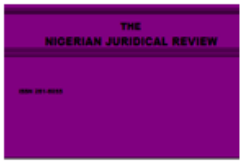

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INVESTIGATING THE MORAL AND LEGAL CONUNDRUM OF JUGGLING HUMAN RIGHTS WITH HUMAN LIFE IN THE NIGERIAN MEDICARE AND MEDICAID SERVICES

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Abstract

In modern healthcare administration, the connection between preserving human life and protecting human rights creates a difficult ethical quandary. The idea of beneficence highlights healthcare practitioners' responsibility to prioritise efforts that promote well-being and life preservation. This notion is typically visible in decisions regarding blood transfusions, triage measures, and end-of-life care. However, this pragmatic approach can also clash with the ideas of self-governance and fairness, particularly when it results in unequal access to medical treatment or affects individual liberty. The ideals of autonomy highlight the importance of protecting patients' rights to make their own decisions and guaranteeing equitable access to healthcare services. Patients have the right to make well-informed decisions about their own medical care, even if those decisions do not align with the primary goal of maximum life preservation. When health treatment conflicts with religious convictions, Africans choose their religion over their own lives. Most patients do not consider the persons who may be impacted by their actions, including children, parents, and dependents. It is then necessary to safeguard dependents by establishing paternalism as a legal exception to autonomy. Using doctrinal research methods, this study investigates the complicated ethical terrain where the need to preserve lives frequently conflicts with the need to respect individual autonomy and dignity. This study looks into the difficulties that arise when dealing with competing priorities. This study suggests that the Nigerian legal and healthcare systems be modified to make paternalism a statutory exception to autonomy.

Keywords: human rights; moral and legal issues in healthcare; human rights and Medicare; Medicaid; Nigeria

1. Introduction

Human life and human rights are like Siamese twins, relying on each other to thrive. As a result, denying one is proportional to denying the other. Human

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rights apply to every aspect of human life, including health care. Human rights should continue to be valued in the administration of health care and the safeguarding of human lives. An individual's various health-care rights are combined into a single phrase known as autonomy. Individuals who violate their autonomy may face criminal and civil repercussions. However, there are various occasions where these co-joined twins dispute, with each attempting to prioritise one over the other, and prioritising one has the potential to do harm to the individual's dependents, particularly when right is prioritised above life. This creates a lacuna in terms of how the law could be used to balance such conflicts in order to protect the rights of the individual while not jeopardising the interests of the dependents, who are usually minors. This paper is broken into four parts after the introduction. Section two discusses human rights in health-care administration, while Section three discusses biomedical ethics principles. Section four examines the issues between human rights and health care, and section five closes the paper.

2. **Human Rights and Health Care Administration**

Human rights are the rights that people have just by virtue of being human. While there are many human rights, there are certain that are particularly important in the governance of healthcare. These include the right to life, the right to personal liberty, the freedom from torture, inhumane and humiliating treatment, and the freedom to think, conscience, and practise religion. These rights are legally protected; yet certain disputes emerge when one right must be surrendered to safeguard another;[1] for example, when personal liberty or free thought, conscience, and religion are compromised to safeguard the right to life.

Battery, assault, and false detention are all possible consequences for violating the right to personal liberty. This breach always happens in health care when a patient, particularly a psychiatric patient, refuses treatment and is imprisoned in a medical facility, where treatment is forced. [2]

These fundamental rights are embodied in a patient's right to autonomy, which is the right to self governance. Simply said, people have the right to decide what healthcare they receive and how it is delivered to them. This also entails being able to make decisions based on one's own free will, rather than being swayed by external forces such as coercion or 'internal' causes such as drugs, alcohol, mental illness, or other emotions. Many international charters and national

[1] National Human Rights Commission **'**Right To Health (Thematic Team**'** <https://www.nigeriarights.gov.ng/focus-areas/right-to-health.html#:~:text=Regionally%2C%20the%20Right%20to%20Health,Scheme%20Act%20(1999)%20etc> accessed 10 June 2024

[2] Emma Cave, ' The ill-informed: Consent to Medical Treatment and the Therapeutic Exception (2017) (46) (2) *Common Law World Review*140-168. Available online at https://doi.org/10.1177/1473779517709452. See also, Mason and McCall Smith's Law and Medical Ethics (London, Butterworths 1999) 56.

constitutions recognise the right to autonomy or self-government. In Nigeria, for example, it is enshrined as the right to human dignity (as guaranteed in Section 34), personal liberty (as provided in Section 35), and privacy (as provided in Section 37).

The right to autonomy prioritises consent in health care, and failure to comply may result in legal and criminal charges. Obtaining consent is an important aspect of providing healthcare, whether it is through signed documentation or just asking the patient to be contacted. While there are other sorts of consent, such as inferred, expressed, informed, and unanimous, this article will focus on informed consent. To provide consent to a treatment, a patient must be educated on the potential risks, outcomes, and healing processes related with the treatment.[3]

When consent is not obtained, every Medicare provided to the patient is considered a trespass against the individual. As previously stated, trespass to a person can be classified into three types: assault, battery, and false detention. [4] Assault occurs when one party threatens to harm or use force against another party, and the second party is reasonably concerned that the first party will use unlawful or unjustified force against them at any time. Assault is defined as any act, gesture, or threat made by the defendant that causes the plaintiff to fear the use of force against him. Sections 252-253 and 351-360 of the Criminal Code Act define a variety of assault crimes.

Assault requires evidence of an imminent threat to use force, or that the conduct in question would cause a reasonable person to fear for their own safety. In other words, the plaintiff had reasonable grounds to expect an immediate battery and a clear threat to use force. Assault is not always synonymous with battery. It is not necessary to show that the victim was actually terrified in order to establish an attack. The plaintiff must prove that he or she reasonably anticipated immediate battery. For example, in *R v Barrett*, the defendant charged at the complainant, clenched his fist angrily, and threatened to strike the complainant on the spot, causing the complainant to fear for his safety. The court ruled that there was an assault. Threats in assault include both words and deeds, but assault can also occur when words are not spoken, as in Ireland and Burston v. R.[5] The defendants repeatedly called three victims but did not talk to them. During some calls, he resorted to excessive breathing. For months, the victims were stalked relentlessly, leaving them scared of being alone. Many of

[3] Irsch, A. Relational Autonomy and Paternalism – Why the Physician-Patient Relationship Matters (2023) *ZEMO* **6**, 239–260. https://doi.org/10.1007/s42048-023-00148-z

[4] Nwabueze RN. The Legal Protection and Enforcement of Health Rights in Nigeria. In: Flood CM, Gross A, eds. *The Right to Health at the Public/Private Divide: A Global Comparative Study*. Cambridge University Press; 2014:371-393.

[5] [1997] 3 WLR 534

the victims suffered from depression or other mental health problems. The House of Lords declared an assault. Assault was perpetrated when the victims were threatened with violence via silent phone conversations.

In *Sweeney v Janvier*,[6] the complainant in this case was an Englishwoman from France who was betrothed to a German imprisoned on the Isle of Man during WWI. During the war, one of the defendants approached her at her house and falsely claimed to be speaking on behalf of the military authorities, accusing her of being wanted for her correspondence with her fiancé, the German, who was suspected of being a spy. The plaintiff suffered from nervous shock as a result of the bogus threat, and she sought damages after discovering the accusation was baseless. The court ruled that she could sue for trespass and person damages as a result of her injuries.

The plaintiff's lack of fear is irrelevant; the purpose of the law is to protect people from threats of violence or the immediate application of battery. In *Brady v Schatzel*,[7] the defendant threatened to shoot the plaintiff, who filed for assault. However, the plaintiff testified in court that he was not scared. Regardless, the court found the defendant guilty of assault.

Battery on the other hand is the aggressive or unjustifiable application of force on another person's person, regardless of how minor that force may be. It is also the purposeful use of force against another person. It is defined as the unlawful application of force to another individual without his agreement. To prove battery, the plaintiff must demonstrate that the offender intentionally made offensive and injurious contact with them. In Wilson v Pringle[8] and Lane v Holloway[9], it was ruled that physical contact between parties does not have to be violent or produce pain to constitute battery. As a result, any illegal, willful, or angry touching of a person, their clothing, or any other attached item might constitute battery. Similarly, a surgical surgery conducted without the patient's consent might be considered battery. As a result, even the tiniest contact, touch, or force can be used, and no injury is necessary. In healthcare, battery is defined as a damaging or offensive touching of a patient by a medical worker in a healthcare context. A healthcare provider can be charged with medical battery if the patient was not properly informed before to a surgery, which is known as informed consent. The bulk of medical battery claims are for surgical operations. When speaking with patients, providers must have a calm and compassionate demeanour, regardless of whether the patients reciprocate.

Under no circumstances should a healthcare provider physically or verbally abuse a patient, as this may result in the patient's damage or a medical battery complaint against the practitioner. False incarceration happens when a person is

[6] [1919] 2 KB 316.
[7] St R Qd 206.
[8] 1986] 2 All ER 440.
[9] [1968] 1 QB 379.

physically restrained without his consent or without legal authority. Imprisonment is more than just losing movement power; it also entails being constrained within a narrow space determined by someone else's will or power.[10] False imprisonment requires an intention to deprive the claimant of their liberty, although ill will or malice is not required to establish it. Intention is sufficient. Every restriction on a free man's liberty is a type of imprisonment, even if he is not physically confined to a prison.[11]

In a similar spirit, Sir William Blackstone said, "Every confinement of the person is an imprisonment," whether it occurs in a public prison, a private dwelling, the stocks, or even the streets.[12] The patient's awareness of confinement, or the reasonable assumption that they could not be released from their involuntary detention in a healthcare facility, nursing home, or even an ambulance, is an important component of a false imprisonment claim in healthcare.

Patients have the freedom to refuse treatment, even if nurses or doctors disagree with the reasoning behind their decision. Exceptions include cases of mental incompetence, individuals who endanger themselves or others, and those whose capacity has been compromised by drug or alcohol use. Medical institutions and clinicians should always treat patients as autonomous individuals without force.

Another right granted to patients under the Nigerian Constitution is the right to privacy, which means that medical workers cannot access a patient's body, telephone, or other personal information without the patient's consent. [13]

One of the most contentious rights in health care is the freedom of thought, conscience, and religion. This right becomes an issue when a patient's religious views conflict with the healthcare being provided. This right is protected by Section 38 of Nigeria's constitution. Furthermore, the European Convention of Human Rights, Article 9, All persons have the right to freedom of religion, thought, conscience, and speech, which includes the ability to change one's religious views and practices, as well as the freedom to publicly or privately

[10] J Thomas and G Moore, 'Medical-legal Issues in the Agitated Patient: Cases and Caveats' *West J Emerg Med* (2013) 14(5):559-65. doi: 10.5811/westjem.2013.4.16132. PMID: 24106559; PMCID: PMC3789925.

[11]GO Mgbodi, (2023) 'Inadequate Healthcare Service Administration and Management In Nigeria and Solutions' https://www.researchgate.net/publication/372769855_INADEQUATE_HEALTHCARE_SERVICE_ADMINISTRATION_AND_MANAGEMENT_IN_NIGERIA_AND_SOLUTIONS accessed 10 June 2024

[12] Sir William Blackstone, *Commentaries on the Laws of England* (Book 3, Chapter 8 Of Wrongs, and Their Remedies, Respecting The Rights of Persons 1765-1769) <https://lonang.com/library/reference/blackstone-commentaries-law-england/bla-308/> accessed 15 August 2024.

[13] Ibid.

express one's religion or belief. Article 18 of the ICCPR guarantees freedom of religion or belief, as well as freedom of thought, conscience, and expression. [14].

Furthermore, for the abolition of all types of racial discrimination, read Articles 5 of the CERD and 14 of the CRC. Nonetheless, as mentioned in article 18(3), the freedom to express religion or beliefs may be regulated in compliance with legislative requirements and in circumstances when such limits are required to protect public safety, order, health, morals, or the basic rights and freedoms of others. National security is not specifically mentioned among the grounds for permissible limitations, though other limitations may address it. The Human Rights Committee has underlined that limits must be proportionate to the need they serve and necessary to accomplish the intended goal. [15].

According to a study published in the Ghana Medical Journal, patients must be fully informed of all relevant facts in order to grant informed consent, and practitioners cannot rely on therapeutic privilege. The preceding article's reasoning was backed by the following decisions: Meyers Estate et al. v Rogers[16], in which a 37-year-old woman died after getting an intravenous injection of contrast material during a normal radiographic examination. The doctor intentionally withheld information about the hazards connected with contrast media. The Ontario court dismissed the radiologist's claim of therapeutic privilege as a defence for neglecting to warn the patient about the risks of intravenous contrast medium injection. In the previous case, the court used the case of Reibl v Hughes[17] to back up its reasoning and decided that "the therapeutic privilege exception to the doctor's duty of disclosure should not be part of Canadian law because of its potential to erode informed consent".

To show that a doctor performed a treatment or procedure without valid informed consent, the patient must typically demonstrate that if he or she had known about the specific risk, outcome, or alternative treatment that was allegedly not disclosed, the patient would not have chosen the chosen treatment or procedure, thereby avoiding the risk. In other words, the patient must show that the purported failure to disclose caused harm.[18]

The Ghana Patients' Rights Charter, which was released on May 4, 2018, states that healthcare facilities shall protect and respect the rights and obligations of patients/clients, families, health professionals, and other healthcare providers. Healthcare institutions must also consider patients' socio-cultural and religious backgrounds, age, gender, and other differences, as well as the needs of people with disabilities. The patient charter ensures that all care providers,

[14] *Schloendorf v Society of New York Hospit*. 1914105 NE 92
[15] Ibid.
[16] (1991) 78 DLR.
[17] [1980] 2 SCR 880
[18] C Ojumu 'An Examination of the Exceptions to Consent as a Requirement to Medical Treatments and Procedures' (2023) 19 (2) *UNIZIK, Law Journal* 10.

patients/clients, and their families are informed of their rights and responsibilities. [19]

3. Principles of Biomedical Ethics

Biomedical ethics are the sacred ideals that healthcare workers are supposed to respect in order to have seamless interactions with their patients. These principles include autonomy, beneficence, non-maleficence, and fairness. Autonomy, or the right to self-governance, has sparked controversy, particularly when self-governance by some patients leads to self-destruction. Medical practitioners are often allowed to be paternalistic. Simply said, this entails acting as a father figure. Fathers can overrule the decisions of children in their care, just as medical professionals can override the decisions of patients in their care if they potentially lead to self-destruction. In other words, "paternalism" happens when a physician or another healthcare professional takes decisions on behalf of a patient without the patient's explicit agreement.[20] The doctor believes that the decisions are in the patient's best interest. However, the physician has more influence in the relationship than the patient, just as the parents have more control in a family than the children. In the previous paternalistic approach, it was permissible for the physician to determine what to tell the patient about the actual diagnosis, and in cases of terminal disease, the patient was sometimes not told the full nature of the condition (maybe the family was informed instead). If the patient is informed of the diagnosis, the doctor may offer the prescribed treatment plan as the only option rather than mentioning alternatives that should be examined. Or, if the patient is presented with choices, the physician may make the recommended treatment plan appear plainly preferable in order for it to be chosen. [21]

Diverse scholars have advanced several arguments for and against paternalism. One common argument for paternalism in healthcare is that the physician or other provider has such vastly superior technical knowledge of the medical situation, the certainty of the diagnosis, the nature of the treatment options and potential benefits, and the risks involved—that it makes more sense for the provider to evaluate the options and make the decisions. Patients are easily overwhelmed by technical details and risk talk, so they are not in the best position to make the decision. [22] The patient suffering from an illness is frequently in a weakened and vulnerable state, and has come to the provider for expert advice, assistance, and judgement that the patient lacks. Furthermore, any

[19] *Schloendorf v Society of New York Hospit* 1914105 NE 92

[20] Patricia Imade Gbobo and Mercy Oke-Chinda, 'An Analysis of the Doctrine of Informed Consent in Nigeria's Health Care Services' (2018) (69) 17 *Journal of Law, Policy and Globalisation* 23.

[21] R Fernández-Ballesteros and others, 'Paternalism vs. Autonomy: Are They Alternative Types of Formal Care? Front Psychol' (2019) Jun 28; 10:1460. doi: 10.3389/fpsyg.2019.01460. PMID: 31316428; PMCID: PMC6611139.

[22] Iibid

decision should be made logically, based on an objective assessment of the facts, rather than emotionally.[23] The patient is usually very emotionally involved and possibly scared by all the talk about risks and uncertainties, which may impair the patient's judgement. The physician is less emotionally involved in the situation, allowing him to make the best decision. [24] In fact, upsetting information presented to the patient may harm him or her by causing sadness and depression, and the physician has a duty not to harm the patient. Some scholars argue that doctors' treatment of their patients is inherently paternalistic. This is because patients cannot potentially know all of the information about a procedure, including the potential advantages and hazards, and the physician's personal decisions about what to disclose with them will undoubtedly play a role in this decision-making process. [25]

Those who disagree with the concept of autonomy believe that patients should not be unable to make informed decisions owing to a lack of relevant information. According to this viewpoint, physicians should not be permitted to withhold critical information from their patients or subjects and then make life-changing decisions on their behalf. The critic of paternalism may argue that when a provider makes critical decisions for a patient or withholds important information in order to influence a patient's decisions without involving the patient in the process, the provider appears to be implicitly assuming to know everything about what type of life people in general should live and want out of life.[26]

Beneficence is an additional facet of biological ethics. The principle of beneficence requires physicians to act in their patients' best interests and supports a variety of moral standards aimed at protecting and defending others' rights, preventing injury, removing hazardous conditions, assisting those with disabilities, and rescuing those in danger. The principle focuses not only preventing harm, but also improving and boosting patients' well-being. While physicians' beneficence is moral and unselfish, it is also true that in many circumstances, it can be considered as a payback of the debt given to society for education (often subsidised by governments), ranks and privileges, and to patients themselves (learning and research). [27]

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[23] F O Emiri, *Medical Law and Ethics in Nigeria* (Malthouse Press Ltd 2012} 304.

[24] L Murgic and others, 'Paternalism and Autonomy: Views of Patients and Providers in a Transitional (Post-Communist) Country (2015) 16(1) *BMC Med Ethics* 65. doi: 10.1186/s12910-015-0059-z. PMID: 26420014; PMCID: PMC4589086.

[25] Murgic (n24).

[26] C Katsakou and S Priebe, 'Patient's Experiences of Involuntary Hospital Admission and Treatment: A review of qualitative studies (2007) 16(2) *Epidemiologia e Psichiatria Sociale*.172-178. doi:10.1017/S1121189X00004802.

[27] B Varkey, 'Principles of Clinical Ethics and Their Application to Practice' (2021) *Med Princ Pract* 30(1) 17-28. doi: 10.1159/000509119. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7923912/#:~:text=The%20principle%

Nonmaleficence, on the other hand, is a doctor's promise not to harm the patient. This principle supports a number of moral norms, including the prohibition on killing, causing pain or suffering, incapacitating, offending, or depriving others of the necessities of life. The practical application of nonmaleficence necessitates the physician weighing the benefits and burdens of all operations and treatments, avoiding those that are unduly burdensome, and selecting the best course of action for the patient.[28] This is especially important in difficult end-of-life care decisions like withholding and withdrawing life-sustaining treatment, medically administered food and hydration, and pain and symptom management. The obligation and intention of a physician to relieve a patient's suffering (e.g., refractory pain or dyspnea) by the administration of appropriate drugs, including opioids, supersedes the anticipated but unintentional detrimental effects or outcome (doctrine of double effect).[29]

Justice is frequently characterised as treating people fairly, equitably, and appropriately. Distributive justice is the most significant category of justice in clinical ethics. Distributive justice is the fair, equitable, and appropriate distribution of healthcare resources based on justifiable norms that set the boundaries of social cooperation. How is this done? There are a few viable distributive justice principles. These are: (i) an equal share for everyone, (ii) based on need, (iii) based on effort, (iv) based on contribution, (v) based on merit, and (vi) based on free market exchanges. Each concept is not mutually exclusive; they can and are routinely combined in practice. It's evident how difficult it is to choose, balance, and develop these concepts in order to create a unified and viable system for allocating medical resources. [30]

4. **Conflicts in Human Rights and Healthcare Administration**

The healthcare industry is constantly confronted with ethical quandaries in which human rights and the preservation of human life are in conflict. This contradiction is especially evident in cases involving blood transfusion, and

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20of%20beneficence%20is,and%20rescue%20persons%20in%20danger> accessed 10 June 2024

[28] Patricia Imade Gbobo and Mercy Oke-Chinda, 'An Analysis of the Doctrine of Informed Consent in Nigeria's Health Care Services'(2018) (69) *Journal of Law, Policy and Globalisation* 17.

[29] TL Beauchamp and JF Childress, *Principles of Biomedical Ethics*. (New York: Oxford University Press; 2009)162. See also, RA Mularski and others, 'Pain Management Within the Palliative and End-Of-Life Care Experience in the ICU' (2009) 135(5) *Chest* 1360.

[30] S Fleishacker, *A Short History Of Distributive Justice*. Cambridge ((MA): Harvard University Press; 2005).

patient autonomy. While both principles are vital, their reconciliation frequently necessitates a sophisticated and context-specific approach. [31]

As noted previously, respect for human rights in healthcare guarantees that patients are treated with dignity, that their preferences are honoured, and that their uniqueness is recognised. This also requires healthcare personnel to respect patients' choices, even if they differ from medical recommendations. on the other hand, preserving human life is healthcare's primary purpose. It is founded on the ethical principle of beneficence, which requires healthcare personnel to behave in patients' best interests by increasing their well-being and avoiding damage. This principle frequently necessitates medical measures aimed at preserving or extending life.[32]

To properly represent this area, various case studies need to be examined.

Novak v Cobb County-Kennestone Hospital Blood Transfusions Authority:[33] A 16-year-old Jehovah's Witness was injured in an auto accident. The injuries necessitated surgery. He informed EMS and hospital personnel that he was refusing blood transfusions. There were no blood transfusions administered during the operation. Regular blood tests revealed that the hemoglobin level was dropping. Physicians tried to persuade the patient and his mother (who is divorced and has custody of her son) to accept a blood transfusion, but they refused. After the surgeon stated that the patient was in immediate danger of death, hospital legal counsel filed a late afternoon petition in state court for guardian ad litem without notifying the patient or his mother.

The state judge held an informal hearing that evening, attended solely by the hospital's risk manager and two solicitors. The state judge has designated guardian ad litem. The next morning, the risk manager informed the state judge that the patient's condition had worsened. The judge ordered an emergency hospital hearing and said who should present. Both the surgeon and the second doctor confirmed the need for a transfusion. The guardian ad litem requested that the state judge issue a transfusion order. The judge granted the order and the patient was held and given three units of packed red blood cells. The patient was discharged 1.5 months after the transfusion and recovered successfully. On behalf of her son and herself, the mother filed a federal lawsuit against the hospital, the risk manager, the surgeon, the second treating physician, and two hospital attorneys. She also sued another doctor but eventually dropped the case.

The accusations were supported by a variety of culpability grounds under the Civil Rights Act of 1983 and other state statutes. The defendants filed for

[31] ED Pellegrino and D C. Thomasma, 'The Conflict between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution' (1985-2015) 3 (1) *Journal of Contemporary Health Law & Policy* 23.
[32] Ibid.
[33] Case number 849F. Supp. 1559, ND Ga 1994.

summary judgment on all federal civil rights complaints, claiming there was no debate over the facts. in command. After analysing each claim and theory, the federal trial court granted all defendants' summary judgment requests for the patient's and mother's cases. The court ruled that the risk manager, a 'state actor' under civil rights law, did not violate the patient and mother's fourteenth amendment right to noninterference with their familial relationship by engaging in "shocking and egregious conduct" that would be a substantive due process violation. No evidence contradicted the patient's or parent's emergency necessity to forego the pre-deprivation objective, hence the court found no infringement. Whether there is an emergency. The court acknowledged that children's religious freedom is protected, but it also determined that parents 'can and must' make treatment decisions, and that the court can order treatment despite religious objections, indicating that there was no substantive due process violation. As a minor (even if grown), the patient did not have a constitutional or common law right to refuse medical treatment.[34]

Nicoleau v. Brookhaven Memorial Hospital:[35] The New York Court of Appeals ruling expanded the right to decline potentially life-saving medical treatment. The court concluded that the state cannot compel treatment, even if a parent's refusal harms a child's interests.

In prior decisions, lower courts recognised reasons in favour of saving the child's life to justify forcing medical treatment on an unwilling patient. However, a recent order dated January 18, 1990, clearly states that this method is no longer authorised. The case in question concerned a Long Island lady who suffered a hemorrhage shortly after giving birth and was given a blood transfusion, which the hospital determined was essential to save her life. The woman, a 35-year-old Jehovah's Witness, objected to the transfusion for religious reasons, and the Court of Appeals found that her desires should have been respected. Previously, a lower court rushed to order the transfusion without a full hearing, and the woman survived.

Denise J Nicoleau, a Moriches, New York resident, sued Brookhaven Memorial Hospital in Patchogue because they failed to follow her directives. Chief Judge Sol Wachtler's opinion categorically rejected the notion that a minor's 'overriding interest' may be utilised to disregard a parent's wishes in a scenario where the child refused lifesaving care. This was the first time the Court of Appeals heard a case like this one. [36]

Hay v B [37]was a case in which a practitioner had to obtain a court order to authorise a life-saving blood transfusion for a Jehovah's Witness infant whose

[34] See also, Isaac Mesiha v South Eastern Health (2004) NSWSC 1061

[35] (from Hospital Ethics. 1990. March/April.)

[36] See also, Jehovah's Witness v King Country Hospital 278 F. Supp. 488 (ND Wash. 1967)

[37] 2003 (3) SA 492 (W)

parents refused one. However, this case was heard prior to the implementation of the Children's Act. According to the Children's Act, a medical practitioner may overlook a parent's reluctance to consent to a blood transfusion purely for religious or other reasons. This is true even if the parent can show proof of a medically suitable alternative.

Nigeria needs special courts with the power to bypass consent. Many people use religion as a crutch. What happens if opposing beliefs create irreversible harm? Religion is dynamic, and many people change their minds. [38]

Some Jehovah's Witnesses have been excommunicated or socially alienated from their religious group for knowingly undergoing blood transfusions, believing that getting blood violates God's will. This includes turning down blood transfusions, even if the donor's blood is their own. The treating physician must carefully inquire about the patient's attitude on this topic, as a minority of Jehovah's Witnesses do not believe that the Bible forbids blood transfusions and will thus accept them. Some Jehovah's Witnesses may believe it is appropriate to get blood plasma fractions or reinfusion of their blood.

Africa is a deeply religious continent where people do things they don't completely comprehend to please God. Africans are so fascinated with spirituality that they are eager to heed any command given by a spiritual leader, even if the instruction appears ludicrous to them. It's no surprise that Karl Max stated, "Religion is a protest against real suffering." Religion is the oppressed creature's sigh, the heart of a heartless world, and the soul of soulless situations. It's the opium of the masses." Interestingly, these allegiances shift as people transition from one religious group or denomination to another and believe they have gained a greater knowledge. This raises the question of what occurs when a permanent decision is based on a temporary religious conviction. For example, if a Jehovah's Witness refuses to transmit his child and the child dies, he may later alter his faith and convictions, but his child is no longer alive.

When evaluating people's rights to self-government, it is also critical to provide a comprehensive assessment of the absoluteness and exclusivity of those rights. Do humans own themselves entirely? A person is the principal owner of himself, but it should be remembered that someone else owns them, either as mother, father, child, or benefactor; should not the interests of the other co-owners be taken into account as well? Every patient means something to their relatives; in the case of children, many parents have refused blood transfusions for religious reasons and died, leaving their children to suffer immeasurable pain. It is also critical that the law intervene to extend self-governance in medical circumstances to protect the interests of dependents, particularly children, who would be directly affected by their parents' religious decisions.

[38] Okey Nnebedum and Oloruntobi Opawoye, 'A Doctor's Dilemma – Parent 's Right to Refuse Consent' (2021) *JEE Sector Thought Leadership Series* 4.

Article 3(1) of the Childs Rights Act of 2003 states that the best interests of the child must be the primary priority in all activities involving children, whether taken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies. Sub-section 2 states that States Parties undertake to provide the child with such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and to this end, shall take all appropriate legislative and administrative measures.

When a person makes a decision or performs an act that is known to endanger his life, it is common to mention that he tried suicide. In Nigeria, suicide is not a crime, but attempting suicide is. According to Section 327 of the Criminal Code Act, attempting to kill oneself is a misdemeanor punishable by one year in prison. Furthermore, section 231 of the penal code, which pertains to Northern Nigeria, stipulates that: Whoever attempts suicide and does everything to facilitate the commission of such offense shall be punished with imprisonment for a term of up to one year, a fine, or both. Although Nigerian law is silent on whether contrary medical decisions that endanger a patient's life should be considered attempted suicide. Nonetheless, there is no distinguishing element between euthanasia, which is illegal in Nigeria, and denial of treatment, which may potentially cost the patient's life. Euthanasia can be performed either actively or passively. Passive euthanasia occurs when a person is killed as a result of withdrawing or omitting medical treatment with the purpose of ending the patient's life. Refusal of medical care when it is clear that if medical treatment is not provided, the patient will die, and this conclusion is communicated to the patient, and the patient prefers to die rather than get treatment, the patient's decision is no different than attempting suicide. [39]

The main essence of law is justice, and justice is all-encompassing in order to protect all those who are impacted by the subject matter. Because Nigerian society is formed in families and families exist in units where all members are interdependent, a member of the family's action that is likely to adversely affect other members of the family, especially children, should be prevented in the interest of justice. [40]

5. Conclusion

The conflict between upholding human rights and preserving human life in healthcare is a long-standing and difficult ethical issue. Healthcare providers

[39] V Pelto-Piri and others, 'Paternalism, Autonomy And Reciprocity: Ethical Perspectives In Encounters With Patients In Psychiatric In-Patient Care(2013) *BMC Med Ethics* **14**, 49. https://doi.org/10.1186/1472-6939-14-49

[40] Patricia Imade Gbobo and Mercy Oke-Chinda, 'An Analysis of the Doctrine of Informed Consent in Nigeria's Health Care Services' (2018) (69) Journal of Law, Policy and Globalisation 17.

can effectively manage this issue by taking a balanced and context-sensitive approach. Respect for human rights and the urge to save lives do not have to be diametrically opposed; rather, they can be balanced via ethical deliberation, proportionality, shared decision-making, and supportive legal and regulatory frameworks.[41]

In Nigeria's complex healthcare administration landscape, the ethical challenge of balancing human life and human rights is a pressing issue that requires careful consideration and nuanced responses. Throughout this article, it has become obvious that the country has a number of challenges resulting from cultural and religious convictions, as well as systemic inadequacies. While the primary goal of healthcare is to protect and improve human life, it regularly violates individuals' fundamental rights and dignity. The conflict between these two imperatives highlights the significance of a balanced strategy that prioritises both life's sanctity and individual autonomy.

To maintain this delicate balance, the law should be utilised to establish whether life should be prioritized over rights, particularly when life is at risk merely because of religious beliefs or when the loss of life in such circumstances would have a negative impact on the dependents. Furthermore, hospital administrators must uphold ethical norms including beneficence, nonmaleficence, fairness, and autonomy. This includes ensuring equitable access to healthcare resources, advocating for culturally sensitive treatment approaches, and empowering people to make their own health decisions.

Furthermore, collaboration between governments, healthcare institutions, civil society organisations, and international partners is essential to address systemic concerns and advance the right to health for all persons. Stakeholders in Nigeria can work together to create a more just and equitable healthcare environment by strengthening healthcare systems, improving infrastructure, and expanding capacity-building programmes. Finally, while the ethical quandaries inherent in healthcare administration may be complex and numerous, they are not insurmountable. We can work towards a healthcare system in West Africa that cherishes both human life and human rights equally by sticking to ethical principles, adopting collaborative action, and respecting each individual's inherent dignity.

[41] Ibid.