994] (2)(1) *Medical Law Review* 77-91.

²⁵ Hanneretha Kruger, 'The Protection of Children's Right to Self-Determination in South African Law with Specific Reference to Medical Treatment and Operations' [2018] (21) *Potchefstroom Electronic Law Journal*, 4-5.

²⁶ *Ibid.*, 6.

²⁷ Child Rights Act 2003 (CRA), s1.

²⁸ United Nations Committee on the Rights of the Child, General Comment No 7 (2005) Implementing Child Rights in Early Childhood CRC/C/GC/7/Rev.1, para 13.

²⁹ CRA, s2.

The CRA unlike the Constitution expressly guarantees the right to health and health services for children.³⁰ It provides that ‘every child is entitled to enjoy the best attainable state of physical, mental and spiritual health’.³¹ The government has certain responsibilities to perform in attaining the best state of health for children. These duties range from endeavouring to reduce the infant mortality rate to providing support through technical and financial means and mobilisation of national and local community resources in the development of primary healthcare for children.³² It also places a duty on parents and caregivers in the custody of children under the age of two years to ensure they are provided full immunisation. Failure to do so is an offence punishable by fine, imprisonment or the Court may substitute such punishment and compel that parent or caregiver to get the child immunised.³³

Although the CRA recognises the evolving capacity of children when it refers to ‘age and ability’ regarding their responsibilities like the ACRWC, a review of the CRA shows that nothing is mentioned about mature children and consent to selected kinds of medical treatment. Whether such consent can be independently given or must be in conjunction with the parents or caregivers is not stated. Nothing is also mentioned about the assessment of maturity for this purpose. However, the CRA refers to a child’s consent within the context of taking scientific samples for purposes of giving effect to section 63 of the CRA on the power of the Court to require scientific tests in determining the maternity or paternity of the child.³⁴ Thus, the CRA clearly states that:

the consent of a child who has attained the age of sixteen years to the taking from himself of a scientific sample shall be as effective as it would be if he had attained the age of majority and where a child has by a virtue of this subsection given an effective consent to the taking of a scientific sample, it shall not be necessary to obtain any consent for it from any other person.³⁵

Consent to take scientific samples must be sought and obtained from persons who have care and control of the child if the child is below the age of 16 years.³⁶

There are some other categories of children who require the consent of the person who care for them, whether they are above the age of 16 years or not. In this regard, the CRA states that a child who is mentally ill as defined by any applicable Nigerian legislation and is unable to comprehend the nature and purpose of the scientific testing may still have a scientific sample obtained from them. The only condition will be if the person responsible for the child’s care and control consents and the doctor who is responsible for the child’s care has certified that the taking of the scientific sample from the child will not interfere with his or her proper care and treatment.³⁷

³⁰ *Ibid*, s13.

³¹ *Ibid*, s13(1).

³² *Ibid*, s13(2)(3).

³³ *Ibid*, s13(4)(5).

³⁴ *Ibid*, ss63-64.

³⁵ *Ibid*, s64(2).

³⁶ *Ibid*, s64(3).

³⁷ *Ibid*, s64(4)(a)-(b).



3.2 Code of Medical Ethics in Nigeria 2008

This Code of Medical Ethics in Nigeria (CMEN) is the rules of professional conduct for medical and dental practitioners in Nigeria, published by the Medical and Dental Council of Nigeria in 2008.³⁸ It guides the medical practitioner in the exercise of his or her skills in ways that uphold the ethics of the profession in Nigeria.

In dealing with consent, the confidentiality of patients must be protected by the medical practitioner. The CMEN in upholding the principles of medical confidentiality provides that all communications between the patient and the practitioner made in the course of treatment should be treated as confidential. The practitioner does not divulge information unless compelled by law or overriding common good, with the consent of the patient.³⁹ This helps to build trust in medical relationships and safeguards the patient's right to privacy regarding their medical status and history. Violation of this may result in professional misconduct leading to disciplinary actions against the medical practitioner. Also, medical practitioners are at liberty to choose whom they can render services but they must do so without discrimination in an emergency and to the best of their ability in the prevailing circumstance.⁴⁰ The CMEN does not provide for how confidentiality should be handled in cases of sexual abuse, substance abuse and mental health cases affecting children. It is suggested that the medical practitioner exercises care in sharing information to avoid further abuse of the child, particularly in cases where the abuser is someone who is in legal care of the child.

The procedure for obtaining consent for major medical procedures, in ways that enhance the protection of the rights of patients is spelt out in rule 19 of the CMEN. This is what the CMEN refers to as 'informed consent' which has already been defined earlier. Informed consent is part of the general guidelines in medical and dental practice. A practitioner involved in a procedure requiring the consent of a patient, his or her relation or appropriate public authority must ensure that consent is obtained before such procedures are carried out whether they are invasive or not.⁴¹ Explanations to the patient whose consent is needed should be simple, concise and unambiguous. Proper counselling should precede the signing of the consent form. Consent forms should be printed or written form with the name of the health establishment boldly indicated.⁴² Where the patient is under-age (that is, below the age majority by Nigerian law), is unconscious or mentally impaired, a next of kin should stand in. In the absence of this, the most senior doctor in the institution can give appropriate directives to preserve life.⁴³ In special situations, a Court order may be needed to enable life-saving procedures to be carried out.⁴⁴

Although the voluntary self-offer for professional care by the patient to the practitioner is an expression of consent coming from the patient, the profession insists that certain interactions deserve specific and

³⁸ Code of Medical Ethics in Nigeria 2008 (CMEN), pt A-H.

³⁹ CMEN, rule 9f.

⁴⁰ *Ibid.*, rule 9g.

⁴¹ *Ibid.*, rule 19.

⁴² *Ibid.*

⁴³ *Ibid.*

⁴⁴ *Ibid.*



expressly defined and documented forms of consent. The Medical and Dental Council has approved a simple format for guidance and use in clinical management. It is called form MDCN/COMEIN/R19. This provides the standard layout to be used by a registered medical practitioner in Nigeria to obtain appropriate consent to carry out procedures on any patient. The consent form contains amongst other information, the full name of the medical doctor carrying out the treatment, the specific procedure to be carried out and the name of the patient on whom the procedure is to be carried out (it could be for self, for a child, spouse, mother or father or other. The person giving consent is to specify). On the consent form, the patient also affirms that he or she clearly understands the language of explanation, and was given the option to think over the procedure for some time before assenting. Finally, the patient or his or her guardian signs the consent form and dates it. The witness of the patient or guardian also signs with their full name, address and date.⁴⁵ Failure to comply with rule 19 which is under the general guidelines will amount to infamous conduct for which the affected practitioner may be punished if found guilty.⁴⁶ It will also constitute professional negligence.⁴⁷

The CMEN envisaged situations where parents or caregivers may refuse to provide consent for the treatment of their children or wards for religious reasons. For the clinical management of religious adherents, rule 39 of the CMEN is instructive. It makes it clear that whatever the religious orientation of the practitioner or the patient is, it must not determine the quality of treatment offered.⁴⁸ The commitment of medical practitioners to this rule has led to conflict between patients, their relatives and practitioners. In managing such patients, it is essential to establish the religious views held by the patient and record them. Their acceptance or rejection of treatment should also be recorded and witnessed. The practitioner should then decide whether they are willing to accept the limitation in management of the patient and if so, should plan and offer optimal care or withdraw care and refer such patient for further opinion or other healthcare centres which might be willing to handle such cases.⁴⁹

Concerning children's religious inclination and consenting to treatment, the CMEN recognises three age categories. They are children aged 16 to 18 years, children who are younger than 16 but not below the age of 13 years (13 to 15 years) and children who are under 13 years. It states that those between the ages of 16 years to 18 years have a statutory right to consent to procedures and this takes precedence over parental objection but does not invalidate the right of others to consent on their behalf. The CMEN does not cite the law it refers to. Where a child of this age group objects to treatment and parental consent is obtained in emergencies, appropriate treatment or procedure can be given.⁵⁰ The CMEN does not state the law it refers to as these provisions are not supported by the MDPA. Considering that it clothes children aged 16 years to 18 years with the capacity to consent to medical treatment, it does not

⁴⁵ CMEN, rule 19.

⁴⁶ *Ibid*, rule 26.

⁴⁷ *Ibid*, rule 28e.

⁴⁸ *Ibid*, rule 39(a)(i).

⁴⁹ CMEN, rule 39(a)(ii-v).

⁵⁰ *Ibid*, rule 39(c)(i).

state if such children can refuse medical treatment in non-emergency cases neither does it state the kind of treatment they are allowed to consent to.

The CMEN also provides that children younger than 16 years but not below the age of 13 years are regarded as children, but can provide acceptable consent if they are of sound mind, capable of understanding the positive and negative aspects of either accepting or rejecting a suggested course of treatment.⁵¹ Again, the CMEN does not state the law in Nigeria it is referring to nor does it state the kind of treatment these age category of children can consent to and if it is the same with children aged 16 to 18 years of age. For children under 13 years, if after full parental consultation treatment is refused, the practitioner should approach the Court and obtain an order to protect the health interest of the child. Treatment should be administered and a child who needs a blood transfusion should be given.⁵² A practitioner who refuses to get a Court order for administering treatment in the interest of the child, and allows the minor to die, in circumstances that might have been avoidable, may be charged with negligence and is also vulnerable to criminal prosecution.⁵³

The CMEN recognises that persons below the age of 18 are mature enough to make certain medical decisions. Those between the ages of 16 years to 18 years can give consent. However, it does not harmonise this with the CRA which still pegs the age of consent at 18 years. The Health laws do not have provisions on medical consent for children and the CMEN does not state the law it refers to when it categorises children to provide consent to treatment. The CMEN does not clearly state the type or scope of permissible treatment these children can consent to, and neither does it reference the law in Nigeria from which it draws its position.

3.3 National Health Act 2014

The National Health Act 2014 (NHA) is an Act of the National Assembly of the Federal Republic of Nigeria to provide a framework for the regulation, development and management of a national health system and set standards for rendering health services and related matters.⁵⁴ This is without prejudice to extant professional regulatory laws and protects, promotes and fulfils the rights of the people of Nigeria to have access to healthcare services.⁵⁵ The NHA is the first comprehensive health legislation in Nigeria and recognises the right to health. It establishes the national health system and provides a framework for standards and regulation of health services in Nigeria. The standards set by the NHA are to provide the best possible health services within the limits of available resources for persons living in Nigeria and protect, promote and fulfil the rights of the people to have access to healthcare services.⁵⁶

The NHA mandates that persons who are using health facilities should be provided with relevant information to enable them make an informed medical decision. A health provider is obligated to give

⁵¹ *Ibid*, rule 39(c)(ii).

⁵² *Ibid*, rule 39(c)(iii).

⁵³ *Ibid*.

⁵⁴ National Health Act, 2014 (NHA), explanatory memorandum.

⁵⁵ NHA, s(1)(a)-(e).

⁵⁶ *Ibid*.

relevant information about the patient's state of health and necessary treatment relating to the health status, the range of diagnostic procedure, benefit, risk, cost of associated options and the right to refuse health services and its implication.⁵⁷ The healthcare provider concerned where possible, is to inform such a person in a language that he or she understands and in a manner that takes into account his or her level of literacy.⁵⁸ The NHA does not indicate what procedure must be carried out in cases where the patient is a minor and if such a minor can make informed medical decisions independently or with a parent or caregiver. It is assumed that these provisions apply to only adults in need of health services.

4.0 Legal Framework on Children's Consent to Healthcare in the United Kingdom

4.1 Family Law Reform Act 1969

The Family Law Reform Act of 1969 (FLRA) is an 'Act to amend the law relating to the age of majority, to persons who have not attained that age and to the time when a particular age is attained...'.⁵⁹ The Act reduced the age of majority from 21 years to 18 years.⁶⁰ As regards consent to medical treatment, the law pegs the age of medical consent at 16 years, stating that consent to medical, surgical or dental treatment provided at such age is effective. Where a minor has provided such consent, it is not necessary to obtain consent from his or her parent or guardian.⁶¹ Surgical, medical or dental treatment as defined in the Act includes any process carried out for diagnosis or any procedure which is supplementary to any treatment as it applies to that treatment. It also includes the administration of anaesthetics for treatment.⁶² The Family Law Reform Act of 1969 allowed minors of 16 years and 17 years to consent to medical procedures as if they were at the age of majority (18 years), but the situation of minors under 16 years was not addressed. Incapacity was assumed, and parents or guardians took proxy decisions on medical issues for their children.⁶³

4.2 Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA) of the United Kingdom is an Act to make new provisions relating to persons who lack capacity.⁶⁴ The primary objective of this Act is to address legal ambiguities and modernize the existing law, particularly when it comes to decision-making for individuals who are incapable of making choices themselves. This legislation oversees decision-making for adults aged 16 years and above, in situations where they lose mental capacity due to various factors such as dementia, brain injury, or congenital conditions. It encompasses a broad spectrum of decisions involving personal well-being and provides clarification when there is no formal process in place.⁶⁵ One of the aims of the MCA is to limit paternalistic decision-making to those cases where a person lacks capacity (as defined

⁵⁷ *Ibid*, s23(1)(a)-(d).

⁵⁸ *Ibid*, s23(2).

⁵⁹ Family Law Reform Act 1969 (FLRA) c.46 <<https://www.legislation.gov.uk/ukpga/1969/46>> accessed 14 October 2023

⁶⁰ FLRA, s1(1).

⁶¹ *Ibid*, s8(1).

⁶² *Ibid*, s8(2).

⁶³ Cave, Emma, 'Maximisation of Minors Capacity' [2011] (23)(4) *Child and Family Law Quarterly*, 433.

⁶⁴ Preamble to the Mental Capacity Act 2005 (MCA); Mental Capacity Act, 2005 (MCA), 'Summary and background' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/2>> accessed 9 August 2023.

⁶⁵ MCA, ss1-8.

in the Act).⁶⁶ Additionally, the MCA establishes a recourse to the Court, when needed and appropriate, to handle all personal welfare (including healthcare) and financial decisions for adults lacking capacity.⁶⁷ On the age threshold for the application of the MCA, it is clear that the powers granted under the Act are not exercisable by a person under the age of 16 years.⁶⁸ The Act applies to persons aged 16 years and above.⁶⁹ Thus the MCA applies to persons who are aged 16 years and above and have been adjudged as lacking decision-making capacity due to mental infirmity.

The provisions of the MCA are based on five statutory principles, aimed at assisting and supporting people who may lack the capacity to make particular decisions, not to restrict or control their lives.⁷⁰ The first is that a person is presumed to have the capacity to make decisions except it is established that he or she cannot do so.⁷¹ Secondly, before such a person is treated as one who cannot make a decision, all practicable steps must have been taken without success, to help him or her do so.⁷² The third principle is that the fact such a person makes an unwise decision does not mean that he or she must be treated as one who cannot make a decision.⁷³ The fourth principle is that actions taken under the MCA on behalf of an incompetent person must be made in the individual's best interests. The fifth and final principle is that before taking any action, consideration must be given to whether the objective for which it is required can be accomplished in a manner that is less restrictive of the individual's rights and freedom of action.⁷⁴

According to the MCA's requirements, a person is considered to lack capacity if, at the relevant time, they are unable to decide for themselves about the issue at hand due to a disability or disruption in their mental or neurological processes. It makes no difference if the impairment or disruption is transient or permanent.⁷⁵ To buttress this definition, the Mental Capacity Act Code of Practice defines a person who lacks capacity as someone who 'lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken'.⁷⁶ This reflects the fact that people may lack the capacity to make medical decisions for themselves, but will have the capacity to make other decisions not related to their healthcare.

It is not sufficient to prove someone is incapable of doing something based only on their age, appearance, health, or behaviour, as this could mislead others into believing that they are unable to

⁶⁶ Cave (n66) 89.

⁶⁷ MCA, ss15-23; *Ibid.*

⁶⁸ *Ibid.*, s2(5).

⁶⁹ *Ibid* ss2, 18(3), 21; MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023; Carolyn Johnston and Jane Liddle, 'The Mental Capacity Act 2005: A New Framework for Healthcare Decision Making' [2007] (33)(2) *Journal of Medical Ethics*, 94-97.

⁷⁰ Mental Capacity Act Code of Practice, 19-20.

⁷¹ MCA, s1(2).

⁷² *Ibid*, 1(3).

⁷³ MCA, s(4); Mental Capacity Act Code of Practice, 19.

⁷⁴ MCA, s1(6).

⁷⁵ *Ibid*, s2(1)(2).

⁷⁶ Mental Capacity Act Code of Practice, 40.

perform the task at hand.⁷⁷ The fact such a person makes an unwise decision does not mean that he or she must be treated as one who cannot make a decision introduces a principle of equal consideration concerning determinations of a person's capacity. Any preconceptions and prejudicial assumptions held by a person assessing capacity must therefore have no input into the assessment of capacity. The reference to 'condition' captures a range of factors, including any physical disability a person may have. So, in assessing capacity, the fact that the person in question has a learning difficulty should not in itself lead the person assessing to assume that the person with the learning difficulty would lack the capacity to decide. The reference to 'appearance' would also include skin colour.⁷⁸ Still, on proving capacity, the MCA further provides that '... any question whether a person lacks capacity within the meaning of this Act must be decided on the balance of probabilities'.⁷⁹

It has already been stated that a person is considered to be mentally incapable if, at the relevant moment, they are unable to decide for themselves regarding the issue at hand due to a disability or disruption in their mental or neurological processes. Thus, in assessing capacity, the Code of Practice sets out the two-stage test. First, does the person have a permanent or temporary impairment of the mind or brain, or some kind of disturbance affecting the way their mind or brain works? If so, does that impairment or disturbance mean that the person is unable to decide a question at the time it needs to be made?⁸⁰ If the capacity test is passed, the next stage will be to assess if such a person can decide the question. The test will ascertain if the individual has an overall appreciation of what decision they need to make and why they need to make it. Secondly, does the person have a general understanding of the likely consequences of making, or not making, this decision? Thirdly, is the person able to understand, retain, use and weigh up the information relevant to this decision? Lastly, can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?⁸¹

A person is unable to decide for himself or herself if he or she is unable to:

- (a) understand the information relevant to the decision,
- (b) retain that information,
- (c) use or weigh that information as part of the process of making the decision,
or
- (d) communicate his decision (whether by talking, using sign language or any other means).⁸²

Based on the explanatory note of this legislation, the above provisions of the MCA set out the 'functional' test which looks at the decision-making process itself. Four reasons are given why a person may be unable to make a decision. The first three conditions (subsection (1)(a) to (c)) will cover the

⁷⁷ MCA, s2(3).

⁷⁸ MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023.

⁷⁹ MCA, s2(4).

⁸⁰ Mental Capacity Act Code of Practice, 40-41.

⁸¹ *Ibid*, 41.

⁸² MCA, s3(1)(a)-(d).



vast majority of cases.⁸³ Subsection (1)(d) provides for the fourth situation where someone is unable to make a decision where he cannot communicate it in any way. This is intended to be a residual category and will only affect a small number of persons, in particular, some of those with the very rare condition of 'locked-in syndrome'. It seems likely that people suffering from this condition can still understand, retain and use the information and so would not be regarded as lacking capacity under subsections (1)(a) to (c). Some people who suffer from this condition can communicate by blinking an eye, but it seems that others cannot communicate at all. Subsection (1)(d) treats those who are completely unable to communicate their decisions as unable to make a decision. Any residual ability to communicate (such as blinking an eye to indicate 'yes' or 'no' in answer to a question) would exclude a person from this category.⁸⁴

In addition to the position of the law on the inability to make a decision, the law is that:

(2) a person is not to be regarded as unable to understand the information relevant to a decision if he can understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).⁸⁵

(3) The fact that a person can retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

(4) The information relevant to a decision includes information about the reasonably foreseeable consequences of-

(a) deciding one way or another, or

(b) failing to make the decision.⁸⁶

Subsection (2) of the above provision makes it clear that a determination of incapacity may not be reached without the relevant information having been presented to the person in a way that is appropriate to his circumstances. Secondly, the person must be able to retain this information (for long enough to make the decision, as explained in subsection (3) above). And thirdly, he or she must be able to use and weigh it to arrive at a choice. If the person cannot undertake one of these three aspects of the decision-making process then he or she is unable to make the decision.⁸⁷

⁸³ MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023.

⁸⁴ MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023.

⁸⁵ MCA, s3(2).

⁸⁶ *Ibid*, s3(2)(3)(4).

⁸⁷ MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023.



In safeguarding the interest of those who lack capacity, the Act has extensive provisions to abide by in the best interest of the person who lacks capacity. The law is that in determining what is in a person's best interests, the person making the determination must not make it merely based on:

- (a) the person's age or appearance, or
- (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.⁸⁸

The above provision makes clear that best interests determinations must not be based merely on a person's age, appearance, or unjustified assumptions about what might be in a person's best interests based on the person's condition or behaviour. Best interest determinations must not therefore be made based on any unjustified and prejudicial assumptions. For example, in making a best interests determination for a person who has a physical disability it would not be acceptable to assume that, because of this disability, they will not have a good quality of life and should therefore not receive treatment.⁸⁹ In addition to taking into account all pertinent information, the decision-maker should specifically follow these steps.⁹⁰ He or she has to decide whether it is likely that the individual will have the necessary capacity for the matter at hand at some point, and if so, when that is likely to happen.⁹¹

It is a key principle of the MCA is that all steps and decisions taken for someone who lacks capacity must be taken in the person's best interests. The best interest principle is an essential aspect of the MCA and builds on the common law while offering further guidance. Given the wide range of acts, decisions and circumstances that the MCA will cover, the notion of 'best interests' is not defined in the MCA. Rather, subsection (2) makes clear that determining what is in a person's best interests requires a consideration of all relevant circumstances.⁹² The MCA has defined relevant circumstances as those 'of which the person making the determination is aware, and which it would be reasonable to regard as relevant'.⁹³ The decision maker must consider whether the individual concerned is likely to have capacity in the future. This is in case the decision can be put off until the person can make it himself. Even if the decision cannot be put off, the decision is likely to be influenced by whether the person will always lack capacity or is likely to regain capacity.⁹⁴

In determining what is in the best interest of a person who lacks capacity, the MCA further provides that such a person making the determination must carry along the person who lacks capacity in the decision-making process. He or she must, to the extent that it is practically possible, allow and support

⁸⁸ MCA, s4(1)(a)(b).

⁸⁹ MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023.

⁹⁰ MCA, s4(2).

⁹¹ *Ibid*, s4(3)(a)(b).

⁹² MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023; Mental Capacity Act 2005 Code of Practice (The Department for Constitutional Affairs, United Kingdom, 2007) 15.

⁹³ MCA, s4(11).

⁹⁴ MCA 'Explanatory note' <<https://www.legislation.gov.uk/ukpga/2005/9/notes/division/6/1/2/1>> accessed 9 August 2023.



the individual who is unable to participate, or endeavour to enhance his or her capacity to engage fully in the process.⁹⁵ When it comes to life-sustaining treatment, the healthcare provider must not be driven by a desire to cause death to the person who lacks capacity while determining whether the treatment is in the best interests of the person who lacks capacity.⁹⁶

5.0 A Review of the United Kingdom's Approach to Consent to Healthcare for Minors

The legal basis for medical consent to treatment for minors below the age of 18 years is traced to the Family Law Reforms Act 1969 (FLRA). The FLRA pegs the age of medical consent at 16 years, stating that consent to medical, surgical or dental treatment provided at such age is effective. Where a minor has provided such consent, it is not necessary to obtain consent from his or her parent or guardian.⁹⁷ Considering the provisions of the FLRA, the English case of *Gillick v. West Norfolk and Wisbech Area Health Authority*⁹⁸ provided the criteria for the medical competence of children under the age of 16 years. The House of Lords as per Lord Scarman propounded the Gillick competency test. Competency entails understanding the type, purpose, broad nature and effect of treatment and also possessing the capacity to choose whether to accept treatment or refuse same. Also, competence must include the ability to appreciate the reasonably foreseeable consequences of both accepting and refusing the treatment.⁹⁹ With this, a child under the age of 16 years can consent to medical treatment if found to be Gillick competent.¹⁰⁰ Where the minor does not meet this degree of maturity, the minor is incompetent and the provisions of the Mental Capacity Act 2005 become applicable.

The competency test relies on the capability of the minor. This reflects the legal presumption that minors under the age of 16 lack competence until proven otherwise. The medical practitioner has to assess the competence of the minor so, he or she can establish how much information can be given to the minor and how it is given. Full disclosure can be given if the intention is to assess the actual understanding of the minor. Aside from this, the competency test absolves the medical practitioner from the tortious liability of battery where the minor eventually claims that he or she did not understand the information before deciding after the medical practitioner has taken reasonable steps to ensure the minor is competent.¹⁰¹

The Mental Capacity Act 2005 (MCA) also applies to minors aged 16 years and above (it views them as adults) who lack capacity.¹⁰² In the context of this legislation, the following principles are applicable:

⁹⁵ MCA, s4(4).

⁹⁶ *Ibid*, s4(5).

⁹⁷ Family Law Reform Act 1969 (FLRA), s8(1); Stenger, Robert L, 'Exclusive or Concurrent Competence to make Medical Decisions for Adolescents in the United States and United Kingdom' [1999] (14) *Journal of Law & Health*, 225; Perera, Anthony, 'Can I decide please? The State of Children's Consent in the UK' [2008] (15)(4) *European Journal of Health Law*, 411-420.

⁹⁸ [1986] *AC* 112; [1985] 3 All ER 402.

⁹⁹ [1985] 3 All ER 402 at 418-422.

¹⁰⁰ Eduardo Osuna, 'Legal Protection of Informed Consent of Minors' [2010] (29)(2) *Medicine and Law*, 218.

¹⁰¹ Emma Cave, 'Goodbye Gillick? Identifying and Resolving Problems with the Concept of Child Competence' [2014] (34)(1) *Legal Studies*, 106-107.

¹⁰² Anthony Perera, 'Can I decide Please? The State of Children's Consent in the UK' [2008] (15)(4) *European Journal of Health Law* 411-420.



First, it is presumed that an individual possesses the capacity to make decisions unless evidence proves otherwise. Secondly, a person is not considered incapable of decision-making unless every reasonable effort to assist them in making a decision has been exhausted without success. Thirdly, the fact that an individual makes an imprudent decision does not automatically categorize them as incapable of decision-making. Lastly, any action or decision carried out under this Act on behalf of an individual lacking capacity must prioritize and align with their best interests.¹⁰³ Accordingly, an individual is considered to lack capacity concerning a specific matter if, at the relevant time, they are unable to decide that matter due to a disturbance or impairment in the functioning of their mind or brain. Whether this impairment or disturbance is permanent or temporary is irrelevant.¹⁰⁴

Cave¹⁰⁵ has interpreted this to mean that competent minors will have the relevant maturity and understanding, which is a question of fact and specific to the particular decision in hand. This notwithstanding, fluctuating capacity will not necessarily render the person incapable of consenting, and measures designed to maximise capacity should be employed if treatment can be delayed. This reasoning resonates with the MCA which still encourages that every reasonable effort is made to assist such a person make a decision and such effort was unsuccessful.

The determination of a lack of capacity should not be based solely on factors such as the person's age, appearance, or conditions that might lead others to unjustly assume their incapacity. In legal proceedings under the MCA or any other related law, the question of whether an individual lacks capacity, as defined by the MCA, must be decided based on the balance of probabilities.¹⁰⁶ In light of this, an individual cannot decide for themselves if they are unable to comprehend the pertinent information, remember it, use it or consider it when making the decision, or communicate the decision (whether verbally, nonverbally, or through any other means).¹⁰⁷

The MCA and the FLRA apply to adults and minors aged 16 years and 17-year-olds, allowing them to consent to treatment in the same way as an adult. Like the MCA, the FLRA operates a presumption of capacity, but unlike the MCA, the FLRA does not define capacity. Where the need arises, the Court of Protection may be called upon to judge the capacity or best interests of a 16-year-old with impaired capacity as defined in the MCA, whereas the High Court will usually judge disputed competence and best interests under the FLRA. The legal requirement to maximise capacity applies only to the MCA.¹⁰⁸ Based on the *Gillick case*, competency entails understanding the type, purpose, broad nature and effect of treatment, possessing the capacity to choose whether to accept treatment or refuse the same and the ability to appreciate the reasonably foreseeable consequences of the decision made. In terms of the

¹⁰³ MCA, s1.

¹⁰⁴ *Ibid*, s2(1).

¹⁰⁵ Cave (n63) 433-434.

¹⁰⁶ MCA, s2(1)-(4).

¹⁰⁷ *Ibid*, s3(1)(a)-(d); Cave (n101) 106.

¹⁰⁸ Cave (n66) 433.



MCA, capacity is defined as having the capacity to comprehend and remember pertinent information, as well as to use and consider it during the decision-making process and also communicate the decision.

Considering that the MCA applies to both mature minors and adults, the high level of understanding required by law which has to do with not just understanding the information but also retaining, using, weighing or communicating the decision is balanced because it will only come into question if s 2(1) of the MCA is satisfied, namely that the patient has 'an impairment of, or a disturbance in the functioning of, the mind or brain'. ¹⁰⁹ Where a patient over the age of 16 years lacks capacity and their past and present wishes cannot be ascertained, the medical practitioner can consult with relevant others where practicable, to determine which of the clinically relevant options is in the patient's best interests. Where the patient is under the age of 16 and lacks capacity, the MCA does not apply. A proxy will provide consent in non-emergency situations and they will choose between the options selected by the medical practitioner.¹¹⁰

Situations may arise in which the medical practitioner may be required to treat contrary to their view of the patient's best interests. Where the Court contradicts the medical view of what treatment is in the best interest of the child patient, the medical practitioner will not be required by the Court to carry out the treatment but may come under a professional duty to act if others are not willing to treat. Additionally, there may also be increased pressure to acknowledge a parental right to choose treatment that does not cause significant harm to the child, notwithstanding that the medical practitioner considers the treatment to be contrary to the child's best interests. The Courts in such instances do not interfere with the exercise of parental responsibility unless the child is suffering or is likely to suffer significant harm as a result of the care given to the child. Such care given by a parent must be such that a reasonable person will expect a parent to offer. This is because parental views are relevant to the best interest of the child but are not determinative.¹¹¹

There are groups of people whose decisions regarding medical treatment are vetoed by their status, despite their ability to make autonomous decisions. Much of the MCA applies to those 16 years and over, but the Code of Practice recognises that while some 16 and 17-year-olds might lack capacity due to an impairment of the mind or brain (to satisfy the test for incapacity in section 2), others will be unable to decide for some other reason in which case they should be assessed under common law principles. Common law focuses on maturity and understanding concerning the specific decision.¹¹²

5.0 Impact of Cultural and Social Context of the United Kingdom's Model in Nigeria

Various states of the federation have domesticated this federal legislation thereby giving the CRA a binding force in these states while some states are still grappling with the importance of the legislation. One problem is that the 1999 Constitution of Nigeria does not situate issues concerning children within

¹⁰⁹ Cave (n101) 106-107.

¹¹⁰ Emma Cave, 'Selecting Treatment Options and Choosing Between Them: Delineating Patient and Professional Autonomy in Shared Decision-Making' [2020] (28)(4) *Health Care Analysis*, 14-15.

¹¹¹ *Ibid*, 16.

¹¹² Cave (n66) 89 – 90, 96; Cave (n63) 431-449.



the legislative competence of the federal legislature which is the National Assembly but within that of the federating States as part of residual matters. Nwazuoke¹¹³ posits that any law from the federal legislature on issues not within their legislative competence is null and void and this is the position with the CRA. The remedies to situations will be for States to adopt such a law as a state law.¹¹⁴ Another problem is the application of the CRA with Islamic law in Northern Nigeria and the conflict between provisions.¹¹⁵ Bappa¹¹⁶ is of the view that cultural diversity, social values and religious inclination were not given due consideration before enacting the CRA and some provisions have formed a direct attack on Islamic principles and practices. Abubakar and Musa¹¹⁷ suggest that for a Nigerian child to be better protected, each state should be allowed to enact their respective child rights law which is in tandem with their local customs and peculiarities. Although these challenges exist, the Constitution which is the *grundnorm* and applicable to all persons irrespective of age, sex or religion still applies to children and also provides human rights protection for all children in Nigeria.¹¹⁸ This is so even for children in states that do not have the CRA domesticated as state laws.

Secondly, irrespective of this provision, the traditional conception of childhood still plays a role in how children are managed and children's best interests are dependent on the interest of parents or caregivers. Parental wishes are given credence over the wishes of the child if it is perceived to be in the child's interest. Sometimes, this may be beneficial to the child. Other times, this may not. With children's healthcare and the exercise of autonomy, the law makes it such that children are to rely on parents or caregivers to protect their health interests. This implies consenting to their medical treatment. They are dependent on adults to make this decision on their behalf. The State only steps in to ensure that whatever decision is being made serves the health interest of the child.¹¹⁹ This dependency approach to children exercising autonomy has been described as the authoritative framework of children's rights. It is rooted in the common law property theory which views children as the property of their parents who can exercise absolute control over their lives. Presently, this is expressed through laws that are committed to fostering parental rights over the rights of the child.¹²⁰ The challenge with this framework for children's rights is that it does not promote children's interests but constitutes children as lesser adults, leading to a legal regime grounded in a distorted vision of children's lives, parental rights, and the

¹¹³ *Chief Saatsaha Thaddeus Yenge v Attorney General of the federation* (2023) LPELR-61122(CA) Per Jamilu Yammama Tukur, JCA (Pp 15 - 16 Paras C - C); AN Nwazuoke, 'Status of the Girl Child in Nigeria and the Child Rights Act 2003' [2003] (5)(1) *Nigerian Bar Journal*, 116.

¹¹⁴ AN Nwazuoke, 'Status of the Girl Child in Nigeria and the Child Rights Act 2003' [2003] (5)(1) *Nigerian Bar Journal*, 117; Patricia Imade Gbobo and O.W Igwe, 'Child Rights Law and Practice in Nigeria: A Lesson From South Africa' [2021] (17)(1) *UNIZIK Law Journal*, 97-113.

¹¹⁵ Abubakar Isa Bappa, 'The Child Rights Act 2003: Understanding its Peculiarities and Conflict in its Application in Northern states of Nigeria' in Prof Yusuf Aboki (ed), *Nigeria's March Towards Global Political Stability: An assessment of her laws and statutes. Legal Essays in Honour of Senator Bala Mohammed* (Micro Media Computers, A publication of the department of public law, Ahmadu Bello University Zaria-Nigeria 2013) 232.

¹¹⁶ *Ibid*, 246.

¹¹⁷ Garba Abubakar and Idris Musa, 'Examining the Legal Basis for the Promotion and Protection of the Rights of the Child in Nigeria' [2020] (1) *International Journal of Law and Clinical Legal Education*, 83-90.

¹¹⁸ ES Nwauche 'Child Marriage in Nigeria: (Il)legal and (un)constitutional' [2015] (15) *African Human Rights Law Journal*, 421-432.

¹¹⁹ U Anyamele 'Parens patriae Jurisdiction and Religious Beliefs of Parents in Medical Treatment of a Minor: Examining the Supreme Court's decision in *Tega Esabunor v. Faweya & Ors* (2019) LPELR 46961 (SC) in light of International Practice' [2023] (16)(1) *South African Journal of Bioethics Law*, 29.

¹²⁰ Anne C. Dailey and Laura A. Rosenbury, 'The New Law of the Child' (2018)(127)(1448) *The Yale Law Journal*, 1457-1459.



potential for state support of families.¹²¹ The provisions of the CRA and the NHA are such that both legislation submerge children's health interests within the rights of their parents or families. Although there are no express provisions that state this, the rights and responsibilities of parents towards children in both laws indicate this. This is coupled with the way children are raised in Nigeria to be dependent on adults and the paternalistic nature of medical practice in Nigeria.

In as much as the CRA adopts the dependency approach in the exercise of medical autonomy, parental rights over the health needs of the child are not absolute and the State may interfere when a parent acts contrary to the best interest of the child.¹²² In healthcare situations, certain circumstances may encroach upon the parent's ability to determine the appropriate healthcare decision for a minor and the extent to which the parent may interfere with medical treatment or decision-making may be limited, like in cases of a medical emergency or where the parent refuses treatment on religious grounds. The medical practitioner will be duty-bound to administer life-saving treatment. In the latter case, if after full parental consultation treatment is refused, the practitioner should approach the Court and obtain an order to protect the child's health interest. Treatment should be administered.¹²³ A practitioner who refuses to get a Court order for administering treatment in the interest of the child, and allows the minor to die, in circumstances that might have been avoidable, may be charged with negligence and is also vulnerable to criminal prosecution.¹²⁴

Lastly, the patient's autonomy is a manifestation of the patient's legitimate exercise of freedom and is given substance by the process of obtaining informed consent.¹²⁵ Considering that choices are influenced by values and beliefs it is not uncommon to seek validation from family members before making certain decisions. In such instances, the exercise of autonomy is no longer individual-based but relational. Relational autonomy highlights the significance of relationships, social interactions, and power dynamics in shaping and influencing our capacity to make autonomous decisions. It acknowledges that our ability to exercise autonomy is influenced by the broader social structures, cultural norms, and interpersonal relationships in which we are embedded.¹²⁶ It expands upon the traditional understanding of individual autonomy by emphasizing the interconnectedness of individuals within social, cultural, and relational contexts by recognizing that our identities, choices, and actions are shaped by our relationships and social environments.¹²⁷ A broad understanding of relational autonomy (as recognition that an individual's ability to make decisions is connected to his or her

¹²¹ *Ibid*, 1459.

¹²² Osifunke Ekundayo, 'Legal Basis for the Court's Intervention over Medical Treatment of Children' [2022] (122) *Journal of Law, Policy and Globalization*, 41; Eunice NU Uzodike, 'Implications and Limits of Parental Rights in Nigeria' [1990] (2)(2) *African Journal of International and Comparative Law*, 282-297.

¹²³ Code of Medical Ethics in Nigeria 2008 (CMEN), rule 39(c)(iii); *Ibid*, s14(2).

¹²⁴ U Anyamele 'Parens patriae Jurisdiction and Religious Beliefs of Parents in Medical Treatment of a Minor: Examining the Supreme Court's decision in *Tega Esabunor v. Faweya & Ors* (2019) LPELR 46961 (SC) in light of International Practice' [2023] (16)(1) *South African Journal of Bioethics Law*, 30.

¹²⁵ CMEN, rule 39(c)(iii).

¹²⁶ Eduardo Osuna, 'Legal Protection of Informed Consent of Minors' [2010] (29)(2) *Medicine and Law*, 218.

¹²⁷ Cave (n66) 96.

¹²⁸ Elizabeth Wicks, *The State and the Body: Legal Regulation of Bodily Autonomy* (Hart publishing Oxford, 2016) 7; Ho, Anita, 'Relational Autonomy or Undue Pressure? Family's Role in Medical Decision-making' [2008] (22)(1) *Scandinavian Journal of Caring Sciences*, 128-135.

relationships with others) is not the opposition to individual autonomy but can be utilized to ensure that those capable of exercising an individual autonomy right (the right to decide) are empowered to do so.¹²⁸ Concerning medical decision-making, focusing on the individual's choice has the potential to generate unwillingness among doctors to challenge decisions that are irrational, ill-thought-out, and will lead to considerable harm. Hence, relational autonomy is gaining credence as patients make medical decisions.¹²⁹

This approach to autonomy is practised particularly in African communities where the decision-making process is generally a shared process with members of one's family. African societies are known to uphold communal values such as mutual reciprocity, collective loyalties and solidarity. Here, the rights of an individual become docile whilst duties owed to his or her community are held to be of great import. The highest weight is assigned to relationships shared within a community. Thus, a person must preserve the continuity of such relationships by pursuing the communal good, whatever this may entail. A person's existence is interrelated and dependent on his or her community, owing much to the relational nature of human beings.¹³⁰

6.0 Lessons for Nigeria and Conclusion

The United Kingdom offer valuable lessons on medical consent for mature minors. They provide a rich source of information on the legal frameworks, the balance between autonomy and protection and the evolving nature of minors' capacity to make informed medical decisions. These lessons are valuable in enhancing the legal foundations governing medical consent for mature minors in Nigeria while upholding their best interest and evolving capacity.

Children can be involved in medical decision-making where there is room for reflection and deliberation, where advice from experienced adults or experts are available and emotional or social influences are either minimized or mitigated. Examples of such decisions include decisions for undergoing medical treatment, pursuit of legal matters and participation as subjects of research studies where advice and guidance by medical or legal practitioners, or research investigators are available or mandated by law.¹³¹ In such circumstances, the minor is guided through the decision making process, thereby fostering individual autonomy.

Some laws in Nigeria have adopted different age thresholds for liabilities or capacities in codified laws which the Courts have adopted in administering the law. Age only forms the basis for which the minor may be allowed to make such decisions but the process may be guided by adults (in this case parents or guardians) and experts (in this case the medical practitioner) depending on the circumstances.¹³² This notwithstanding, circumstances that can affect competence to make decisions must be taken into

¹²⁸ Cave (n66) 96.

¹²⁹ *Ibid*, 95.

¹³⁰ Wandile Ganya and others, 'Autonomy of the Child in the South African Context: Is a 12 Year Old of Sufficient Maturity to Consent to Medical Treatment? [2016] (17)(66) *BMC Medical Ethics*, 6.

¹³¹ Cauffman, Elizabeth and Laurence Steinberg, 'The Cognitive and Affective Influences on Adolescent Decision-Making' [1995] (68) *Temple Law Review*, 1763.

¹³² John Eekelaar, 'The Emergence of Children's Rights' [1986] (6) *Oxford Journal of Legal Studies*, 181.



consideration irrespective of age set out by the law. This underscore the need for a competency test.¹³³ The minor must acquire the requisite mental capacity and sufficient understanding of the information given to make the decision. Where the medical practitioner who evaluates the minor for competence is in doubt of the minor's capacity to make such a decision, the parents or guardian or even the Court can consent to the treatment on behalf of the minor. An age-based criterion should not be the sole criterion to make decisions. This is because scientific evidence also indicates that age alone is not the best gauge of whether a good or bad decision can be made.¹³⁴ Rather, the maturity of judgement of the individual is the more accurate predictor.¹³⁵

This being said the role of parents cannot be undervalued in the welfare of children. They provide the enabling environment for children to develop the capacity to address life situations as they advance in age till adulthood. In Nigeria, parents play a major role in the lives of minors and influence their choices to a large extent. Although the Child Rights Act of 2003 recognises parental responsibilities over the child, the cultural setting in which children are raised determines how parents relate with children and also influences the choices children make. In exercising autonomy and consent to treatment, the cultural background of the patient should be considered. This is because English medical law embraces the individual-based concept of decision-making and it may be difficult for adults and even children in culturally conservative countries where parents are involved in decision-making to exercise absolute independence in medical decision-making. Hence, the relational approach to patient autonomy where the patient's social context is considered is proposed in most cases.¹³⁶ This approach is suitable in the Nigerian context. Relational autonomy highlights the significance of relationships, social interactions, and power dynamics in shaping and influencing our capacity to make autonomous decisions. It acknowledges that our ability to exercise autonomy is influenced by the broader social structures, cultural norms, and interpersonal relationships in which we are embedded.¹³⁷ It expands upon the traditional understanding of individual autonomy by emphasizing the interconnectedness of individuals

¹³³ L Doyal, 'Can Medicine be Torture? The Case of children' 155–174 in G. Van Bueren (ed.), *Childhood Abused: Protecting Children Against Torture, Cruel, Inhuman and Degrading Treatment and Punishment* (Dartmouth: Ashgate, 1988) 162; Irma Hein and others, 'Why is it Hard to Make Progress in Assessing Children's Decision-Making Competence?' [2015] (16) *BMC Medical Ethics*, 1-6; Wadlington, Walter, 'Medical Decision Making For And By Children: Tensions Between Parent, State, And Child' [1994] *University of Illinois Law Review*, 311; Fundudis, Trian. 'Consent Issues in Medico-Legal Procedures: How Competent Are Children to Make Their Own Decisions?' [2003] (8) (1) *Child and Adolescent Mental Health*, 18-22; McCabe, Mary Ann, 'Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations' [1996] (21)(4) *Journal of Pediatric Psychology*, 505-516.

¹³⁴ John H Flavell, 'Cognitive Development: Children's Knowledge about the Mind' [1999] (50)(1) *Annual Review of Psychology*, 21-45; Miller, Scott A., 'Parents' Beliefs about Children's Cognitive Development' [1988] *Child Development*, 259-285; Davidson, Denise, 'Children's Decision-Making Examined with an Information-Board Procedure' [1991] (6)(1) *Cognitive Development*, 77-90.

¹³⁵ Wee Ling Loo, 'Full Contractual Capacity: Use of Age for Conferment of Capacity' [2010] *Singapore Journal of Legal Studies*, 336.

¹³⁶ Roy Gilbar and Jose Miola, 'One Size Fits All: On Patient Autonomy, Medical Decision-Making, and the Impact of Culture' [2015] (23)(3) *Medical Law Review*, 376-377.

¹³⁷ Cave (n66) 96.



within social, cultural, and relational contexts by recognizing that our identities, choices, and actions are shaped by our relationships and social environments.¹³⁸

For mature minors to access healthcare seamlessly, an amendment of the National Health Act 2014 and the Child Rights Act 2003 to cater to the health needs of all children, particularly mature children. The amendment is to fill the consent and decision-making gap in healthcare situations. Both legislation will take into consideration the age threshold for medical competence, the type of treatment mature minors can consent to, the scope of permissible treatment and the competency test. The amendments should also incorporate provisions of Rule 39(3) of the Code of Medical Ethics in Nigeria (CMEN) that recognizes that mature minors aged 16 years to 18 years or above the age of 13 years who are Gillick-competent can give consent but cannot refuse medical treatment without parental involvement. This will give legal backing to this provision of the CMEN. The provisions of section 64 of the Child Rights Act 2003 (CRA) which allows children aged 16 years to give consent to have scientific samples obtained from them for paternity tests, if they can comprehend the nature and purpose of the scientific testing should be amended to extend to consent for medical treatment. By allowing minors to consent to certain types of treatment within defined parameters, these laws acknowledge their evolving capacity for decision-making while also providing safeguards against potential harm.

¹³⁸ Elizabeth Wicks, *The State and the Body: Legal Regulation of Bodily Autonomy* (Hart publishing Oxford, 2016) 7; Ho, Anita, 'Relational Autonomy or Undue Pressure? Family's Role in Medical Decision-making' [2008] (22)(1) *Scandinavian Journal of Caring Sciences*, 128-135.