Balancing Parental Rights and Child Welfare: The Best Interests Threshold in Healthcare Decisions in *Tega Esabunor & Anor v. Tunde Faweya & ors.* in Focus.
https://doi.org/10.53982/alj.2024.1201.04-j

ABUAD Law Journal (ALJ)
Vol. 12, ISSUE 1, 2024, Pages 65-83 https://doi.org/10.53982/alj.2024.1201.04-j
Published by College of Law, Afe Babalola University Law Journal,
College of Law, Afe Babalola University, Km 8.5, Afe Babalola Way,
P.M.B. 5454, Ado Ekiti, Ekiti State, Nigeria ISSN: *2971-7027*
www.abuad.edu.ng, abuadlawjournal@abuad.edu.ng

BALANCING PARENTAL RIGHTS AND CHILD WELFARE: THE BEST INTERESTS THRESHOLD IN HEALTHCARE DECISIONS IN *TEGA ESABUNOR & ANOR v. TUNDE FAWEYA & ORS. IN FOCUS.*

Hadiza O. Okunrobo* and Olaitan O. Olusegun (Ph.D.) **

Abstract

Children have the right like other human beings, to enjoy the best attainable standard of health, which includes access to healthcare services. Yet there is no escaping the reality that because of children's vulnerability and lack of capacity, parents have the responsibility to act on their behalf and must ensure to make these decisions in the child's best interest. Hence, a refusal to give consent to lifesaving treatment for the child will not be authorised, even if such refusal is from the parents. In cases of this nature, it has become the norm in most jurisdictions for the State to subrogate parental rights in the best interest of the child, this was the posture of the Supreme Court in the case of *Tega Esabunor & Anor v. Dr Tunde Faweya & Ors.* [2019] 7 NWLR (Pt. 1671) 316 (SC). The paper through doctrinal analysis, reviews and discusses the best interests threshold as a basis for overriding parental rights in protecting the child's wellbeing. It highlights the responsibilities of parents vis- a - viz the State in ensuring that the child's interests are best achieved, irrespective of religious or socio-cultural factors. This notwithstanding, the paper asserts that to effectively apply the principle, there must be a well-established standard of practice that completely overrides parental authority to authorise and pay the medical bills of the child and for further issues that may arise between parents in cases of lack of consensus and proper guidelines for medical practitioners.

Balancing Parental Rights and Child Welfare: The Best Interests Threshold in Healthcare Decisions in *Tega Esabunor & Anor v. Tunde Faweya & ors.* in Focus.
https://doi.org/10.53982/alj.2024.1201.04-j

1. Introduction

Patients have rights to autonomy and bodily integrity which entails that the integration of the self with the rest of the objective world is related to bodily integrity. Therefore, a violation of it differs greatly from meddling in decisions regarding your body. This explains why there needs to be more justification for interfering with bodily integrity than there is for interfering with autonomy.[1] In furtherance of this right, is the capacity to give informed consent to medical procedures or examinations. Informed consent is the capability of an adult to exercise the right to bodily integrity, hence, touching someone without their permission can be likened to battery.[2] The Code of Medical Ethics 2004, which regulates the professional conduct of medical practitioners in Nigeria, provides that practitioners must obtain the consent of patients before performing invasive or non-invasive procedures on them.[3] Informed consent to be valid, must be voluntary, given by a patient who has the capacity and sufficient knowledge of the facts and issues surrounding the proposed treatment, including the diagnosis, treatment options, risks and benefits of these options, consequence of treatment refusal, as well as the medical practitioner's opinion and recommendations.[4] Thus, a medical practitioner cannot force a proposed treatment or procedure on a patient who refuses it, even at the risk of death or grievous harm.[5]

However, when children are involved, different considerations apply in medical decision-making. Children's access to medical treatment is important because their quality of life, well-being and future are largely dependent on their health. Under international legal

*Department of Public Law, Faculty of Law, University of Benin, Benin City, Edo State Nigeria, email: hadiza.okunrobo@uniben.edu
**Department of Jurisprudence and Private Law, Obafemi Awolowo University, Ile-Ife, Osun State, Nigeria, email: o.olusegun@hotmail.com

[1] Jonathan Herring & Jesse Wall, 'The Nature and Significance of the Right to Bodily Integrity' *The Cambridge Law Journal* (2017) 76 (3) 566-588.

[2] See the case of *Okekearu v Tanko* (2002) 15 NWLR (Pt. 791) 657 (SC), where the defendant's failure to obtain consent from a 14-year-old boy, before amputating his finger, was held to be battery; See also *Schloendorf v. Society of New York Hospital* (1914) 105 N E 92.

[3] Code of Medical Ethics, 2004, Rule 19. See further, s.23 of the National Health Act 2014 (Nigeria)

4 See National Health Act 2014, s. 23; Peter De Cruz, Comparative Healthcare Law 117 (Cavendish Publishing Limited, 2001).

[5] (2001) 7NWLR (Pt.711) 206.

https://doi.org/10.53982/alj.2024.1201.04-j

instruments, established provisions enable children to have access to medical treatment.[6] The provisions of these international legal instruments are replete in the Child Rights Act 2003 (CRA), which is a template for the protection of the rights of children in Nigeria.[7] Under the CRA, every child is entitled to enjoy the best health possible.[8] Thus, parents, guardians, institutions, and governments, collectively have a responsibility for the care of the child as well as an obligation to fulfil the right.[9]

Based on this obligation, children rely on proxies (parents or guardians) to either give consent to or refuse treatments on their behalf because of their tender age and immaturity. In the absence of clear legal guidelines, parents could make unreasonable decisions, either for their benefit or for third parties such as the child's siblings. Failure to weigh the negative impact of any prescribed treatment for a child by the medical personnel or parent can result in the deprivation of their right to access health care services. Hence, it is important to regulate these medical decisions made on behalf of children for their best interests.

Nevertheless, as children grow older, they develop an increased capacity for autonomy with an improved ability to reason and assimilate information.[10] The level of parental control thus reduces, since, at that stage, children are in most cases capable of identifying their preferences and understanding the consequences of their decisions. From the standpoint of Article 12 of the United Nations Convention on the Rights of the Child (UNCRC), children who can, should express their views in all matters concerning them, according to their age and maturity. Also, they should be given the chance to be heard in judicial and administrative proceedings, either directly or through a representative.[11] The case of *Gillick v. West Norfolk and Wisbech AH*[12] promotes the principle that a minor who is of 'sufficient age and understanding is *prima facie* entitled to make her own decisions and give valid consent

[6] See, for example, the United Nations Convention on the Rights of the Child (UNCRC), Art. 24(1); African Charter on the Rights and Welfare of the Child, Art. 14(1-2).
[7] CRA Act, 2003, Cap C50 Laws of the Federation of Nigeria 2004.
[8] Ibid, s. 13 (1).
[9] CRA, 2003, s. 13(2).
[10] Claire Breen, *Age Discrimination and Children's Rights: Ensuring Equality and Acknowledging Difference* (Brill, 2005). See further the case of *Okekearu v. Tanko* [2002] 15 NWLR (Pt. 791) 657.
[11] UNCRC, Article 12(2); See also section 217 of the CRA in Nigeria. This section permits hearing children's voices during proceedings.
[12] 1985 3 All ER 402.

https://doi.org/10.53982/alj.2024.1201.04-j

concerning medical treatment'. In that case, the court decided that a 16-year-old is mature enough to have sufficient capacity to provide valid consent. The court may refuse the medical decision of a 16-year-old presumed to be competent if it is discovered that the child cannot understand relevant information.

In Nigeria, it is presumed that a 13-year-old child who has a 'clear mind and can grasp the benefits and consequences of accepting or rejecting a proposed treatment, is capable of giving valid consent to a medical procedure or treatment, despite parental objections.[13] Where parents refuse life-saving medical treatment for a child below 13 years, an order can be obtained from the court to protect the child.[14] According to Rule 20 of the Code of Medical Ethics, medical practitioners should take measures to save the lives of vulnerable patients including paediatric patients and those below the age of 18 years, who are incapable of making informed decisions for themselves. This includes the procurement of a court order to get legal validation for treatment. Most often, healthcare practitioners will resort to court orders for the following reasons. Firstly, when the acts of the parents though within the private sphere of the family, will result in harm if not curtailed. Courts are also able to prevent the abuse, maltreatment, and injury of the child through the examination of peculiar circumstances in each case. The implication of such an order will require the state to regulate the affairs of the parent in breach of their responsibilities under public law as well.[15] Secondly, court orders may prevent the child from growing up to detest the decision made on his or her behalf, which may even lead to claims in court. Non-interference by Nigerian courts has been the norm, until the recent decision of the Supreme Court in the case of *Tega Esabunor & Anor v. Dr Tunde Faweya & Ors*[16] which introduced a change in perspective. The case lasted for 22 years and set the standard of practice for cases of this nature in cases of parental refusal precedent for refusal of consent on behalf of children who cannot make such decisions themselves in life-threatening cases.

[13] Code of Medical Ethics, Rule 39(c)(ii).

[14] Code of Medical Ethics, Rule 39(c)(iii). See further, the case of *Tanko's,* where the Supreme Court (Apex court in Nigeria) held that a child of 14 years who can understand the questions asked and give rational answers under cross examination, can as well give consent to a medical procedure.

[15] See section 301 of the Criminal Code 1990 Laws of the Federation of Nigeria (LFN), which provides that the head of a family taking care of a member of the family below the age of fourteen years, will be held liable for neglecting to perform his duties which results in harm to the life or health of such child.

[16] [2019] 7 NWLR (Pt. 1671) 316 (SC).

Balancing Parental Rights and Child Welfare: The Best Interests Threshold in Healthcare Decisions in *Tega Esabunor & Anor v. Tunde Faweya & ors.* in Focus.
https://doi.org/10.53982/alj.2024.1201.04-j

Existing literature on the case of *Esabunor* has extolled the relevance of the Supreme Court decision in addressing the limits of parental responsibilities in areas, of life-saving healthcare treatments in the child's best interest particularly from the viewpoint of religious beliefs where both parents agree.[17] However, most of these scholars have not addressed the application of the decision of the Supreme in cases outside the religious beliefs of parents, or in cases of non-compliance as to refusal by parents to pay the medical bills of the child and also cases of lack of consensus between parents on the best treatment for the child. Hence this paper seeks to address these gaps by examining and discussing the extent to which the decision in the case of *Esabunor v. Faweya* has brought a remarkable twist in child rights jurisprudence in Nigeria and a post-Esabunor's application of the cases through an established standard of practice that will adequately address these issues in the future. To further this discourse, the paper has five sections. The first part consists of the introduction and highlights the rights to autonomy, informed consent and bodily integrity which seek to protect the rights of persons undertaking medical treatment with particular focus on the child patient. The second part of the paper examines the framework for children's rights, exposing the readers to the concept of children's rights and the connection of these rights, while also discussing the dependence of children's rights as a basis for parental responsibilities to fulfilling these rights for the child's interests and wellbeing. The third section examines the role of the State in overruling parental rights over the child's best interests in cases of life-saving medical treatments. The fourth part analyses the *Esabunor v. Faweya* case, highlighting the facts of the case and the principle involved and this is followed by the conclusion.

[17] Uche 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' *S Afr J Bioethics Law* (2023) 16 (1) e828. https://doi.org/10.7196/SAJBL.2023.v16i1.828; David Tarh-Akong Eyongndi & Samuel A. Adeniji, 'Judicial Balancing of Parental Objection to Medical Treatment on the Basis of Religious Beliefs and Children Right to Life in Nigeria' *The Age of Human Rights Journal* (2022) *18*, 523-544. https://doi.org/10.17561/tahrj.v18.7009

https://doi.org/10.53982/alj.2024.1201.04-j

2. The Framework for Children's Rights: Interrelation and Interdependence of Rights

There is no contention that children's rights are interrelated and interdependent. The nature and relevance of this relationship are emphasised in most human rights instruments such as the UNCRC and the African Charter on the Rights and Welfare of the Child (ACRWC), 1990. Children's rights are interrelated when there is a connection between the rights. In other words, non-fulfilment of one of such rights may impede the realisation of the other or drastically affect it. On the other hand, the rights are interdependent as the realisation of these rights depends on the level of parental support for children. This section discusses the interrelated and interdependence of children's rights from two vantage points. These are the horizontal and the vertical perspectives. From the horizontal point of view, these treaties afford protection to the child's civil and political rights, such as the rights to life, religion, association, privacy, dignity, name, nationality and non-discrimination,[18] which are largely intertwined with economic, social and cultural rights of the child, such as the right to education, health, right to leisure, creation and cultural activities. The emergence of civil and political rights is an indication that there is a need to protect and promote economic, social, and cultural rights with equal zeal and determination. These rights are interdependent and failure to effectively implement these provisions will affect the implementation of other rights. For instance, section 3 of the CRA, guarantees the enjoyment of all the rights consistent with the provisions of Chapter IV of the Constitution of the Federal Republic of Nigeria, 1999 (CFRN, 1999).[19] One such right is the right to life. The right to life is contingent on other rights such as the right to health and in continuum, encompasses the right to a healthy environment, adequate nutrition and safe drinking water. From the foregoing, a child's right to life is subsistent on the right of the child to; live in an environment free from pollution, access health care services, and receive the adequate provision of food and good sanitation. On the other hand, the vertical points, view children's rights as flowing down, that is, from the parent to the child. The CRA is replete with provisions defining the relevance and

[18] See the International Covenant on Civil and Political Rights see articles 6 and 24, which provides for the right to life and the rights of the child to enjoy certain civil rights such as the right to non-discrimination, birth registration and identity i.e., to acquire a nationality.

[19] Chapter IV contains provisions on fundamental rights, such as the right to life, dignity of person, religion etc.

https://doi.org/10.53982/alj.2024.1201.04-j

nature of this relationship such as the right to a name,[20] freedom of association and peaceful assembly,[21] freedom of thoughts, conscience and religion,[22] right to privacy and family life,[23] right to freedom of movement,[24] right to health and health services,[25] right of the child to free, compulsory and universal primary education.[26] Even though these rights are solely for the benefit of the child, enforcement is practically impossible, unless there are parental interventions for the enforcement of these rights. A perusal of these sections will reveal the extent to which parental intervention or guidance is relevant to the attainment of these rights. Under section 13 for instance, in cases of immunisation, parental support is required for the child to receive full immunisation. Furthermore, according to the right to access health care services for children, tender age limits their capacity to make health care decisions for their benefit. Hence, common law and other statutes, situate parents with the responsibility to do so for the benefit of the Child.

The Criminal Code mandates that parents provide for their children's needs and failure to provide these necessaries will incur criminal sanctions.[27] The neglect, abandonment and refusal of access to medical services have been interpreted as issues against public policy, a reason why criminal sanctions are imposed under the Act. Most cases of child protection were centred on the parental failure to provide the child's necessities for life and not from a human rights-based approach which is child-centred. However, with the global recognition of the rights of the child, under the CRC and the CRA, the definition of rights was defined in terms of parental responsibilities.[28]

Parental responsibilities include but are not limited to, the upkeep and provision of needs for children in the fulfilment of their right to maintenance, depending on the resources available to their parents or guardians. Failure to fulfil this responsibility is a violation of the rights of

[20] CRA, S.5.
[21] CRA, s.6.
[22] CRA, s.7.
[23] CRA, s. 8.
[24] CRA, s.9.
[25] CRA, s. 13.
[26] CRA, s. 15.
[27] See the Criminal Code, ss 300, 301.
[28] See UNCRC, art. 3(2) and 5.

https://doi.org/10.53982/alj.2024.1201.04-j

the child and gives the child the power to seek redress in the family court.[29] Furthermore, parents should fulfil the responsibility of directing their children in the exercise of their religious freedoms, freedom of thought and conscience, while considering their evolving capacities in line with their best interests. These parental duties must be respected by others such as the state and its agencies.[30] Parents are to determine a child's religious preferences, and such a decision cannot be interfered with, except if it is contrary to the child's best interest. This duty or right wanes as the child becomes older and can make decisions.

Parents are entrusted with the responsibility for the welfare of their children because they are presumed to have their best interests at heart. The government is also reluctant to interfere in the privacy of the home and expects parents to handle issues without monitoring, especially since decision-making does not necessitate acquiring special skills.[31] Furthermore, it is assumed that parents know their children better than others and understand their special needs.[32] According to Breen, limitations placed on the rights of the child to medical treatment must be beneficial to the child and fulfil the objective of protecting such a child.[33]

Refusal of consent is mostly due to religious convictions, which is a right recognised by law. The CFRN, for example, protects the right of persons to freedom of thought, conscience, and religion.[34] Despite the relevance of parental rights or responsibilities in ensuring the rights or welfare of the child are met, these rights or responsibilities should not interfere with the child's rights to life, health, and dignity, as well as survival and development. Hence, balancing the rights of the child and parental rights through State intervention is germane in fulfilling the rights of the child to life, survival and development.[35] Such an intervention is

---

[29] CRA, 2003, s. 14(2).

[30] CRA 2003, s. 7(1-3); *Adewale and Ors v. Jakande and Ors.* [1981] 1 NCLR, 262; See also, Okojie v. Attorney General of Lagos State [1981] 2 NCLR 337.

[31] Auckland Cressida & Goold Imogen, 'Parental Rights, Best Interests and Significant Harms: Who Should have the Final say over a Child's Medical Care?' *Cambridge Law Journal* (2019) 78 300.

[32] Linda A. Oti-Onyema, 'Parental Responsibility Over Child's Health: Dispensing with Court Proceedings in Emergency Situations' *Nnamdi Azikiwe University Journal of International Law and Jurisprudence* (2020) 11 (1) 170-180 at 175.

[33] Claire Breen, (n 10), 48.

[34] CFRN, s. 38(1).

[35] Claire Breen, (n 10), 48.

https://doi.org/10.53982/alj.2024.1201.04-j

known as *parens patriae,* that is, acting as guardians and caring for those who are unable to care for themselves.[36]

3. The Role of the State in Protecting the Welfare of Children

Over the years, the State has intervened in the private realm of the family to protect the interest of the child.[37] For the benefit of the child, health professionals have legal duties to children in their care, creating a tripartite relationship between a child, the doctor, and the holder of parental responsibility.[38] In addition, medical practitioners are further enjoined as part of the Physician Oath, to put the safety and health of their patients as the uppermost consideration against any odds.[39] Therefore, an important context for the law governing the provision of medical treatment to children and the individual cases to determine the treatment of specific children are the professional duties of doctors to the welfare and protection of children in their care. Based on these provisions, doctors can seek the permission of the court to override any refusal of life-saving treatment for a child, in the child's best interest. In most intractable cases, judicial overriding of parental responsibility over the child has been based on two thresholds, that of the best interest of the child principle and the other, on the harm principle. This was the basis of the Supreme Court decision in *Esabunor* v. *Fawaye's* case.

4. The Principle in *Esabunor* v. *Fawaye's case*: A Brief Summary of the Case

E a neonate was sick and taken by his mother to a clinic for treatment. The medical doctor attached to the clinic examined him and found out that he had an infection which caused blood deficiency in his body. The doctor placed him on antibiotics and by the next day, the medications were not effective. E was convulsing and could not breathe properly and as such, the doctor administered oxygen therapy.

---

[36] K Knepper, 'Withholding Medical Treatment from Infants: When Is It Child Neglect?' *University of Louisville Journal of Family Law* (1994) 33 (1) 1– 53 at 1-2.

[37] Jo Bridgeman, Medical Treatment of the Child And The Law: Beyond Parental Responsibility 16 (Routledge, 2021).

[38] S. 2(2) of the CRA insists on appropriate and established standards being met by relevant individuals and institutions involved in taking care of the safety, health, and welfare of children.

[39] See the Declaration of Geneva (Physicians' Oath Declaration) adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, in September 1948 and amended by the 22nd World Medical Assembly at Sydney, Australia in August 1994, (Mar. 15, 2021, 10:04 AM) https://www.wma.net/policies-post/wma-declaration-of-geneva/.

https://doi.org/10.53982/alj.2024.1201.04-j

At this stage, the doctors believed that E would lose his life without a blood transfusion. The mother a Jehovah's Witness was informed of the danger of what a lack of blood transfusion can cause. Despite the information, she refused to give consent on religious grounds. The management of the clinic, reported to the Police. The Police sought permission, which the magistrate granted to transfuse blood on the minor against parental objection. After the transfusion, E's health improved, and he was discharged from the hospital. Subsequently, the mother brought an application at the Magistrate court to set aside the order on the grounds of fraud. Since the order was already performed, the court dismissed the application. Dissatisfied, the mother appealed to the High Court and then to the Court of Appeal, which further dismissed her appeal. Hence, she further appealed to the Supreme Court (Apex court).

The analysis of this case is from two perspectives. The first aspect will consist of the analysis of the judgement of the Court of Appeal from the harm perspective under the realm of public law which promotes public policy. Secondly, the paper seeks to bring to the fore, the child-centred human rights approach of the Supreme Court, using the best interest principle.

4.1. Analysis of the Judgements

4.1.1 Court Appeal's Standpoint: Application of the Harm Principle

Before delving into the Court of Appeal's position on the harm principles as a basis for state intervention, a short exposition of the concept of the harp principle is apposite. There have been suggestions by critics of the best interest principle that the harm threshold is a better basis for judicial intervention by the State in medical decisions concerning children and should either complement or replace the best interest threshold. The harm principle is argued to give a wider discretion to parents and serve as a better form of guide and standard for medical practitioners.[40] Diekema, the most influential proponent of the harm principle, incorporated and popularised this principle from John Stuart Mill's 'On Liberty', an essay published in 1859 which, applies the harm principle more widely to the relationship between

---

[40] Giles Birchley, 'Harm is all you Need? Best Interests and Disputes about Parental Decision-Making' *Journal of Medical Ethics* (2016) 42 111-115.

https://doi.org/10.53982/alj.2024.1201.04-j

the society and its citizens.[41] Mill notes that power can rightly be exercised over a person only to protect the person from harming others.[42]

For children, the harm threshold permits the State legitimate intervention in parental decision-making only when serious and preventable harm to children is probable.[43] Thus, when a child is not at risk of serious harm, there should be no interference with parental decisions made on his or her behalf.[44] Diekema argued that the best interest principle is not the actual benchmark for judicial interpretation in practice, even though cited in medical practice and legal instruments. According to him, an intervention occurs when serious harm, which is imminent and requires urgent attention, is envisaged. He defines serious harm to include an interference with interest necessary for more ultimate goals " interference with interests necessary for more ultimate goals such as physical health and vigour, integrity and normal functioning of one's body, absence of absorbing pain and suffering, or grotesque disfigurement, minimal intellectual acuity, and emotional stability.''[45] In cases where the child is not at risk of serious harm, he suggests that parties involved, work together to resolve the differences in opinion amicably.[46]

Diekema links harm to another concept, known as 'basic needs', which for children, is defined as minimum requirements that will 'enable children to embark … on the process of self-discovery, self-determination and self-fulfilment'.[47] He thus argues that the provision of the basic needs of children will determine whether they are being harmed and a high level of this form of deprivation will require state intervention.[48] Diekema went further to highlight eight factors that must be present before the medical decision of a parent can be interfered

---

[41] Johan C. Bester, 'The Harm Principle Cannot Replace the Best Interest Standard: Problems with Using the Harm Principle for Medical Decision Making for Children', *American Journal of Bioethics* (2018) 18 (8) 9-19.

[42] John S. Mill 'On Liberty' in John Stuart Mill (ed) *On Liberty and Utilitarianism* (Bantam Classics, 1993) 12.

[43] Maggie Taylor, 'Conceptual Challenges to the Harm Threshold' *Bioethics* (2020) 34 (5) 502-508.

[44] ibid at 502.

[45] Douglas S. Diekema, 'Revisiting the Best Interest Standard: Uses and Misuses' *Journal of Clinical Ethics* (2011) 22 (2) 128-133 at 132.

[46] Douglas S Diekema, 'Parental Refusal of Medical Treatment: The Harm Principle as Threshold for State Intervention' *Theoretical Medicine and Bioethics* (2004) 25 (4) 243-264 at 253.

[47] Richard B. Miller, *Children, Ethics and Modern Medicine* (Indiana University Press, 2003) 42.

[48] Birchley (n 40) 112.

https://doi.org/10.53982/alj.2024.1201.04-j

with. These include: the child is in danger of being harmed; the harm is imminent; the intervention is essential in preventing the harm; the intervention is known to be efficient; the benefit of the proposed treatment is more than the parents' option; other options which will prevent harm are not available; the same standard will be applied to similar circumstances irrespective of the parents' reasons and the intervention will be accepted as reasonable from most parents.[49]

Ross argues that judicial intervention can occur when the refusal of a parent to consent to medical treatment puts the child's life at risk and the proposed treatment is effective with a great chance of being successful when conducted on the child.[50] Kopelman, while noting the importance of the BIC principle in justifying state intervention over parental medical decisions, argues that the principle is more suitable for regulating issues and should not apply literally. She further argues that failure to prioritise the interests of the child is insufficient to justify state involvement as parental interest as well as responsibility towards the child are crucial. She believes that State intervention is necessary, only when parental decisions will cause harm to the child or are unreasonable. Hence, the best interest principle should only guide the State in deciding the appropriate treatment for the child.[51] Most scholars have also criticised the harm principle based on its indeterminacy and ignorance of moral and parental obligations to avoid harm to the child.[52]

In Nigeria, before the CRA, statutes and case law contain provisions that recognise the harm principle as a justification for State intervention. Under the statute, the Criminal Code and the Children and Young Persons Law (CYPL) 2004, contains provisions protecting the child from harm. Sections 339 of the Criminal Code provides that:

> Any person who is being charged with the duty of providing for another the necessaries of life, without lawful excuse fails to do so, whereby the life of

[49] Diekema, Revisiting the Best Interest (n 45); Rosalind J. McDougall & Lauren Notini, 'Overriding Parents' Medical Decisions for their Children: A Systematic Review of Normative Literature' *Journal of Medical*

[50] LF Ross & TJ Aspinwall, Religious Exemptions to the Immunization Statutes: Balancing Public Health and Religious Freedom, (1997) 25 *Journal of Law, Medicine, & Ethics*, 203.

[51] McDougall & Notini, (n 49) 450.

[52] Taylor, (n 43) 502.

https://doi.org/10.53982/alj.2024.1201.04-j

> that person is or likely to be endangered, or the health is or likely to be permanently injured….

Section 341 of the Criminal Code provides that:

> Any person who unlawfully abandons or exposes a child under the age of seven years, in such a manner that any grievous harm is likely to be caused to it is guilty of a felony, and is liable to imprisonment…

From the foregoing, these sections criminalise acts or omissions that may cause harm to a child. Invariably, these sections lay support to Diekema's argument that harm can result from the deprivation of the basic needs of the child which will warrant state intervention. Such necessaries can also involve a denial of consent by a parent for a child to medical treatment.

In the application of the section, the provisions in CYPL provide the procedural guide for any violation. In section 27(1) and section 30 of the CYPL, police officers and any authorised officers can bring any child before the juvenile court based on any suspicion of harm. The court presented with this application, makes interim orders to protect the child brought under the provision of section 27 (1).[53] In the momentum case of *Tega Esabunor & Anor v. Dr Tunde Faweya & Ors,* the Supreme Court interpreted these statutory provisions. The case was the first in Nigeria, where the court had to examine the extent of parental rights with the rights of the child, particularly on the refusal to consent to life-saving treatment for the benefit of an incompetent minor. a refusal of the parental right to consent to life-saving medical treatment. The judgement, in this case, is commendable in laying the foundation for the promotion of children's rights in Nigeria.

Interestingly, from the trial court up to the Court of Appeal, the harm principle was a dominant basis for overriding parental rights to consent to medical treatment on behalf of their child.

A peep at the application of the harm principle in the other lower courts was a necessary condition based on statutory provisions that existed at that time. These laws were the only

[53] CYPL, s. 30(1).

https://doi.org/10.53982/alj.2024.1201.04-j

piece of legislation which regulated family relations from public law purview. These are the CFRN, the Criminal Code and the Children and Young Persons Law (CYPL).[54] These legislations were under the public law domain, which criminalises any act or omission on the part of the parents that endangers the life of minors less than 16 years of age under their care. Of particular interest to the case are the above-mentioned sections 339 and 341 of the Criminal Code and 27(1) and 30 of the CYPL.

At the trial court, these were the provisions that brought the case within the jurisdiction of the court. As earlier discussed, the provisions of the Criminal Code prohibit and make it an offence for a parent or guardian to deny a child the necessities of life that are necessary for the child's wellbeing and survival. This Court of Appeal applied the same approach. Justice Galinje JCA opined that:

> Section 33(1) of the Constitution of Nigeria provides that everyone has a right to life, and no one can be deprived intentionally of his life, save in the execution of the sentence of a court in respect of a criminal offence of which he has been found guilty.

The court interpreted the provision of the CFRN above to justify the reason for intervention in the interest of protecting the child from harm. The approach of the court has been criticised for its limited application of centralising its decision on whether the actions of the parents were criminal or not and failed in that process to centralise its judgement on the child, being that at the time these issues were presented to the Court of Appeal, the Child's Rights Act has already been enacted.[55]

4.1. 2. Supreme Court -Application of the Best Interest of the Child

The Best Interests of the Child (BIC)Threshold

The recognition of the BIC principle as a right of the child began with the United Nations Declaration on the Rights of the Child, 1989.[56] It states that the BIC shall be the paramount

---

[54] The CYPL was the only piece of legislation that applied specifically to children.

[55] Hadiza O. Okunrobo, 'Judicial Overriding of Parental Right to Refuse Life-Saving Treatment on a Child: A Review of *Esabunor* v. *Faweya' University of Benin Law Journal* (2015) 16 103-117.

[56] United Nations Declaration of the Rights of the Child, G.A. res. 1386 (XIV), 14 U.N. GAOR Supp. (No. 16) at 19, U.N. Doc. A/4354 (1959). (Jan. 29, 2022, 11:14 PM) http://hrlibrary.umn.edu/instree/k1drc.htm.

https://doi.org/10.53982/alj.2024.1201.04-j

consideration while enacting laws to protect the child.[57] The UNCRC, in its provision, adopts the BIC thus:

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.[58]

This provision is reiterated in section 1 of the CRA in Nigeria. The Committee on the Rights of the Child further explained the BIC principle in its General Comment 5 by stating that:

> Every legislative, administrative and judicial body or institution is required to apply the best interests principle by systematically considering how children's rights and interests are or will be affected by their decisions and actions – by, for example, a proposed or existing law or policy or administrative action or court decision, including those that are not directly concerned with children, but indirectly affect children.[59]

The BIC principle requires that reasonable choices which protect the rights and well-being of children are made in all circumstances surrounding them.[60] The refusal of parents to grant consent to a medical procedure or treatment on behalf of a child will be overridden by the court if the likely consequence of such refusal will not be beneficial to the child, either at that moment or in the long run.

Thus, if refusing a particular treatment will lead to the death of a child, and the treatment has a high possibility of curing the child, courts will order the administration of the medical procedure, despite parental refusal.[61] However, the word 'primary' used by the drafters of the

---

[57] United Nations Declaration on the Rights of the Child, Principle 2.

[58] UNCRC, Art. 3(1); see also, African Charter on the Rights and Welfare of the Child, 1990, Art. 4(1).

[59] Committee on the Rights of the Child (2003), General Comment No. 5: General measures of implementation for the Convention on the Rights of the Child, at para 12.

[60] Ma'n H. Zawati, David Parry & Bartha M. Knoppers, 'The Best Interests of the Child and the Return of Results in Genetic Research: International Comparative Perspectives' *BMC Medical Ethics (*2014) 15 72 at 79.

[61] Linda A. Oti-Onyema, (n 32) 177; J.C. Bester, The Best Interest Standard and Its Rivals: The Debate About Ethical Decision-Making Standards in Pediatrics, in Nico Nortje and Johan C. Bester (eds) *Pediatric Ethics: Theory and Practice* (Springer, 2022); Sarah Elliston, *Best Interest of the Child in Healthcare* (Routledge-

https://doi.org/10.53982/alj.2024.1201.04-j

UNCRC and CRA, indicates there are other factors to be considered in reaching a medical decision apart from the BIC.[62] Thus, while focusing on achieving the best outcome for the child in a particular situation, the interests of other family member s and the effect of decisions taken on them, are considered.[63] According to John Lantos, 'the interests of children are neither absolute nor unambiguous, as they intertwine with the interests of others, and often must be weighed against those other interests.'[64] The vagueness of the BIC creates an avenue for its criticism, despite its universality and recognition in most legal instruments.[65] Furthermore, the absence of a coherent definition makes it difficult to define and apply as its use is for several purposes and interpreted differently, with inadequate standards in practice.[66]

The decision of the Supreme Court in *Esabunor's* case addresses some of these fundamental issues. Are parental rights over their children absolute? Or to what extent can the rights be subrogated? When it pertains to the welfare or interest of the child who determines what is best for the child? The Supreme Court's verdict to override the rights of the parents for refusing to consent to E's medical treatment is discernible from the provisions of the CRA 2003 and the CFRN.

Section 1 of the CRA asserts that the best interest of the child should be of paramount consideration in all actions involving children. By implication, individuals, a public or private body, institutions, the court of law, or administrative or legislative authority should have a child-centred approach when adjudicating matters involving children. Furthermore, Section 13 of the Act guarantees the right to health and access to health services for the child. Section 13(2) of the Act provides that: "Every Government, parent, guardian, institution, service, agency, organization or body responsible for the care of a child shall endeavour to provide for

---

Cavendish, 2007) 25-27; Jo Bridgeman, 'Our Legal Responsibility to Intervene on Behalf of the Child': Recognising Public Responsibilities for the Medical Treatment of Children,' [2021] 21 (1) Medical Law International 19-41

[62] Degol Aron & Shimelis Dinku, 'Notes on the Principle "Best Interest of the Child": Meaning, History and its Place under Ethiopian Law' *Mizan Law Review* (2011) 5 (2) 319-337 at 328.

[63] Ben Saunders, 'A Sufficiency Threshold is not a Harm Principle: A Better Alternative to Best Interests for Overriding Parental Decisions' *Bioethics* (2021) 35 (1) 90-97.

[64] John D. Lantos, Do *We Still Need Doctors? A Physician's Personal Account of Practicing Medicine Today* (Routledge, 1997) 57.

[65] Linda A. Oti-Onyema, (n 32) 175.

[66] Douglas Diekema, (n 46) 246.

https://doi.org/10.53982/alj.2024.1201.04-j

the child the best attainable state of health." The section makes it a collective responsibility of all stakeholders to work together for the fulfilment of the right.

The degree for the realisation of the 'best attainable state of health' is contained in the provisions of section 13(3). It enjoins the government at all levels, is to promote the child's right to survival and development, by reducing infant mortality and also ensuring that all children have access to healthcare services. Finally, Section 59(a) gives the court the discretion to direct the appropriate authority to investigate any allegation on the welfare of the child before the court issues a care supervision order.

From the above provisions, it is apparent that the court in a bid to uphold and safeguard the well-being of the child, will in all circumstances, place the best interest of the child to be its paramount consideration. In this case, the court emphatically held that it would be unfair for the court to allow a child the right to access life-saving treatment just because of the religious beliefs of the parents. The court further opines, that in circumstances where the child's life is at risk, such as in E's case, the decision to save his life through blood transfusion is more important than religious beliefs, particularly where the patient is a child.

It is critical at this point to examine the arguments raised by the counsel representing E and his mother. He submitted that the right to accept or decline medical treatment is an inalienable right recognised globally. He argued that the objection of the mother to a particular course of treatment cannot constitute an offence or an attempt to commit one.[67] He relied on the case of *M.D.P.D.T. v. Okonkwo*[68] to further argue his points. In that case, a 29-year-old woman had suffered complications after delivery. Due to the complication, the doctor advised that a blood transfusion was needed to save her life. The woman and her husband being devout Jehovah's Witnesses refused to consent to be transfused even after the doctor had explained the consequences of such refusal. The medical practitioner commenced treatment without a blood transfusion, after which she died some days later. The doctor was charged before the Medical and Dental Disciplinary Tribunal for failing to adhere to the ethics of the profession and treating the patient negligently. He was found guilty by the Tribunal, and he appealed to the Court of Appeal, which quashed the decision of the

[67] The constitutional rights guaranteed under the Constitution as defined in s. 37, entails the right to privacy; and s. 38, which provided for the right to freedom of religion, thought and conscience.

[68] (2001) 7NWLR (Pt.711) 206.

https://doi.org/10.53982/alj.2024.1201.04-j

Tribunal. The Tribunal then appealed to the Supreme Court. The Supreme Court held that a patient with capacity has the right to refuse a medical treatment or procedure based on grounds of religion, irrespective of whether such an objection can lead to death. In the absence of any judicial intervention overriding the patient's decision, the doctor has no option left but to respect such a decision.[69]

The Counsel further opines, that criminalising the mother's action, cannot outweigh her constitutional rights to give or refuse consent as guaranteed under the CFRN. He cited the statement by the Supreme Court in the case of *M.D.P.D.T* v. *Okonkwo,*[70] which clearly stated that:

> the right to freedom of thought, conscience or religion implies a right not to be prevented, without lawful justification, from choosing the course of one's life, fashioned on what one believes in, and a right to be coerced into acting contrary to one's religious belief. The limits of these freedoms … are where they impinge on the rights of others or where they put the welfare of society or public health in jeopardy. The total of the rights of privacy and of freedom of thought, conscience, and religion which an individual has…, is that an individual should be left alone to choose a course for his life unless a clear and compelling overriding state interest justifies the contrary. If a decision to override the decision of a competent patient not to submit to blood transfusion or medical treatment on religious grounds, is to be taken on the grounds of public interest or the recognised interest of others, such as dependent minor children, it is not to be taken by the courts.[71]

From the ratio of the court above, the argument stands that an adult (such as a parent) of sound mind and capacity, has the freedom to consent or refuse a medical treatment that is against his or her religious rights. However, this right is not absolute, as the court has emphasised limitations on the grounds of public policy and the interest of dependent minor

[69] ibid, particularly the ratio of Per Ayoola J.S.C. at 245, paras. G-H.
[70] *M.D.P.D.T.* v *Okonkwo* (2001) 7NWLR (Pt.711) 206.
[71] ibid at 244-245 (italics mine).

https://doi.org/10.53982/alj.2024.1201.04-j

children. The Supreme Court distinguished *Okonkwo's* case from the case of *Esabunor*, it notes that since the decision in *Okonkwo's* case involved an adult patient, the law is settled on this position that an adult whose mental faculties are fully active, is entitled to accept or reject medical treatment. The medical practitioner cannot act contrary to the patient's decision, as all individuals of full capacity can make choices based on the principle of autonomy and self-determination.

However, for children, different principles apply when making medical decisions. The Supreme Court places reliance on the CFRN which deals with the restriction and derogation from fundamental rights as thus: 'nothing in sections 37,[72] 38,[73] 39,[74] 40[75] and 41 of this Constitution shall invalidate any law that is reasonably justifiable in a democratic society…b) to protect the rights and freedom of other persons'.[76] The court held that due to the lack of capacity to make decisions for themselves, the law has the responsibility to protect children from exploitation and abuse, based on the religion of the parents, as they may detest the parents' decisions when they grow up.

The Supreme Court's reliance on the provisions of the Child's Rights Act 2003 and also the provisions of the CFRN, to advance the best interest of the child is commendable in this area. This is a total departure from the earlier decision of the Court of Appeal. Justice Rhodes-Vivour elucidates that courts can intervene in the medical decision-making of parents in three instances, that is, to protect best interests, to save his life and to prevent the commission of a crime. It further expressed that although the practice of one's religion is a right, protecting the life of the child is more important than adhering to the religion of the parents, especially as the child might not choose that religion as an adult. Parents and medical practitioners are not to allow their religious doctrines, personal convictions and biases, to cloud their medical decisions on behalf of their children.

[72] Right to private and family life.
[73] Right to freedom of thought, conscience, and religion.
[74] Right to freedom of expression at the press.
[75] Right to peaceful assembly and association.
[76] CFRN, s. 45 (1) (b).

4.2 Post-Esabunor

It is apparent from the decision of the Supreme Court in this case that a guideline has been established for medical practitioners to seek judicial intervention for life-saving treatment on behalf of the child which has not existed before now. This case may have been commended for having established the above premise, however, insufficient focus was placed on the threshold to judicial intervention in the Esabunor case and it is hoped that more light will be shed on this area of law in subsequent cases, even as awareness of rights in the medical sphere increases. For example, there are still questions about the appropriate guidelines to follow when a medical practitioner needs the intervention of the courts. Also, is the threshold going to remain the same if one parent disagrees with the other parent to a treatment which the medical practitioner recommends? In addition, is there a welfare code in cases of payment of medical bills due to parental refusal to act? In writings from the 1980s, Ian Kennedy and Michael Freeman argued that for physicians to practice in a way that reflected best practices and safeguarded the interests of both their patients and society at large, they were required to operate within a framework that was socially, ethically, and legally acceptable.[77] Hence, this paper argues that these guidelines are necessary to address future issues that may arise effectively.

5. Conclusion and Recommendations

The paper explores the connection between the rights of children and parents in Nigeria. It further interrogates the relationship between these rights and highlights areas of interrelation and dependency, particularly the rights of the children in Nigeria. In the area of healthcare decision-making, *Esabunor's* case has laid down the principle that parental rights will be subrogated in the interest of the child in cases of life-saving treatment, as the rights are merely responsibilities for which parents are enjoined to act in the best interest of the child. These authors believe that the case will provide a guideline for an adequate legal and policy

---

[77] Ian Kennedy, 'Response to the Critics' *Journal of Medical Ethics* (1981) 7 202–211.; Ian Kennedy, *The Unmasking of Medicine* (Granada, 1981, revised 1983); Michael Freeman, *The Rights and Wrongs of Children* (Frances Pinter, 1983); Michael Freeman, 'Freedom and the Welfare State: Child-Rearing, Parental Autonomy and State Intervention' *Journal of Social Welfare and Family Law* (1983) 5 (2) 70 -91.

https://doi.org/10.53982/alj.2024.1201.04-j

framework for medical practitioners in this area, as it will assist in bridging the gap between parental rights and the best interest of the child in cases of this nature.

The authors suggest that medical practitioners should be educated on the principles in the Esabunor case and the guidelines concerning the actions to be undertaken when similar cases arise. The State should also handle the cost of care received by a child whose parent(s) have denied medical treatment contrary to their best interests. This is because the lack of funds could restrict the assistance that could have been rendered by the medical practitioner to the child.