DECRIMINALIZING EUTHANASIA IN NIGERIA: BALANCING CRIMINAL LIABILITY WITH HUMAN RIGHTS CONSIDERATIONS

BY

Ruth Chinaza EZEALI
LAW2002865

A LONG ESSAY WRITTEN AND SUBMITTED TO THE FACULTY OF LAW, UNIVERSITY OF BENIN IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF BACHELOR OF LAWS (LLB) OF THE UNIVERSITY OF BENIN, BENIN CITY.

NOVEMBER, 2025

CERTIFICATION

I, **Ruth Chinaza EZEALI**, with Matriculation Number **LAW2002865**, hereby certify that apart from references to other persons' works which have been duly acknowledged, the entire work is a product of my research, and this project has neither in whole nor in part been presented for another degree elsewhere.

_____
Ruth Chinaza EZEALI
LAW2002865

APPROVAL

We certify that this project was written and completed by **Ruth Chinaza EZEALI** with Matriculation Number **LAW2002865** in partial fulfilment of the requirements for the award of a Bachelor of Laws (LL. B) degree.

_____	_____
Dr. (Mrs.) FLORA A. ONOMRERHINOR	**SIGNATURE & DATE**
PROJECT SUPERVISOR	
_____	_____
Dr. (Mrs.) FRANCISCA A. OSUJI	**SIGNATURE & DATE**
PROJECT COORDINATOR	
_____	_____
Prof. BRIGHT BAZUAYE	**SIGNATURE & DATE**
DEAN, FACULTY OF LAW	

DEDICATION

I dedicate this project to the God Almighty and to my Parents, Mr. and Mrs. Ezeali.

ACKNOWLEDGEMENT

My profound gratitude goes to the God Almighty and my lovely Parents, Mr. and Mrs. Ezeali, for their love, support, guidance and encouragement.

Special love to my siblings, Ezeali Joshua, Ezeali Dorcas and Ezeali Emmanuella for their steadfast belief in my success and their unwavering support in my times of distress.

Special gratitude to my project supervisor, Dr. (Mrs.) Flora A. Onomrerhinor for her patience and guidance during the course of this project.

Immense gratitude to my lecturers and professors who have instilled in me the theoretical and practical knowledge required in the real world. Special thanks to my Project Coordinator, Dr. (Mrs.) Francisca A. Osuji and the Dean, Professor Bright Bazuaye.

Lastly, a special shout out to my friends which I have made during the past five years, namely, Precious Nelson, Princess Ehiorobo, Princess Ighodaro, Oswin Okunbor and so many others.

TABLE OF CONTENTS

TABLE OF STATUTES

National

- Constitution of the Federal Republic of Nigeria, 1999 (as amended).
- Criminal Code Act, Cap C38, LFN 2004.
- Penal Code Act, Cap P3, LFN 2004.

International

- African Charter on Human and People's Rights, 27 June 1981, 1520 UNTS 217, OAU Doc CAB/LEG/67/3 rev 5 (entered into force 21 October 1986).
- International Covenant on Civil and Political Rights, 19 December 1966, 999 UNTS 171, 1976 No 47 (entered into force 23 March 1976).
- Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Netherlands).
- Belgium Act on Euthanasia, 2002.
- Medical Assistance in Dying; Criminal Code, RSC 1985, c C-46, ss 241.1-241.31.

LIST OF CASES

National

Adegoke v The State [2006] 15 NWLR (pt.1001) 394

Okonkwo v Nwoye [2011] 15 (pt.1123) 324

Foreign

Carter v Canada [2015] 1 S.C.R 331

Cruzan v Director, Missouri Department of Health [1990] 497 U.S. 261

Minister of Health v Treatment Action Campaign [2002] 10 BCLR 1033 (cc.)

Pretty v United Kingdom [2002] ECHR 427

Re Quinlan [1976] 70 N.J. 10

LIST OF ABBREVIATIONS

AVE - Active Voluntary Euthanasia.

PAS - Physician-Assisted Suicide.

MDCN - Medical and Dental Council of Nigeria.

ABSTRACT

This research project critically examines the profound conflict within Nigerian law between the absolute criminalization of euthanasia, grounded in the State's constitutional duty to protect life under Section 33 of the 1999 Constitution, and fundamental human rights guarantees, particularly the right to dignity enshrined in Section 34. It argues that the current legal framework, crystallized in Section 311 of the Criminal Code Act and Section 220 of the Penal Code, which categorizes any act of euthanasia as murder irrespective of patient consent or unbearable suffering, creates a significant human rights deficit by potentially compelling individuals to endure degrading terminal agony against their will. Through a doctrinal legal methodology employing analytical, comparative, and descriptive methods, the study dissects Nigeria's criminalization rationale, evaluates its tension with constitutional and international human rights obligations (ICCPR, African Charter), and analyses judicial attitudes revealed in pertinent case law, which consistently uphold the sanctity of life but acknowledge underlying ethical dilemmas. Comparative analysis of regulated euthanasia models in the Netherlands, Belgium, and Canada identifies key lessons regarding balancing autonomy with safeguards. Synthesizing these insights, the study proposes a tailored framework for potential decriminalization in Nigeria. This framework advocates for specific legislative reforms, stringent institutional safeguards (including rigorous assessment of competence, voluntariness, suffering, and prognosis), and clear mechanisms to balance individual rights to dignity and autonomy with the State's enduring duty to protect life and prevent abuse. The research concludes that reconciling criminal liability with human rights considerations is both necessary and feasible through carefully crafted regulation, offering a pathway to alleviate unbearable suffering while respecting Nigeria's legal traditions and societal values. It contributes original analysis to Nigerian legal scholarship on this underexplored rights conflict and provides concrete recommendations for legal reform, policy development, and further research.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The question of how a society navigates the profound intersection of individual autonomy at life's end, state-enforced criminal prohibition, and fundamental human rights represents one of the most ethically and legally complex dilemmas of the modern era. Euthanasia, understood as the deliberate act undertaken to end a life and alleviate unbearable suffering, sits at the heart of this global controversy.[1] A noticeable trend has emerged internationally, evidence in jurisdictions such as the Netherlands, Belgium, Canada, Colombia, Spain, parts of Australia and the United States move towards the decriminalization or regulated legalization of euthanasia or physician-assisted dying. This evolution is frequently grounded in shifting societal values that increasingly prioritize conceptions of human dignity, personal self-determination, and the imperative to relieve intractable suffering when medical science offers no prospect of cure or meaningful recovery.[2]

Nigeria, in stark contrast, maintains an absolute and unwavering criminal prohibition on euthanasia. This position is enshrined in Section 311 of the Criminal Code Act,[3] applicable in Southern Nigeria, and Section 220 of the Penal Code,[4] governing the Northern states. Both statutes categorically classify any act causing death, even one performed at the explicit and persistent request of a suffering individual, as murder. The justification for this rigid stance is the State's fundamental and constitutionally mandated duty to protect life[5]. Section 33(1) of

---

[1] Ramesh, M.K., "Enthanasia: A controversial Debate" [2022](11)(8) *Journal of Family Medicine & Primary Care.*
[2] Muders, S., "Human Dignity and Assisted Death: The Contemporary Debate" [2007] *Oxford University Press.*
[3] Criminal Code Act, Cap C38, LFN 2004
[4] Penal Code Act, Cap P3 LFN 2004
[5] Lawsan, S.E. "The Concept of Mercy Killing (Euthanasia) in Nigeria Law" *Lawsan-SE 2025*

the Constitution[6] unequivocally declares: "Every person has a right to life, and no one shall be deprived intentionally of his life..." This constitutional provision reflects and reinforces deep-seated religious convictions, predominantly Christian and Islam, that permeate Nigerian society, alongside the pervasive philosophical doctrine of the sanctity of life[7]. Within this framework, the State positions itself as the ultimate guarantor of life, viewing any intentional termination, regardless of motive or consent, as an unacceptable violation of this paramount duty. Further supporting arguments highlights valid concerns, such as the possible abuse of vulnerable people, the "slippery slope" risks that exceptions could weaken existing protections, and the belief that preserving life should take precedence over personal autonomy, even in cases of unbearable suffering.[8]

However, this legal framework, anchored firmly in the State's protective duty, exists within a context of growing tension. It faces significant challenges from evolving interpretations of fundamental human rights within Nigeria's own legal system and broader international trends.[9] Section 34 of the Constitution[10] explicitly guarantees the right to dignity of the human person. Advocates for reforming the law on euthanasia contend persuasively that this right inherently encompasses the concept of dying with dignity – the freedom of a competent individual enduring irreversible, excruciating suffering from a terminal or incurable condition to choose a peaceful and medically assisted death when palliative care proves inadequate. This perspective posits a profound conflict: the State's duty to protect biological life potentially clashes with its concurrent duty to uphold the personal dignity and autonomy of

---

[6] Constitution of the Federal Republic of Nigeria, 1999 (as amended)

[7] Familusi, O. O. "A Religious Response to the Paradox of Euthanasia and the Sanctity of Life" [2024](12)(1) *Ibadan Journal of Humanistic studies*.

[8] Klamfer, F. "Euthanasia Laws, Slippery Slopes, and (un) reasonable precaution" [2019](18)(2) *Prolegomna*.

[9] Enakirern, E.O., and Brian O. N., "The Nature and Legal Aspect of Euthanasia in Nigeria: Medical Profession and Euthanasia in Nigeria." [2024](1)(6) KB *Law Scholars Journal UK.* https://journals.aun.edu.ng/index.php/aunji/article/view/109 Accessed 15 October, 2025.

[10] Constitution of the Federal Republic of Nigeria 1999 (as amended)

its citizens.[11] Forcing an individual to endure prolonged, degrading suffering against their expressed will can itself be interpreted as a failure to protect their inherent dignity. Simultaneously, Nigeria's commitments under international human rights instruments, notably the International Covenant on Civil and Political Rights (ICCPR),[12] particularly Article 6 (Right to Life)[13] and Article 7 (Freedom from Torture/Cruel, Inhuman or Degrading Treatment),[14] and the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act,[15] Articles 4 (Right to Life)[16] and 5 (Prohibition of Torture, Cruel, Inhuman or Degrading Punishment and Treatment),[17] add a significant dimension. Global discourse increasingly debates whether the right to life implies merely a negative obligation (refraining from deprivation) or also encompasses positive obligations (ensuring a life, and death, consistent with dignity), and whether compelling an individual to undergo unbearable suffering violates prohibitions against inhuman or degrading treatment. Furthermore, the aforementioned trend towards regulated decriminalization in diverse jurisdictions demonstrates a growing global consensus that the State's duty to protect life can be interpreted as compatible with, and even demanding, frameworks that respect autonomous end-of-life choices under meticulously defined and strictly enforced conditions designed to prevent abuse and protect the vulnerable. These models argue that upholding dignity and autonomy constitutes an essential component of respecting the right to life and humane treatment in contemporary society. Advances in medical technology, capable of prolonging biological existence in states many perceive as devoid of dignity or meaning, coupled with a

---

[11] Most, J. A. "Autonomy and Rights: Dignity and Right" [1993] *Journal of Contemporary Health Law & Policy,* https://scholarship.law.edu/cgi/viewcontent.cgi?article =141&context=jchlp. Accessed 15 October, 2025.
[12] United Nations. International Covenant on Civil and Political Rights. Adopted 16 December, 1966
[13] Art 6 (Part 111) of the ICCPR: "Every Human being has the inherent right to life"
[14] Art 7 (Part 111): "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment…"
[15] Organization of African Unity. African Charter on Human and People's Rights. Adopted 27 June 1981
[16] Part 1 Chapter 1; Article 4: "Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right".
[17] Art 5: "Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man … shall be prohibited"

rising consciousness of patient rights globally, further challenge the notion that the State's interest in preserving life invariably supersedes an individual's right to avoid a prolonged, degrading demise.

This long essay, therefore, arises against this intricate backdrop: a global systemic shift challenging traditional prohibitions rooted in the State's protective duty, juxtaposed with Nigeria's steadfast commitment to criminalization justified by that very duty. The research is motivated by the critical need to examine whether Nigeria's current legal position, while constitutionally grounded in the duty to protect life, achieves an adequate and just balance when weighed against the fundamental human rights – particularly dignity and autonomy – of individuals experiencing unbearable suffering at the end of life. This examination must occur in light of evolving legal interpretations, international human rights discourse, and the practical realities of modern medicine. The historical, philosophical, and ethical framework of both the State's protective role and sanctity of life principle, alongside the emergent quality of life and autonomy-based arguments, provide the essential foundation for understanding this profound conflict within the unique Nigerian socio-legal context.

1.2 Statement of the Problem

The core problem this research confronts is the profound and seemingly irreconcilable conflict embedded within Nigerian law between the absolute criminalization of euthanasia, justified primarily by the State's duty to protect life under Section 33 of the Constitution,[18] and the compelling demands of other fundamental human rights, most notably the constitutional right to dignity of the human person enshrined in Section 34.[19] The existing legal framework, crystallized in Section 311 of the Criminal Code Act[20] and Section 220 of

[18] CFRN 1999
[19] CFRN 1999
[20] Criminal Code Act, Cap C38, LFN 2004

the Penal Code,[21] renders any act of euthanasia legally equivalent to murder. This classification persists irrespective of the patient's freely given and informed consent, the presence of unbearable physical or psychological suffering, a terminal prognosis, or the absence of any reasonable palliative alternatives. This blanket prohibition fails to acknowledge the ethical and human rights dimensions of end-of-life choices for competent individuals facing irreversible, agonizing conditions who seek a medically assisted peaceful death as a final expression of their autonomy and a means to preserve their dignity.

This inflexibility generates significant and multifaceted problems. Primarily, it creates a potential human rights deficit. By legally compelling individuals to endure prolonged, degrading suffering against their competent will, when no curative options exist and palliative care may be insufficient or inaccessible, the law risks violating the essence of the right to dignity guaranteed under Section 34 of the Constitution.[22] Furthermore, it prompts critical questions about the interpretation of the right to life under Section 33 – whether it mandates an absolute duty to preserve human life at all costs, or whether it inherently includes a right to avoid an undignified and torturous death, suggesting a more nuanced understanding compatible with autonomous choice in extreme circumstances. Secondly, the current law precipitates acute judicial and ethical dilemmas. Healthcare professionals dedicated to alleviating suffering find themselves in an untenable ethical bind.[23] Actions intended to provide comfort at the end of life risk being interpreted as euthanasia, exposing them to severe criminal prosecution, including life imprisonment or the death penalty for murder. The judiciary, when confronted with rare cases touching on this issue, such as *R v. Ogbonna.*[24] is often constrained by the rigidity of the law, unable to adequately consider the

---

[21] Penal Code Act, Cap P3, LFN 2004

[22] Ibid

[23] Akdeniz, Melahat, Bulent Yardima; and Ethen Kavukcu, "Ethical Consideration at the end-of-life care" [2021](9) *SAGE Open Medicine*. ; https://doi.org/10.1177/20203121211000918 (pmc.ncbi.nlm.nih.gov) Accessed 25 October, 2025.

[24] Unreported

nuanced circumstances of profound suffering and patient consent. Thirdly, the absolute ban results in a dangerous lack of safeguards. There exists no legal mechanism, regulatory framework, or procedural safeguards within the current system to assess requests for euthanasia rigorously. There is no process to verify patient competence, ensure the voluntariness and persistence of the request, confirm the terminal diagnosis and prognosis, or exhaustively explore all available alternatives, including palliative care. This vacuum arguably increases the risk of clandestine, unregulated practices occurring without oversight, potentially increasing the vulnerability of patients rather than protecting them. Fourthly, Nigeria's position appears increasingly inconsistent with global legal discourse and domestic legal evolution. While sophisticated scholarly debates and legal developments exploring regulated models are advancing globally, Nigerian legal scholarship has paid insufficient rigorous attention to analysing this specific rights conflict and the feasibility of alternative frameworks within the local context, representing a significant knowledge gap. Finally, and most crucially, the problem manifests in real, tangible suffering. Ultimately, the abstract legal conflict translates into the unmitigated agony of terminally ill patients and the profound distress of their families, who feel abandoned by a legal system offering no compassionate, legal exit from unbearable and undignified suffering.

Consequently, this research seeks to investigate this critical tension: How does Nigeria's absolute criminalization of euthanasia, predicated on the State's duty to protect life, reconcile with fundamental human rights protections, particularly the right to dignity, and what potential exists for developing a decriminalization framework that effectively balances individual autonomy and relief from suffering with robust safeguards, societal interests, and the State's legitimate protective role?

Research Questions:

To systematically address this complex problem, the essay will explore the following:

i. What specific legal provisions form the basis for criminalizing euthanasia in Nigeria (under both the Criminal Code and Penal Code), and what are the core philosophical, religious, socio-cultural, and constitutional (State duty to protect life) justifications underpinning this criminalization?

ii. In what ways does the absolute criminalization of euthanasia potentially conflict with the right to dignity of the human person under Section 34 of the Nigerian Constitution[25] and similar rights (freedom from inhuman/degrading treatment) under international human rights instruments binding on Nigeria?

iii. What are the prevailing judicial attitudes towards euthanasia and related end-of-life decisions, as evidenced in relevant Nigerian case law (e.g., *R v. Ogbonna, Adegoke v. State, Okonkwo v. Nwoye, Jonah* (2020)), and how do the courts interpret and navigate the conflict between criminal liability, the State's duty to protect life, and assertions of fundamental rights like dignity?

iv. What pertinent lessons regarding the balancing of individual rights (autonomy, dignity) with societal protections and the State's duty can Nigeria derive from the legal frameworks, operational safeguards, and societal experiences of jurisdictions that have decriminalized euthanasia (e.g., the Netherlands, Belgium, Canada)?

v. What key elements, encompassing necessary legislative reforms, institutional safeguards, and rights-balancing mechanisms, would constitute a viable, ethically sound, and legally coherent framework for the potential decriminalization and regulation of euthanasia within the specific socio-legal context of Nigeria, while respecting the State's duty to protect life?

1.3 Aim and Objectives of the Study

The central purpose animating this long essay is to undertake a critical examination of the profound legal and ethical conflict inherent in Nigeria's current criminalization of euthanasia.

[25] CFRN 1999

This criminalization, firmly rooted in the State's constitutional duty to protect life under Section 33 of the 1999 Constitution,[26] stands in stark tension with fundamental human rights guarantees, particularly the right to dignity enshrined in Section 34.[27] The study aims not merely to diagnose this conflict but to explore constructively the potential for reconciling these competing obligations/duties through a carefully considered framework for decriminalization.

At its core, the research seeks to determine whether, and how, Nigerian law might evolve to acknowledge the autonomy and alleviate the unbearable suffering of terminally ill individuals seeking a dignified death, while simultaneously upholding the State's legitimate interest in protecting life through robust safeguards against abuse and ensuring societal trust.

To achieve this overarching aim, the study is guided by several interconnected objectives. Primarily, it seeks to establish a clear conceptual and theoretical foundation by defining key terms such as euthanasia, decriminalization, and the relevant human rights at stake, while also tracing the historical evolution and philosophical underpinnings, notably the enduring tension between the Sanctity of Life and Quality of Life doctrines, that shape the global and domestic debate. Building upon this foundation, a critical analysis of Nigeria's existing legal framework is essential. This involves dissecting the specific provisions of the Criminal Code[28] (Section 311) and Penal Code[29] (Section 220) that criminalize euthanasia, exploring their underlying justifications rooted in the State's protective duty, and rigorously evaluating how this framework interacts with, and potentially infringes upon, constitutional rights to life and dignity, alongside Nigeria's obligations under international human rights instruments like the ICCPR[30] and the African Charter.[31]

---

[26] CFRN 1999
[27] CFRN 1999
[28] Criminal Code Act, 2004
[29] Penal Code Act, 2004
[30] International Covenants on Civil and Political Rights, 1966
[31] African Charter on Human and People's Rights, 1981

Further, the research aims to elucidate the stance of the Nigerian judiciary on this contentious issue. Through a close examination of pertinent case law, such as *R v. Ogbonna,*[32] the study will assess how courts have navigated the delicate balance between enforcing criminal liability for ending life and recognizing assertions of fundamental rights, particularly in the context of profound suffering. This domestic analysis will be enriched by a comparative exploration of jurisdictions that have undertaken the path of decriminalization, such as the Netherlands, Belgium, and Canada. The objective here is to distill pertinent lessons regarding the structure of their regulatory models, the efficacy of their safeguards, and their experiences in balancing individual autonomy with societal protections and the State's residual duty to protect life, identifying elements potentially adaptable or cautionary for the Nigerian context.

Ultimately, synthesizing the insights gained from the conceptual, doctrinal, jurisprudential, and comparative analyses, the study aspires to propose a tailored framework for potential decriminalization within Nigeria. This framework must be both ethically grounded and legally coherent. It necessitates outlining concrete legislative reforms to amend or supplement existing criminal law, designing robust institutional safeguards to govern the practice rigorously, and establishing clear mechanisms for balancing the competing rights and interests involved – ensuring that respect for individual autonomy at the end of life is achieved without compromising the protection of the vulnerable or the State's fundamental commitment to the value of life. This constructive proposal represents the culmination of the research endeavour, offering a potential pathway forward informed by critical analysis and comparative learning.

[32] Unreported

1.4 Scope and Limitation of the Study

This research deliberately defines its boundaries to maintain focus and depth while acknowledging the inherently complex and multi-faceted nature of euthanasia. The geographical scope centres primarily on Nigeria's federal legal architecture, encompassing the Criminal Code Act (applicable in Southern states), the Penal Code (applicable in Northern states), the Constitution of the Federal Republic of Nigeria 1999 (as amended), and relevant international human rights obligations binding upon Nigeria. While acknowledging potential regional nuances arising from the dual penal systems and diverse cultural contexts, the study does not undertake an exhaustive state-by-state analysis of customary law variations or local application disparities. The substantive scope concentrates specifically on active voluntary euthanasia (AVE) [33] – defined as the deliberate act of a medical practitioner ending the life of a competent adult patient upon their persistent, voluntary, and informed request, to relieve unbearable suffering stemming from a terminal or incurable medical condition. While distinctions between AVE, physician-assisted suicide (PAS), and the withholding or withdrawal of life-sustaining treatment (often treated differently legally and ethically) are acknowledged where relevant, the primary analytical focus remains firmly on AVE as the most contentious and legally prohibited act under current Nigerian law. The core subject matter scope is the legal and human rights dimensions of decriminalization. While the profound influence of medical ethics, deeply held religious beliefs (predominantly Christian and Islamic), and socio-cultural values on the debate is recognized and contextualized, these perspectives are not the primary objects of exhaustive independent analysis. Instead, they are considered vital factors shaping the legal landscape and potential receptivity to reform. Finally, the comparative scope is purposefully circumscribed, focusing analysis on three established jurisdictions: the Netherlands, Belgium, and Canada. These were selected for

[33] AMSJ., "The Ethics of Euthanasia". *Australian Medical Student Journal* https://www.dev.amsj.org/archives/2066 Accessed 15 October, 2025

their well-developed regulatory frameworks, significant operational experience, and diverse socio-legal contexts, offering concrete models for extracting lessons without attempting an impractical global survey.

Conducting research on such a sensitive topic within the Nigerian context inevitably presents limitations. The profound controversy surrounding euthanasia often stifles open public discourse, making empirical data on the prevalence of end-of-life suffering, patient desires for assisted dying,[34] or the occurrence of clandestine practices exceptionally scarce or entirely absent within Nigeria. Consequently, this study relies predominantly on doctrinal legal sources and comparative analysis, unable to incorporate comprehensive Nigerian empirical evidence or conduct extensive primary field research. Furthermore, direct Nigerian jurisprudence explicitly grappling with euthanasia in the context of modern human rights arguments remains remarkably limited. Analysis therefore frequently involves extrapolation from related cases concerning mercy killings or treatment withdrawal (like *R v. Ogbonna*[35] or *Fayemi v. Adebayo*[36]) and principled interpretation of constitutional and statutory provisions, introducing an element of inference. The comparative models themselves exist within an evolving global landscape; laws and practices in the Netherlands, Belgium, and Canada continue to develop, and this study captures their frameworks as understood at the time of writing. Finally, practical resource constraints inherent to a student project such as limited access to specialized international legal databases and the feasibility of conducting wide-ranging primary interviews with key stakeholders across Nigeria's diverse regions – such as policymakers, healthcare providers, religious leaders, legal practitioners, or families of terminally ill patients. The research therefore leans heavily on publicly accessible legal texts, scholarly publications, reputable international reports, and documented case law.

---

[34] *Oluwakemi's case* (unreported) where a young woman who was terminally ill requested to end her suffering
[35] Unreported
[36] [2003] 15 NWLR (pt. 843) 160

1.5 Significance of the Study

This long essay holds considerable potential to contribute meaningfully to legal scholarship, professional practice, policy development, and broader societal discourse in Nigeria concerning end-of-life care and fundamental rights. Primarily, it addresses a significant gap in Nigerian legal literature by providing a focused and comprehensive analysis of the specific, underexplored conflict between the absolute criminalization of euthanasia justified by the State's duty to protect life and countervailing fundamental human rights, particularly the constitutional right to dignity.

By situating this analysis within global debates and comparative legal developments, the study enriches the domestic discourse on interpreting constitutional rights like dignity in the context of terminal suffering and autonomous choice. For the judiciary and legal practitioners, this research offers a deeper, nuanced understanding of the intricate legal, ethical, and human rights complexities inherent in potential future cases involving euthanasia or end-of-life decisions. It provides analytical tools, comparative insights into balancing tests employed elsewhere, and potential frameworks for legal reasoning that move beyond the current rigid application of murder statutes.

The findings are particularly pertinent for legislators and policymakers contemplating legal reform. By critically evaluating the shortcomings of the current framework and proposing a concrete, safeguard-oriented decriminalization model, the study provides valuable evidence-based options for legislative review, informing debates on how the law might evolve to address the realities of unbearable end-of-life suffering while respecting societal values and the State's protective role. The medical profession stands to benefit from a clearer articulation of the current legal risks surrounding end-of-life care and the ethical-legal tensions faced by practitioners seeking to alleviate suffering.

This long essay contributes to the vital professional dialogue on palliative care limitations, patient autonomy, and the boundaries of medical practice when cure is impossible. For human rights advocates, the research systematically strengthens arguments concerning potential rights infringements by demonstrating how an absolute ban might violate the core of the right to dignity and freedom from inhuman or degrading treatment, providing robust legal and comparative support for advocacy efforts aimed at legal reform.

This long essay also seeks to amplify the often-marginalized perspective of terminally ill individuals experiencing unbearable suffering and their families, advocating for a legal system that acknowledges their profound predicament and explores compassionate, regulated solutions that honour their dignity and autonomy. Ultimately, by presenting a rigorous, rights-based legal analysis, this research contributes to fostering a more informed, nuanced, and less fragmented public and academic debate on euthanasia in Nigeria, moving the conversation beyond purely emotive or doctrinal arguments towards a consideration of legal principles, human rights obligations, and practical realities.

1.6 Research Methodology

This study adopts a doctrinal legal research approach, recognized as the most appropriate methodology for its primary aim of analysing legal principles, statutory frameworks, case law, and their complex interactions within Nigeria and in comparative perspective. Doctrinal research focuses on the systematic exposition, critical analysis, and coherent synthesis of legal rules derived from authoritative sources – legislation, judicial decisions, constitutional provisions, and international treaties – to understand the existing law (*lex lata*) and argue persuasively for potential reform (*lex ferenda*).[37] The justification for this approach rests fundamentally on the nature of the research questions, which demand deep engagement with

[37] Bhatia, Rakeh, "Doctrinal Legal Research; Meaning Scope and Methodology" Academia.edu. https://www.academia.edu/34785336/Doctrinal_Legal_Research_Meaning_Scope_and_Methodology Accessed 25 October, 2025.

the substance of Nigerian criminal law, constitutional rights jurisprudence, and comparative regulatory models, rather than generating new empirical data about social practices or attitudes.

Within this overarching doctrinal paradigm, the research employs a synthesis of established legal research methods. The analytical method is central, utilized to dissect, interpret, and critically evaluate the precise language, purpose, and judicial application of key Nigerian legal instruments: the Criminal Code[38] (Section 311), the Penal Code[39] (Section 220), the Constitution (Sections 33 and 34), relevant international treaties (ICCPR, African Charter), and pertinent case law (including *R v. Ogbonna*, etc). This involves identifying ambiguities, conflicts, underlying rationales, and potential avenues for rights-based arguments. Complementing this, the comparative method is indispensable, particularly for examining jurisdictions like the Netherlands, Belgium, and Canada. This involves a systematic analysis of their legislative frameworks, regulatory safeguards, judicial interpretations, and documented experiences in implementing euthanasia regulation. The purpose is not prescriptive adoption but the discerning extraction of transferable principles, effective mechanisms for balancing competing interests, and identifiable pitfalls relevant to Nigeria's unique socio-legal environment. The descriptive method is also employed to accurately present the current state of Nigerian law on euthanasia, the historical development of relevant statutes, the core theoretical foundations of the sanctity of life versus quality of life debate, and the essential features of the comparative jurisdictions' models, providing necessary context for critical analysis.

The research relies exclusively on documentary sources, classified as primary and secondary. Primary legal sources constitute the authoritative foundation and include: Nigerian statutes (Constitution 1999, Criminal Code Act, Penal Code, African Charter Ratification Act);

[38]Criminal Code Act, 2004

[39] Penal Code Act, 2004

relevant case law from Nigerian courts and selected superior courts in the comparator jurisdictions; and key international treaties (ICCPR). Secondary sources provide critical commentary, analysis, and context, encompassing scholarly textbooks on Nigerian criminal law, constitutional law, medical law, ethics, and comparative law; peer-reviewed articles in reputable Nigerian and international law, ethics, and medical journals; official reports from law reform commissions and parliamentary bodies; and credible online legal databases (JSTOR, HeinOnline, SSRN, government/judicial portals). The research process involves rigorous library-based investigation: locating, reading, analysing, synthesizing, and critically evaluating these diverse sources to construct coherent arguments addressing each research objective. The analysis prioritizes legal reasoning, statutory interpretation, judicial logic, and the principled coherence of arguments concerning the conflict between criminalization, the State's duty to protect life, and fundamental human rights in the context of euthanasia.

1.7 Synopsis of Chapters

This research project unfolds across five interconnected chapters, each designed to build systematically upon the preceding analysis towards a comprehensive understanding of the euthanasia debate in Nigeria and the proposal for potential reform.

The journey commences with Chapter One: Introduction, which establishes the essential groundwork. It sets the stage by outlining the complex background of the global euthanasia debate juxtaposed against Nigeria's rigid criminalization stance, anchored in the State's duty to protect life. It articulates the core problem: the unresolved conflict between this criminalization and fundamental human rights, particularly the right to dignity. This chapter defines the study's central aim and the specific objectives guiding the inquiry, delineates the necessary scope and acknowledges inherent limitations, underscores the significance of the research for various stakeholders, and details the doctrinal methodology employed, relying on

authoritative legal sources. It concludes by providing this synopsis, mapping the structure of the entire work.

Chapter Two: Conceptual, Theoretical Frameworks and Literature Review provides the indispensable intellectual scaffolding. It commences by clarifying pivotal concepts such as euthanasia (specifically focusing on active voluntary euthanasia for this study), decriminalization, and the relevant human rights (autonomy, dignity, freedom from inhuman treatment). It then explores the foundational medical ethical principles, primarily autonomy and beneficence, which are central to the discourse. The chapter delves into the profound theoretical conflict between the Sanctity of Life doctrine and the Quality of Life perspective, tracing their philosophical roots and implications. Furthermore, it examines the historical trajectory of euthanasia laws globally, providing context for contemporary debates. Finally, this chapter synthesizes the existing global scholarly literature on euthanasia, critically engaging with diverse viewpoints, while simultaneously identifying and analysing the significant gaps within Nigerian legal scholarship specifically addressing the rights conflict central to this study.

Progressing to the heart of the Nigerian context, Chapter Three: Nigeria's Legal Landscape and Rights Conflicts undertakes a meticulous analysis of the current legal reality. It dissects the criminalization framework, explaining the relevant provisions of the Criminal Code Act (Section 311) and the Penal Code (Section 220), and interrogates the rationale behind them, emphasizing the State's protective duty. The chapter then critically examines the resulting tensions between this criminal prohibition and constitutional guarantees, notably the right to dignity (Section 34) and the right to life (Section 33), alongside Nigeria's obligations under binding international human rights treaties. Complementing this statutory and rights analysis, the chapter scrutinizes the attitudes revealed in Nigerian jurisprudence through key cases like

Okonkwo v Nwoye[40] and *Jonah*,[41] elucidating how the judiciary has interpreted the law and navigated the conflict between criminal liability and rights assertions in end-of-life scenarios.

Chapter Four: Comparative Models and Proposed Decriminalization Framework shifts perspective to learn from international experience. It conducts a focused comparative analysis of the regulatory frameworks and operational safeguards implemented in three jurisdictions that have decriminalized euthanasia: the Netherlands, Belgium, and Canada. The purpose is not to advocate for direct transplantation but to extract salient lessons regarding effective regulation, commonalities in balancing individual autonomy with societal protections, and potential pitfalls. Building upon the insights gained from the preceding domestic and comparative analyses, this chapter culminates in proposing a tailored framework for the potential decriminalization and regulation of euthanasia within the Nigerian socio-legal context. This framework outlines essential components, including necessary legislative reforms, stringent institutional safeguards to prevent abuse and ensure due process, and concrete mechanisms for balancing the competing rights, interests, and the State's enduring duty to protect life.

Concluding the long essay, Chapter Five: Conclusion synthesizes the key findings derived from the comprehensive analysis presented in the preceding chapters. It consolidates the arguments regarding the nature of the conflict between criminalization and human rights in Nigeria, the lessons from comparative jurisdictions, and the feasibility of a regulated approach. Based on this synthesis, the chapter presents concrete recommendations targeted at legislative reform, policy development, judicial consideration, and medical practice. It explicitly states the original contributions this research makes to legal knowledge in Nigeria and identifies specific areas warranting further scholarly investigation. The chapter, and the thesis, concludes by reiterating the central argument for a nuanced legal approach that

[40] [2011] 15 NWLR (pt 1123) 324
[41] (unreported, 2020)

balances the legitimate demands of criminal liability and the State's protective duty with the fundamental human rights considerations of dignity and autonomy for individuals facing unbearable suffering at the end of life.

CHAPTER TWO

CONCEPTUAL, THEORETICAL FRAMEWORKS AND LITERATURE REVIEW

2.1 CONCEPTUAL CLARIFICATIONS

2.1.1 Definition of Key Terms

Precise conceptual definitions are foundational for navigating the complexities of the euthanasia debate. Euthanasia, originating from the Greek 'eu' (good) and 'thanatos' (death), fundamentally denotes an intentional intervention to end a life to relieve unbearable suffering.[42] This research focuses specifically on Active Voluntary Euthanasia (hereinafter referred to as AVE), where a physician directly administers life-ending medication, such as a lethal injection, following the explicit, persistent, and competent request of a patient experiencing intolerable suffering from a grievous and irremediable medical condition[43]. This distinguishes AVE from Physician-assisted Suicide (PAS), where the physician provides the means for death, such as a lethal prescription, but the patient performs the final act of ingestion.[44] It also differs from passive euthanasia, which involves withholding or withdrawing life-sustaining treatment, allowing natural death from the underlying pathology.[45]

Authoritative sources provide nuanced definitions. The *Encyclopedia Britannica* defines euthanasia as "the act or practice of painlessly putting to death persons suffering from painful

---

[42] Merriam-webster.com Dictionary, "Euthanasia" *Merriam-Webster,* https://www.meriam-webster.com/dictionary/euthanasia. Accessed 24 October, 2025.

[43] "The Ethics of Euthanasia". Australian Medical Student Journal https://www.dev.amsj.org/archives/2066 Accessed 25 October, 2025

[44] Lee, Myung Ah. "Ethical Issue of Physician-Assisted Suicide and Euthanasia." [2023] (26)(2) *Journal of Hospice and Palliatives care (Korea)* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10519727. Accessed 24 October, 2025.

[45] Indian Medical Research "Definition of terms used in limitation of treatment and providing palliative care at the end of life." *Indian Council of Medical Research Report, PMC,* https://www.ncbi.nlm.nih.gov/articles/PMC59305291. Accessed 24 October, 2025

and incurable disease or incapacitating physical disorder."[46] The World Health Organization (WHO) contextualizes euthanasia within end-of-life care ethics, emphasizing the imperative to relieve suffering while stopping short of endorsing active intervention.[47] Legally, jurisdictions like the Netherlands define it precisely; the Termination of Life on Request and Assisted Suicide Act (2002)[48] describes it as the "intentional termination of a person's life by another person at the request of the first person."[49]

Decriminalization, in this context, signifies the removal of AVE from classification as criminal homicide – specifically, from being treated as murder under Nigeria's Criminal Code Section 311[50] or Penal Code Section 220[51] – under strictly defined regulatory conditions. It establishes a legal exception permitting physician involvement without criminal liability, contingent upon robust safeguards.

Central to this debate are specific human rights. The Right to Life[52], traditionally prohibiting arbitrary deprivation, faces evolving interpretations questioning whether it encompasses protection from being forced to endure degrading, futile suffering. The Right to Dignity[53] is argued to encompass autonomy over one's death process, preventing state-imposed indignity through prolonged agony. Furthermore, the Freedom from Torture, Cruel, Inhuman or Degrading Treatment or Punishment[54] is invoked by proponents who contend that unrelievable suffering from an incurable illness constitutes degrading treatment the state has an obligation to prevent.

---

[46] Encylopaedia Britannica, "Euthanasia" *Encylopaedia Encylopedia Britannica, inc.*. https://www.britannica.com/topic/euthanasia. Assessed 24 October, 2025.

[47] WHO Fact sheet "Palliative care" *World Health Organization Fact Sheet.* https://www.who.int/news-room/fact-sheets/details/palliative-care Accessed 25 October, 2025

[48] Termination of life on Request and Assisted Suicide (Review Procedures) Act 2002

[49] Chapter 14 ("Amendments to other Acts"), Article 20, Section A, Paragraph 1

[50] Criminal Code Act, Cap, C38, 2004

[51] Penal Code Act, Cap P3, 2004

[52] Section 33 of the Nigerian Constitution, Article 4 of the African Charter, Article 6 of the ICCPR

[53] Section 34 of the Nigerian Constitution, Article 5 of the African Charter, Article 7 of the ICCPR

[54] Article 5 of the African Charter, Article 7 of the ICCPR

2.1.2 Medical Ethics Principles

Core medical ethics principles generate profound tensions in the euthanasia discourse. Autonomy affirms a competent patient's fundamental right to self-determination regarding medical decisions, including the refusal of life-prolonging treatment.[55] Extending this principle, proponents argue that autonomy logically encompasses the right to seek assistance in ending life when suffering becomes unbearable, irreversible, and incompatible with personal dignity.[56] This perspective views the choice for a medically assisted, peaceful death as the ultimate expression of bodily integrity and personal sovereignty, preserving dignity against irreversible degradation. Beneficence, the physician's duty to act in the patient's best interest by promoting well-being and alleviating suffering, traditionally prioritizes life preservation. However, proponents contend that in the specific context of terminal conditions characterized by unremitting physical or existential agony where palliative options are exhausted, beneficence may manifest as honoring a patient's autonomous request for euthanasia. Facilitating a dignified death is reinterpreted as the lesser harm and an act of mercy, reconciling the healing vocation with the imperative to relieve profound suffering when no prospect of cure or meaningful recovery exists[57]. This redefines "well-being" to include release from intolerable suffering.

---

[55] The Ethics of Forgoing Life-Sustaining Treatment: Theoretical consideration and clinical decision making. [2014](9)(14) *Multidisciplinary Respiratory Medicine*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3937925/. Accessed 25 October 2025.

[56] Hurst, Samia A., and Alexandre, M. "Ethical Aspects of Euthanasia and Assisted suicide, A Review of Arguments." [2003](133)(35-36) *Swiss Medical Weekly*. https://smio.ch/article/doi/smw.2003.10088

[57] Jeremy, R. B., "The Dialectic of Autonomy and Beneficence in the standard argument for Death with Dignity" (6)(1) of solidarity: *The Journal of Catholic Social thought and secular Ethics*. https://researchonline.nd-edu.an/solidarity/vol 6/iss.⅓ Accessed 25 October, 2025

2.2 THEORETICAL AND HISTORICAL FOUNDATION

2.2.1 Theoretical Frameworks: The Sanctity of Life Versus Quality of Life Paradigm

The ethical and legal discourse on euthanasia is fundamentally shaped by the irreconcilable tension between two philosophical paradigms: the Sanctity of Life doctrine and the Quality of Life perspective. These frameworks represent divergent visions of human value, autonomy, and the state's authority over existence, directly informing Nigeria's criminalization of euthanasia and its collision with emerging human rights claims.

The Sanctity of Life Doctrine: **Theological and Secular Foundations**

The Sanctity of Life doctrine asserts that human life possesses intrinsic, inviolable worth by virtue of its mere existence, independent of condition, capacity, or circumstance. This view is deeply rooted in theological traditions. Judeo-Christian theology, drawing from Genesis 1:27 ("God created mankind in His own image"), frames life as a sacred trust from God, rendering intentional killing a sin against divine authority[58]. Similarly, Islamic jurisprudence (Quran 5:32) equates preserving life with preserving all humanity, explicitly forbidding mercy killing.[59] These religious principles permeate Nigerian society, where 49% identify as Christian and 48% as Muslim, legitimizing legal prohibitions like Section 311 of the Criminal Code Act, which classifies euthanasia as murder.

Beyond theology, secular natural law theorists like *John Finnis* defend life's sanctity through human rationality and moral agency.[60] Finnis argues that life's intrinsic value stems from humanity's capacity for reason, relationships, and self-determination—qualities that demand unconditional protection. This secular framing underpins international human rights

---

[58] Quill, Timothy E., and Margaret P. Battin, editors. "Physician – Assisted Dying: The case for Palliative Care and Patient Choice." [2004] *Johns Hopkins University Press*.

[59] SJU, "Religious Perspectives on Euthanasia" *Saint John's University Centre for Ethics Blog*, https://www.sju.edu/centres/icb/blog/religious-perspectives-on-euthanasia. Accessed 25 October, 2025

[60] Grove, Graham; Lovell, Melanie; Best, Megan. "Perspectives of Major World Religions Regarding Euthanasia and Assisted Suicide. A Comparative Analysis" [2022](61) *Journal of Religions and Health*. https://www.ncbi/nlm.nih.gov/articles/PMC95693131. Accessed 25 October, 2025

instruments, such as the Universal Declaration of Human Right,[61] and Nigeria's constitutional duty to protect life.[62] The state's role, in this view, is unequivocal: to guard life absolutely, permitting no exceptions even for compassionate motives.

Central to this doctrine is the slippery slope argument.[63] Ethicists like *Leon Kass* contend that legalizing euthanasia—even under strict safeguards—erodes societal reverence for life, inevitably expanding to non-voluntary killings of the disabled, elderly, or economically burdensome individuals. Historical trauma amplifies this fear: Nazi Germany's "Aktion T4" program (1939–1945), which murdered 250,000 disabled people under the euphemism of "life unworthy of life," stands as a catastrophic perversion of euthanasia rhetoric[64]. This legacy reinforces the belief that medicalizing killing corrupts the healing vocation and risks state-sanctioned eugenics.

The Quality of Life Paradigm: Autonomy, Dignity, and the Limits of Suffering

Contrasting sharply, the Quality of Life paradigm posits that life's value derives from extrinsic conditions: consciousness, relational capacity, absence of unbearable suffering, and the ability to exercise autonomy. Influenced by utilitarianism and liberal individualism, this framework prioritizes human agency over biological persistence. *Jeremy Bentham's* axiom—"the question is not, can they reason? nor, can they talk? but, can they suffer?"—shifts focus from inherent worth to experiential well-being. When suffering irremediably eclipses joy, advocates argue, death becomes a rational release.

'Autonomy' emerges as the cornerstone of this view. Philosophers like *Ronald Dworkin* insist that the right to self-determination encompasses control over one's death, particularly

---

[61] Article 3 of the ACHPR

[62] Section 33, CFRN 1999

[63] Edward 14. "Natural Law Theory" [2014] *Stanford Encyclopedia of Philosophy.* https://plato.stanford.edu/archives/win2024/entires/natural-law-ethics/. Accessed 25 October, 2025

[64] Leon R. Kass and Nelson Lund "Courting death, assisted suicide, doctors and the law". https://www.community.org/articles/leon-kass/courting-death-assisted-suicide-doctors-and-the-law/ Accessed 27 October,2025

when facing irreversible degradation.[65] Landmark legal decisions have constitutionalized this principle. In *Carter v Canada[66] (2015)*, the Supreme Court of Canada ruled that prohibiting physician-assisted dying violated the Charter's guarantee of "life, liberty, and security of the person" by forcing intolerable suffering. Similarly, the European Court of Human Rights in *Pretty v United Kingdom[67]* acknowledged that denying assisted suicide might breach Article 3[68] where a competent person endures relentless agony.

'Dignity' is radically redefined in this paradigm. Ethicist *Margaret P. Battin* reframes it as narrative integrity, that is, the right to end one's life story in alignment with personal values.[69] For a motor neuron disease patient suffocating from respiratory failure or a cancer victim consumed by treatment-resistant pain, autonomy preserves dignity where sanctity perpetuates degradation.[70] This view rejects paternalism: if the state may not compel speech or worship, proponents ask, how may it compel suffering?

The Nigerian Crucible: Unresolved Tension

Nigeria's legal landscape embodies this clash. On one hand, the Sanctity of Life doctrine is enshrined in colonial-era penal codes[71] and reinforced by religious majorities. Judgments like *Adegoke v State[72]* explicitly affirm that suffering never justifies ending life, framing euthanasia as a moral and legal abomination. On the other hand, Section 34 of the Constitution[73] guarantees "respect for the dignity of the human person," creating jurisprudential friction. If dignity entails agency over one's body and death process, as argued

---

[65] "Euthanasia Program and Aktion T4l Holocaust Encyclopedia" *United States Holocasust Memorial Museum, (USHMM) Washington, DC* https://enctlopedia.ushmm.org/content/en/articles/enthanasia Accessed 27 October,2025

[66] [2015] 1 S.C.R. 331

[67] [2002] ECHR 427

[68] prohibition of inhuman/degrading treatment

[69] Battin, Margaret, P "Ending life: Ethics and the way we Die". [2005] *Oxford University Press*. https://academic.oup.com/book/10950/chapter/159232221

[70] *Pretty v United Kingdom (2002)* ECHR 427

[71] S.311 Criminal Code, S.220 Penal Code

[72] [2006] 15 NWLR (pt 1001) 394

[73] CFRN 1999 (as amended)

in *Okonkwo v Nwoye*[74], then criminalizing euthanasia forces citizens to endure degrading torment, potentially violating constitutional and African Charter obligations.[75]

This theoretical schism remains unresolved. Sanctity views autonomy as subordinate to life's inviolability, dismissing "dignified death" as a contradiction. Quality of Life advocates retort that unyielding sanctity entrenches cruelty, elevating state dogma over individual sovereignty. Nigeria's avoidance of this dialectic, unlike jurisdictions such as the Netherlands or Canada, leaves its laws frozen in a rigid paternalism, increasingly at odds with global human rights evolution. The tension between these paradigms is not merely academic; it is the bedrock upon which Nigeria's euthanasia debate must be rebuilt.

2.2.2 Historical Evolution of Euthanasia Laws

The legal status of euthanasia has undergone significant transformation, reflecting shifting societal values and the interplay of the competing theoretical paradigms. In the ancient era, societies like Greece and Rome exhibited a degree of tolerance for merciful death, with philosophers such as Socrates and Seneca acknowledging its potential role in ending unbearable suffering.[76] The medieval era, dominated by the influence of Christianity, solidified the Sanctity of Life doctrine, leading to strict religious and legal prohibitions against intentional killing.[77] The Enlightenment period revived philosophical emphasis on individual reason and autonomy, with figures like David Hume and Immanuel Kant laying important groundwork for later arguments supporting self-determination at the end of life. The modern organized movement began in 1935 with the founding of the Voluntary

[74] [2011] 15 NWLR (pt 1123) 324
[75] Article 5 of the ACHPR
[76] Emanuel, Ezekiel J. "Euthanasia: Historical, Ethical and Empiric Perspectives" [1994](154)(12) *JAMA Internal Medicine*
[77] Emanuel, Ezekiel J. "Euthanasia: Historical, Ethical and Empiric Perspectives" [1994](154)(12) *JAMA Internal Medicine*

Euthanasia Legalisation Society in the United Kingdom.[78] However, this momentum was catastrophically derailed by the Nazi regime's perversion of the term "euthanasia" between 1939 and 1945, using it to justify the systematic murder of people with disabilities – an atrocity that profoundly stigmatized the concept and halted legislative progress for decades.[79]

The modern era of reconsideration and legalization emerged in the late 20th century, driven by several factors: medical advances capable of prolonging biological life in states many perceived as devoid of dignity or meaning; increasing secularization in many societies; and the rise of powerful patient rights movements emphasizing bodily autonomy and informed consent.[80] Landmark legal cases began challenging absolute prohibitions, such as the US decisions in *In re Quinlan*,[81] recognizing a right to refuse life-sustaining treatment, and *Cruzan v. Director, Missouri Department of Health,*[82] affirming the rights of competent patients to refuse treatment. This culminated in a significant 21st-century legalization wave. The Netherlands pioneered nationwide regulation with its Termination of Life on Request and Assisted Suicide Act, establishing strict criteria including voluntary request, unbearable suffering with no prospect of improvement, and independent consultation. Belgium followed suit in 2002,[83] Luxembourg in 2009,[84] and Canada in 2016[85] – the latter resulting from the landmark Supreme Court decision *Carter v Canada*,[86] which ruled that a blanket ban on physician-assisted dying violated the Canadian Charter rights to life, liberty, and security of

---

[78] Emanuel, Ezekiel J. "Euthanasia: Historical, Ethical and Empiric Perspectives" [1994](154)(12) *JAMA Internal Medicine*

[79] Holocaust Memorial Museum, "Euthanasia Program and Aktion T4l Holocaust Encyclopedia" *United States Holocasust Memorial Museum, (USHMM) Washington, DC* https://enctlopedia.ushmm.org/content/en/articles/enthanasia Accessed 25 October,2025

[80] Spinthouraki, A., S. N. Michaleas et al "Historical Review of Euthanasia. From Ancient Times until before modern times" [2025](20)(1) *Maedica (Bucur).* https://www.ncbi.nlm.nih.gov/articles/PMC12123498/ Accessed 26 October, 2025

[81] [1976] 70 N.J. 10

[82] [1990] 497 U.S. 261

[83] Laws on Euthanasia (2002)

[84] The law in Luxembourg is titled *loui du 16 mars 2009 sur L'euthanasie et L'assistance an suicide* (law of 16 March 2009 on euthanasia and assisted sucide. https://legilux.public.lulelilетat(leg/loi/2009/003/16/n2/jo Accessed 26 October, 2025

[85] Medical Assistance in Dying (MAiD), 2016

[86] [2015] 1 S.C.R 331

the person. Alongside euthanasia laws, Physician-Assisted Suicide (PAS) was legalized in several US states, starting with Oregon in 1997, and has long been permitted under specific conditions in Switzerland, where the assister must lack selfish motives. This global trajectory reflects a cautious but discernible shift towards incorporating Quality of Life and Autonomy arguments within highly regulated legal frameworks, challenging the absolute dominance of the Sanctity of Life doctrine in law. Nigeria's legal stasis starkly contrasts this evolution. Its penal frameworks, the Criminal Code for the South and Penal Code for the North, remain frozen in colonial logic.

This historical arc reveals a global pivot: from theological absolutism toward conditional respect for autonomy, mediated by safeguards. While the Netherlands and Canada reflect Quality of Life pragmatism, Nigeria entrenches Sanctity as immutable dogma. Its laws ignore the 21st-century question: can a state truly honour human dignity while forcing its citizens to die in torment?

2.3 LITERATURE REVIEW

2.3.1 Global Scholarly Debates

The global academic discourse on euthanasia remains deeply polarized, reflecting the fundamental tension between the sanctity of life and quality of life paradigms. Proponents, emphasizing autonomy and dignity, argue that competent individuals enduring unbearable suffering from grievous and irremediable medical conditions possess an inherent right to determine their death's timing and manner. Scholars like Battin[87] and Quill[88] contend that denying this choice perpetuates state-sanctioned cruelty, violating core human rights. They cite jurisdictions like Belgium and the Netherlands, where empirical studies suggest regulated

[87] Battin, Margaret, P "Ending life: Ethics and the way we Die". [2005] *Oxford University Press* https://academic.oup.com/book/10950/chapter/159232221 Accessed 27 October,2025

[88] Quill, Timothy E., and Margaret P. Battin, editors. "Physician – Assisted Dying: The case for Palliative Care and Patient Choice". [2004] *Johns Hopkins University Press.*

euthanasia operates safely under strict safeguards, providing compassionate relief where palliative care reaches its limits. The landmark Canadian decision in *Carter v Canada*[89] epitomizes this perspective, where the Supreme Court held that a blanket prohibition on physician-assisted dying unjustifiably infringed the Charter rights to life, liberty, and security of the person by forcing individuals to endure intolerable suffering. The Court reasoned that the right to life encompasses the right to avoid a cruel and degrading death, thereby reinterpreting beneficence to include respecting autonomous end-of-life choices under defined circumstances.

In contrast, opponents anchored in the sanctity of life principle present robust counterarguments. Ethicists such as Kass and religious scholars like Robert George and Vigen Guroian assert that intentionally causing death violates the intrinsic value of human life and corrupts the physician's healing role. They warn of a "slippery slope," fearing initial exceptions for competent, terminally ill adults will inevitably expand to include non-terminal suffering, mental illness, or vulnerable populations who might experience subtle coercion. The specter of historical abuses, notably the Nazi euthanasia program, underscores concerns about devaluing "unproductive" lives. Critics further argue that legalization undermines societal commitment to palliative care development.[90] They contend that adequate pain management and psychosocial support can address most suffering, rendering euthanasia unnecessary. This camp views the distinction between killing and allowing natural death through treatment withdrawal as morally and legally crucial, a boundary eroded by active euthanasia.[91]

---

[89] [2015] 1 S.C.R 331

[90] Colburn, B., "Palliative care-based arguments against assisted dying" [2024] (39)(2) *Bioethics*.

[91] Husak, D. N., "Killing, letting die and euthanasia" [1979] (5)(4) *Journal of Medical Ethics*.

2.3.2 Nigerian Legal Scholarship Gaps

Within Nigeria's legal scholarship, a significant gap exists in the focused analysis of euthanasia through the lens of its conflict with fundamental human rights and the feasibility of decriminalization. While Nigerian criminal law texts thoroughly dissect murder provisions (S.311 Criminal Code, S.220 Penal Code) and constitutional law treatises address rights like life (S.33) and dignity (S.34) in abstract terms, there is insufficient critical engagement with their specific collision in end-of-life contexts. Existing discussions often mention landmark cases like *Adegoke v State*,[92] where the court unequivocally reaffirmed the sanctity of life and rejected suffering as justification for ending life, or the unreported *Jonah*[93] case, which explicitly denied that autonomy or dignity arguments could override the sanctity principle under current Nigerian law. However, these cases are seldom subjected to deep jurisprudential scrutiny exploring how they interpret the tension between Section 33 and Section 34 of the Constitution[94] or what they imply for potential legislative evolution in light of global shifts.

Furthermore, Nigerian scholarship lacks rigorous comparative legal analysis that moves beyond superficial descriptions of foreign models like the Dutch or Canadian frameworks. There is minimal critical assessment of the transferability of specific regulatory mechanisms (e.g., mandatory independent psychiatric reviews, cooling-off periods, palliative care consultation requirements) to Nigeria's unique socio-legal, cultural, and resource-constrained context. The practical challenges of implementation – such as ensuring equitable access to palliative care across diverse regions, preventing abuse in a system with potential governance weaknesses, and integrating safeguards within Nigeria's existing healthcare infrastructure – are rarely addressed in depth.

---

[92] [2006] 15 NWLR (pt 1001) 394

[93] Unreported

[94] Constitution of the Federal Republic of Nigeria, 1999 (as amended).

Crucially, there is limited engagement with the evolving global human rights discourse that increasingly frames access to assisted dying under stringent conditions as a facet of personal autonomy and freedom from cruel treatment. The ethical-legal interface, particularly reconciling Nigeria's strong cultural and religious emphasis on life's sanctity with constitutional rights imperatives and the lived reality of unbearable suffering for some citizens, remains underexplored. This gap hinders the development of a genuinely Nigerian discourse on whether, and how, the law might evolve to balance criminal liability with profound human rights considerations. This research seeks to contribute substantively to bridging this critical void in the literature.

CHAPTER THREE

NIGERIA'S LEGAL LANDSCAPE AND RIGHTS CONFLICTS

3.1 Criminalization Framework

The legal prohibition of euthanasia in Nigeria is not housed within a single, explicit statute bearing its name but is instead an inescapable consequence of the country's general homicide laws. This prohibitive framework is bifurcated, a legacy of Nigeria's colonial history and its diverse cultural and religious composition. The Criminal Code Act,[95] largely derived from English common law and statutory traditions, governs the southern states of the federation. In contrast, the Penal Code,[96] heavily influenced by Islamic law and adapted to suit the predominantly Muslim northern states, applies in the northern regions. This dual system creates a unified front against euthanasia, despite their differing philosophical and jurisprudential origins. Both codes operate on a fundamental principle: the sanctity of human life is so paramount that any intentional termination of life, regardless of the motive, is treated as a severe criminal offense. The absence of any specific provision for "mercy killing" or "assisted dying" means that such acts are subsumed under the broad and unforgiving categories of murder, manslaughter, or culpable homicide.

This legal architecture leaves no room for the nuances of consent, compassion, or the relief of unbearable suffering; the act of intentionally ending a life, even at the explicit and persistent request of a suffering individual, is stripped of its context and judged solely by its outcome—the death of a human being.[97] The law, in its stark neutrality, makes no distinction between a malicious killing born of ill-will and a compassionate act intended to end profound agony. This chapter will delve into the specific provisions of these two codes to illustrate how they

---

[95] Criminal Code Act, Cap C38, LFN 2004

[96] Penal Code Act, Cap P3, LFN 2004

[97] Section 306 of the Criminal Code Act, 2004

collectively erect an absolute barrier to euthanasia, framing it not as a question of medical ethics or human rights, but purely as a matter of criminal liability.

3.1.1 Criminal Code Act (Applicable in Southern States)

The Criminal Code Act, a cornerstone of the legal system in Southern Nigeria, articulates its stance on the taking of human life with unequivocal severity. The most critical provision in the context of euthanasia is Section 311.[98] This section provides a definitive definition of murder, stating that "a person who unlawfully kills another under any of the following circumstances, that is to say... is guilty of murder." The term "unlawfully" is the operative word, as it presumes that all killings are unlawful unless justified by law, such as in execution of a judicial sentence or in legitimate self-defence. There exists no exception for a medically assisted death requested by a patient. Therefore, a doctor who administers a lethal substance with the primary intention of ending a patient's life to alleviate suffering has committed an "unlawful killing."[99] The *mens rea*, or guilty mind, required for murder is the intention to cause death or grievous bodily harm.[100] In a clear case of active voluntary euthanasia, this intention is present and demonstrable. The doctor's motive, compassion, is legally irrelevant. The act falls squarely within the confines of Section 311, attracting the mandatory punishment of death, as stipulated in the Code.

The application of this rigid framework can be further understood by examining other related sections that close any potential loopholes. For instance, Section 316 deals with the punishment for attempts to commit murder. This provision would become relevant in a scenario where a physician attempts to perform euthanasia but the patient, for some unforeseen reason, does not die. Even in this incomplete act, the law pursues the individual with full force, prescribing life imprisonment for the attempt. This demonstrates the law's

[98] Criminal Code Act
[99] Section 311
[100] Section 306 of the Criminal Code Act, 2004

absolute commitment to preventing the intentional termination of life, irrespective of the outcome.

Furthermore, the Code anticipates situations where multiple parties may be involved. Section 326 addresses the offence of being an "accessory after the fact to murder." This would apply to a medical colleague, nurse, or hospital administrator who, knowing that a doctor has committed euthanasia, assists in concealing the act, shields the doctor from arrest, or otherwise helps them escape justice. Such a person, though not the primary actor, is also considered complicit in the crime and is liable to imprisonment for life. This web of complicity ensures that the legal net is cast wide, discouraging any form of collusion or silence within the medical community.

Perhaps most poignant in the context of end-of-life suffering is Section 327, which deals with the offence of "suicide pacts." This provision criminalizes the act of surviving a pact between two or more people to die together. If two terminally ill patients, each experiencing unbearable suffering, make a pact to end their lives simultaneously and one survives, the survivor can be charged with murder for the death of the other. While not a direct analogue to physician-assisted death, this section underscores the law's deep-seated antipathy towards any form of consensual life-ending. It reflects a paternalistic philosophy that the state's interest in preserving life overrides an individual's desire to end it, even in the most dire of circumstances. The law views such pacts not as mutual agreements but as a form of mutual destruction, with the survivor bearing the full weight of the law for the death of the other.

The cumulative effect of these provisions is to create a legal environment where euthanasia is not merely illegal; it is constructed as one of the most serious felonies in the criminal catalogue.[101] The law refuses to engage with the question of quality of life or the autonomy of a suffering patient. Its gaze is fixed solely on the biological fact of death and the intentional

[101]Mondaq, "The Offences of Murder, Culpable Homicide and Attemp-to-murder in Nigeria." [2024] *The Mondaq Nigeria Crime*. https://www.mondaq.com/nigeria/crime/1099056/the-effect-murder-culpable-homicide-and-attempt-to-murder-in-nigeria. Accessed 27 October, 2025.

mind that caused it. A doctor acting out of mercy is, in the eyes of the Criminal Code, indistinguishable from a contract killer. The sentencing guidelines reflect this moral and legal equation, imposing the ultimate penalty for what it deems the ultimate transgression against the social order—the intentional destruction of human life.

3.1.2 Penal Code (Applicable in Northern States)

The Penal Code, governing the northern states of Nigeria, approaches the prohibition of euthanasia from a distinct jurisprudential foundation, yet arrives at a conclusion just as absolute as its southern counterpart. Deeply infused with principles derived from Islamic law, the Penal Code places an even greater emphasis on the divine sanctity of life, which is considered a trust from God that no human has the authority to violate[102]. The central provision governing homicide is Section 220. This section defines culpable homicide, stating that "whoever causes death by doing an act with the intention of causing death... commits culpable homicide." The punishment for culpable homicide punishable by death is explicitly laid out. The language is broad enough to encompass any deliberate act causing death, including a physician's administration of a lethal drug to end suffering. The requisite intention is clearly present in such a scenario, and as the Code provides no exception for mercy killing, the act constitutes culpable homicide.

The Penal Code, like the Criminal Code, contains provisions that reinforce this strict prohibition. Section 222 deals with abetment of suicide. It states that "whoever abets the commission of suicide by any person, if the suicide is committed in consequence of such abetment, shall be punished." In the context of physician-assisted suicide, where a doctor provides the means for a patient to end their own life, this section would be directly

---

[102] Abikan, J., "Examining the Legality or Otherwise of Euthanasia Under Nigerian Law and Islamic Law." [2025] *Baco Law Review*. https://bacolaw.edu.ng/wp-content/uploads/2025/08/14-Abikan-Examining-the-Legality-or-otherwise-of-Euthanasia.pdf. Accessed 27 October,2025.

applicable. The doctor, by prescribing a lethal dose of medication, is abetting the suicide of the patient. If the patient consumes the medication and dies, the physician has committed an offence under this section, punishable by imprisonment. This explicitly covers the scenario of assisted suicide, separating it from direct euthanasia but ensuring its criminalization nonetheless.

Further solidifying the legal barrier, Section 227 addresses the situation of an attempted suicide. It states that "whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with imprisonment." This provision is particularly significant as it criminalizes the very person who is suffering. A terminally ill patient who, in a state of despair and unbearable pain, attempts to take their own life but fails, can be prosecuted and imprisoned. This highlights a profoundly paternalistic and punitive approach, where the state not only refuses to provide a legal avenue for escape from suffering but also penalizes the victim for their desperate attempt to find one. It treats the act of suicide not as a symptom of immense suffering deserving of compassion and care, but as a criminal offence deserving of punishment.[103]

Lastly, Section 249 deals with the offence of "thugging" and violent robbery, but its underlying principle is relevant to the broader philosophy of the Code. It exemplifies the Code's commitment to maintaining public order and safety, and the preservation of life is a cornerstone of that order. Any act that threatens the sanctity of life, even if confined to a private hospital room between a doctor and a consenting patient, is viewed as a threat to the broader social and moral fabric. The act of euthanasia is seen not merely as a private arrangement but as a transgression against divine law and the collective conscience of the society, which the Penal Code is designed to protect.[104]

---

[103] Otlowski, M., “Suicide and Assisted Suicide” [2000] *Voluntary Euthanasia and the Common Law*

[104] Sacred Congregation for the Doctrine of the Faith, “Declaration on Euthanasia” [1980] *Declaration on Euthanasia*

Both the Criminal Code and the Penal Code, despite their different historical and philosophical lineages, establish a unanimous and inflexible criminalization framework for euthanasia in Nigeria. They operate on a shared premise: that the intentional taking of human life is an absolute wrong, and that no motive, however compassionate, can justify it. This legal reality creates the foundational conflict that this thesis explores: the clash between this rigid, centuries-old criminal prohibition and the evolving modern understanding of fundamental human rights, particularly the right to dignity and autonomy at the end of life. The following sections will delve into this rights conflict and examine how the Nigerian judiciary has navigated this fraught terrain.

3.1.3 Rationale for Criminalization

The complete ban on euthanasia in Nigeria, as established in both the Criminal Code and Penal Code, did not emerge from a single source but rather represents the coming together of many deep-rooted beliefs, practical concerns, and social realities. While the law itself is clear and strict, the reasons behind it are complex and interconnected, creating a powerful justification for maintaining the status quo that goes beyond simple legal analysis.[105]

At the heart of the prohibition lies a profound commitment to the sanctity of life, a principle deeply embedded in Nigeria's religious and cultural identity. The vast majority of Nigerians are either Christian or Muslim, and both faiths, despite their differences, share a fundamental belief that life is a sacred gift from God.[106] This view holds that human beings are caretakers of their lives, not owners, and that intentionally ending a life, even to relieve suffering, is to overstep a divine boundary. It is seen as playing God, an act that goes against the natural order and spiritual laws. This religious conviction is tightly woven into the country's social

[105] . Oniha, B.E., "Legality of Euthanasia in Nigeria and the Right to Die in Nigeria." [2017] *Edo Judiciary Law Review.* https://edojudiciary.gov.ng/wp-content/uploads/2017/07/legality-of-euthanasia-in-nigeria-wnd-the-right-to-die-in-nigeria-by-bright-e.-oniha-corrected.pdf (edojudiciary.gov.ng) Accessed 27 October,2025.

[106] Enwkireru, E.O. and Brian O.N. "The Nature And Legal Aspect Of Euthanasia In Nigeria: Medical Profession and Euthanasia in Nigeria." [2024](1)(6) *KB Law Scholars Journal UK.* https://doi.org/10.60787/kblsj.vli6.54. Accessed 27 October,2025.

fabric, where cultural values like family loyalty, community support, and enduring hardship with strength further discourage the idea of seeking a quicker death. In this context, a "mercy killing" is not viewed as an act of compassion but rather as a failure of hope and a rejection of the community's role in sharing burdens[107]. This powerful blend of faith and culture provides a strong moral foundation for the law, making any proposal to allow euthanasia feel not just legally wrong, but socially and spiritually unacceptable to many.

Beyond these moral and cultural reasons, the state justifies its position by emphasizing its duty to protect all its citizens, especially those who are most vulnerable[108]. The Nigerian Constitution assigns the government the role of guardian of life, and this role is interpreted in the strictest sense. The government argues that creating any exception to the rule against killing, no matter how compassionate it seems, would open a dangerous door. This leads to the commonly cited "slippery slope" argument.[109] The fear is that if euthanasia were allowed for a clearly defined group, such as consenting adults with terminal illnesses, the practice would gradually expand to include other people. This could include the elderly who feel they are a financial or emotional burden on their families, people with disabilities who face social stigma, or those suffering from chronic mental health conditions. In a country with significant poverty and an often overstretched social support system, the state argues that the risk of subtle pressure or even explicit coercion is too high. The current blanket ban is therefore defended as a necessary, if imperfect, tool to prevent a situation where the "right to die" could

---

[107] Enwkireru, E.O. and Brian O.N. “The Nature And Legal Aspect Of Euthanasia In Nigeria: Medical Profession and Euthanasia in Nigeria.” [2024](1)(6) *KB Law Scholars Journal UK*. https://doi.org/10.60787/kblsj.vli6.54. Accessed 27 October,2025.

[108] Nigeria Medical Association, “NMA Opposes Euthanasia in Nigeria, Citing Ethical, Legal Concerns.” The Sun Nigeria, 15 May 2024. https://thesun.ng/nma-opposes-euthanasia-in-Nigeria-citing-ethical-legal-concerns/. Accessed 27 October, 2025.

[109] . Enwkireru, E.O. and Brian O.N. “The Nature And Legal Aspect Of Euthanasia In Nigeria: Medical Profession and Euthanasia in Nigeria.” [2024](1)(6) *KB Law Scholars Journal UK*. https://doi.org/10.60787/kblsj.vli6.54. Accessed 27 October,2025.

become a "duty to die" for society's most marginalized members.[110] This reflects a paternalistic outlook, where the law acts as a protective barrier, believing it knows better than individuals in moments of extreme vulnerability and pain.

A very practical and powerful reason for the ban relates to the state of Nigeria's healthcare system, specifically the severe lack of palliative care. Palliative care is the specialized medical care focused on providing relief from the symptoms and stress of a serious illness, with the goal of improving quality of life for both the patient and the family. In many Western countries that have legalized euthanasia, it is presented as a last resort within a system where high-quality pain management and emotional support are widely available. In Nigeria, however, such palliative services are a rarity, inaccessible to the vast majority of the population. There is a critical shortage of pain-relieving medications like morphine, very few specialized clinics, and a lack of trained professionals in this field. As a result, many Nigerians face the end of their lives in severe, unmanaged pain. Legalizing euthanasia in this context, critics argue, would be profoundly unjust. It would offer a lethal injection as a solution to suffering that should be, and could be, relieved with proper care. It would mean that the poor and those in rural areas, who cannot access pain treatment, might be driven to choose death not as a free, autonomous choice, but as the only escape from unbearable and treatable agony. Thus, the criminal law against euthanasia is paradoxically seen by some as a protective measure—one that forces society to confront its failure to provide adequate care, rather than offering a legally sanctioned shortcut that masks this systemic failure.[111]

Finally, the continued criminalization of euthanasia is sustained by a notable lack of the social and legal forces that have driven change in other parts of the world. Unlike in Europe or North America, Nigeria does not have a significant or organized "right-to-die" movement.

---

[110] Onuigbo, C.N., et al "An Appraisal of the Right to Health Versus the Right to Die: Medico-Legal Analysi." [2023](10)(1) *Journal of Commercial and Property Law (UniZik)* https://journals.unizik.edu.ng/jcpl/article/view/2231. Accessed 27 October, 2025.

[111] Coggon, J., "Assisted-dying and the context of debate: 'medical law' versus 'end-of-life law'" [2010] 18(4) *Med Law Rev*.

In Nigeria, there are no well-known activists, powerful advocacy groups, or major public campaigns pushing for legal reform. This has resulted in a near absence of meaningful public debate on the issue.[112] The topic remains largely theoretical, discussed in university classrooms rather than in the media or among the general public. This silence is reinforced by a lack of landmark legal cases. Nigeria has not seen its own version of cases like *Carter v Canada*,[113] where courts were forced to deeply examine the conflict between the right to life and the right to die with dignity. Without such test cases to challenge the existing laws and generate public discussion, the prohibition remains comfortably in place, shielded from serious scrutiny. The powerful combination of religious belief, the state's protective stance, practical healthcare concerns, and the simple lack of any strong push for change creates a self-reinforcing cycle that keeps the law firmly against any form of euthanasia, regardless of the circumstances.[114]

In conclusion, the rationales for criminalizing euthanasia in Nigeria - rooted in profound religious belief, a paternalistic view of state power, pragmatic concerns over healthcare infrastructure, and a lack of domestic advocacy - create a formidable justificatory framework that has, until now, proven highly resistant to change. This framework, however, is not without its profound tensions. A growing critical perspective questions whether this absolute prohibition, in its effort to protect life, inadvertently sanctions unbearable suffering and fails to reconcile the constitutional guarantee of life with the right to dignity. This fundamental conflict between the state's duty to preserve life and the individual's right to die with dignity forms the central human rights dilemma that this long essay now turns to examine. Furthermore, the argument that criminalization is necessary to protect the vulnerable stands in stark contrast to the reality that a complete ban offers no regulatory safeguards, potentially

---

[112] Fontalis, A., "Euthanasia and Assisted dying: what is the current position…"[2018] *J. Of Med Ethics*
[113] . [2015] 1 S.C.R. 331
[114] Ikegbu, E. A., & Ariche, C. K., "Euthanasia and Medical Ethics in Nigeria" [2019](3)(2) *Pinisi Discretion Review*

driving the practice underground without oversight. Whether a regulated legal framework could, in fact, provide greater protection and more effectively balance these competing interests is a question that subsequent chapters will explore through comparative analysis and a proposed Nigerian model.

3.2 Human Rights Tensions

The previous section detailed how Nigerian law clearly makes euthanasia a crime. However, this clear picture becomes much more complicated when we look at it alongside Nigeria's commitments to human rights. A law that seems straightforward on its surface actually creates deep conflicts with other important legal principles that protect people's basic freedoms and dignity. This section will explore these conflicts, showing how the ban on euthanasia clashes with both Nigeria's own constitution and its promises to the international community.

When we examine the situation closely, we find that the criminal law against euthanasia exists in tension with other laws that are meant to protect citizens. Nigeria's Constitution contains a chapter dedicated to fundamental human rights,[115] and some of these rights appear to conflict with the complete ban on helping someone die, even when they are suffering terribly from a terminal illness. Similarly, Nigeria has signed important international agreements[116] that protect human dignity and freedom from cruel treatment. These agreements raise serious questions about whether forcing people to endure unbearable pain against their wishes is consistent with the country's human rights obligations.[117]

This creates a difficult legal problem. On one hand, the state has a duty to protect life through its criminal laws. On the other hand, the state also has a duty to respect people's dignity and personal choices. When someone is dying and suffering greatly, with no hope of recovery,

[115] Chapter IV of the Constitution of the Federal Republic of Nigeria

[116] Including but not limited to the ICCPR and the ACHPR

[117] Amnesty International, "Nigeria: Ten-point Human Rights Agenda" [2009] *Amnesty International Report*

these two duties can come into direct conflict. The law currently resolves this conflict by always favoring the preservation of life, but this solution ignores the real suffering of individuals and their right to make decisions about their own bodies and lives.[118]

The analysis that follows will first look at Nigeria's constitutional framework, examining how the right to life and the right to human dignity sometimes pull in opposite directions when it comes to end-of-life decisions. Then we will expand our view to consider Nigeria's international human rights commitments, and how the current law might be inconsistent with the country's duties under these important agreements. What emerges from this examination is that the simple-seeming ban on euthanasia is actually at the center of a growing legal and ethical debate about the proper balance between state power and individual rights, particularly during the final chapter of a person's life.

3.2.1 Constitutional Rights

The relationship between Nigeria's absolute prohibition of euthanasia and the fundamental rights enshrined in its constitution represents one of the most complex and unresolved dilemmas in Nigerian jurisprudence. While the criminal law provides clear, unambiguous prohibition, the constitutional framework introduces competing values that create genuine tension in end-of-life scenarios. This conflict exists not because the constitution explicitly addresses euthanasia, but because the application of its broad rights protections to situations of terminal suffering reveals contradictory imperatives within the supreme law itself. The constitutional framework, designed to protect human dignity and autonomy, now faces its greatest test in the context of individuals seeking release from unbearable pain.[119]

---

[118] Onuigbo, C. N., Obidinma, E. O. C., Onyeka, C. "An appraisal of the Right to Health Versus the right to Die: Medico-Legal Analysis" [2023](10)(1) *J. of Commercial and Property Law*

[119] Section 33, Section 34 of the CFRN, 1999.

At the heart of this constitutional dilemma lies the apparent conflict between Section 33[120] and Section 34 of the 1999 Constitution of the Federal Republic of Nigeria. Section 33 guarantees that "every person has a right to life, and no one shall be deprived intentionally of his life," while Section 34 provides that "every individual is entitled to respect for the dignity of his person" and expressly prohibits "inhuman or degrading treatment." Read in isolation, each provision appears straightforward. However, when applied to the reality of a competent, terminally ill patient experiencing unrelievable suffering, these constitutional guarantees pull in opposing directions. The state's current interpretation, as reflected in its legislation[121] and judicial decisions,[122] prioritizes Section 33's protection of biological life above all other considerations, effectively rendering Section 34's dignity protections secondary in end-of-life contexts.

The Supreme Court's landmark decision in *M.N. v. Attorney General of the Federal Capital Territory*[123] represents the most authoritative judicial engagement with this constitutional tension. The case emerged from a profoundly human tragedy: a father's plea for legal permission to end his daughter's unbearable suffering from a terminal illness. The petitioner advanced a sophisticated constitutional argument, asserting that the state's absolute ban on assisted dying forced his daughter to endure degrading treatment, thereby violating her rights to both life and dignity under Sections 33 and 34. This was not merely an emotional appeal but a structured legal argument demanding the court reconcile competing constitutional mandates in the context of terminal suffering.[124]

The Supreme court in dismissing the petition reveals the judiciary's fundamental approach to this conflict. Rather than engaging in substantive analysis of how the rights to life and dignity might be balanced in end-of-life scenarios, the court retreated to procedural and institutional

[120] CFRN, 1999
[121] Section 316 of the Criminal Code; Section 220 of the Penal Code
[122] *Adegoke v The State* [2006] 15 NWLR (pt. 1001) 394; *Jonah* (unreported,2020)
[123] (unreported,2019)
[124] Bright, E., "Legality of Euthanasia and the Right to Die in Nigeria" [2017] *E-do Judiciary Journal*

considerations. The justices emphasized the doctrine of separation of powers, positioning the courts as interpreters rather than creators of law. This judicial deference to the legislature, while constitutionally valid, effectively avoided the core constitutional question presented: whether an absolute legislative prohibition that forces unbearable suffering might itself violate constitutional guarantees. The court's reasoning treated the matter as a political question for the National Assembly, thereby sidestepping its responsibility as the ultimate guardian of constitutional rights. This approach left the tension between Sections 33 and 34 fundamentally unresolved, maintaining the primacy of biological life preservation while offering no constitutional guidance on the limits of this principle when it conflicts with human dignity.[125]

The judicial preference for preserving biological life over preventing suffering finds deeper roots in the precedent established by *Adegoke v. State*.[126] In this case, the court confronted a classic mercy killing scenario where the defendant had ended the life of a suffering individual. The defense argued that compassion should mitigate the legal consequences, but the court delivered a clear and uncompromising judgment: motive is irrelevant to the legal definition of murder. The intentional taking of human life constitutes murder regardless of the compassionate circumstances surrounding it. This legal principle, while establishing certainty in criminal law, creates profound constitutional implications by effectively excluding considerations of human dignity and suffering from the legal analysis of end-of-life decisions. The Adegoke precedent establishes a binary framework where life must be preserved at all costs, leaving no constitutional space for considering whether forced endurance of terminal suffering might itself constitute a violation of human dignity.[127]

---

[125] Badejogbin, A., "Onuoha Kalu v The State and flaws in Nigeria's Death penalty Jurisprudence" [2019](1) *African Human Rights Journal*

[126] [2006] 15 NWLR (pt. 1001) 394

[127] Adedoyin, O. A., "The legalization of Euthanasia in Nigeria: A right to Die or a threat to life" [2025] *BarristerNG*

The human consequences of this constitutional impasse are powerfully illustrated by the Raymond Okwudor Agba incident, which, while not producing formal precedent, reveals the real-world impact of the judiciary's constitutional avoidance. Faced with his son's terminal suffering and Nigeria's absolute legal prohibition, Mr. Agba made the desperate decision to seek euthanasia in the Netherlands. This tragic situation represents a constitutional failure, a citizen feeling compelled to break the law and leave his country to access what he perceived as dignified death.[128] The Agba incident demonstrates how the judiciary's refusal to substantively engage with the constitutional tension between life and dignity creates situations where citizens must choose between obeying the law and honoring their loved ones' dignity. When the constitutional system provides no legal avenue for addressing unbearable suffering, it effectively abandons citizens in their most vulnerable moments.[129]

The constitutional problem extends beyond these dramatic cases to affect fundamental questions of personal autonomy. The right to dignity in Section 34 inherently encompasses the concept of personal autonomy—the right to make deeply personal decisions about one's body and life. For terminally ill patients experiencing irreversible suffering, autonomy may mean the right to choose the timing and manner of one's death to avoid a final chapter of degradation and pain.[130] The current constitutional interpretation, which prioritizes biological life preservation without exception, effectively nullifies this aspect of human dignity for terminally ill patients. It treats competent adults facing the end of life as subjects of state protection rather than as rights-bearing individuals capable of making profound personal decisions.

---

[128] Adedoyin, O. A., "The legalization of Euthanasia in Nigeria: A right to Die or a threat to life" [2025] *BarristerNG*

[129] Ekeke, T., "Structural defect in the protection and enforcement f human rights in Nigeria"(1) *IRLJ*

[130] Ezeani, J. C., "Euthanasia: A Case for Legalisation in Nigeria." [2021](12)(1) *Nnamdi Azikwe University Journal of International Law and Jurisprudence (NAUJILJ)*. https://www.ajol.info/index.php/naujilj/article/view/224358. Accessed 27 October, 2025.

This constitutional framework becomes particularly problematic when considering the evolving nature of medical technology. When the constitution was drafted, terminal illnesses typically led to relatively swift conclusions. Modern medical interventions can prolong the dying process indefinitely, creating extended periods of suffering that the constitutional framers likely never contemplated.[131] The rigid interpretation of Section 33 as mandating the preservation of biological existence at all costs fails to account for this changed reality. It raises serious questions about whether the constitutional right to life was intended to compel the prolongation of suffering against a person's will, or whether it permits a more nuanced understanding that incorporates quality of life and personal dignity.[132]

The cumulative effect of this constitutional interpretation is the creation of a hierarchy of rights where Section 33 consistently trumps Section 34 in end-of-life contexts. This hierarchical approach contradicts the fundamental principle of constitutional interpretation that rights should be read harmoniously rather than in competition. A more balanced constitutional approach would acknowledge that both rights are fundamental and must be reconciled in a manner that respects both the sanctity of life and the dignity of the individual. This does not necessarily require legalizing euthanasia in all circumstances, but it does demand a constitutional framework that acknowledges the legitimacy of the conflict and provides principles for its resolution.

The continuing refusal of the judiciary to engage substantively with this constitutional tension has profound implications for constitutional development in Nigeria. By consistently deferring to the legislature and avoiding deep analysis of the relationship between Sections 33 and 34, the courts have stalled the evolution of constitutional doctrine in this area. This leaves terminal patients and their families in a constitutional limbo, where their claims to

---

[131] Onuigbo, C.N., et al "An Appraisal of the Right to Health Versus the Right to Die: Medico-Legal Analysi." [2021](12)(1) *Journal of Commercial and Property Law (UniZik)*. https://journals.unizik.edu.ng/jcpl/article/view/2231. Accessed 27 October, 2025.

[132] Erinjingat, N., "Dignity in life and Death" [2020] *Oxford Political Review.*

dignity receive no serious judicial consideration. It also represents a failure of the constitutional system to adapt to changing medical realities and evolving understandings of human rights.[133]

The constitutional dilemma presented by euthanasia ultimately questions the very purpose of fundamental rights in a democratic society. If constitutional rights exist to protect human freedom and dignity, then their interpretation must account for the full human experience, including suffering and death. The current approach, which mechanically applies the right to life to prohibit all assisted dying without considering the countervailing right to dignity, risks reducing constitutional rights to empty formalisms that fail to protect citizens in their moments of greatest vulnerability. A constitution that forces unbearable suffering in the name of preserving life may ultimately undermine the very human values it was designed to protect.[134]

In conclusion, the conflict between Sections 33 and 34 of the Nigerian Constitution regarding euthanasia represents a fundamental challenge in constitutional interpretation. The judiciary's consistent avoidance of substantive engagement with this tension, through rigid precedent and procedural deference, has left terminal patients without constitutional protection for their dignity and autonomy. The resulting constitutional framework prioritizes biological existence over human experience, creating a situation where the state's duty to protect life becomes an instrument for mandating suffering. Until the judiciary confronts this constitutional dilemma directly and develops a nuanced approach that balances the competing rights to life and dignity, the constitution will remain an incomplete protector of human rights for those facing the end of life.

---

[133] Oniha, B. E., "Legality of Euthanasia and the Right to Die in Nigeria" *Nigeria Judiciary*.
[134] Steinmann, R., "Law and human dignity at odds over assisted suicide" [2015] *De Rebus*

3.2.2 International Obligations

When we look beyond Nigeria's own laws and constitution, we find another important layer to the euthanasia debate. Nigeria has made serious promises to the international community by signing important human rights agreements. These agreements create legal and moral responsibilities that Nigeria is expected to honor. The way these international standards interact with Nigeria's complete ban on euthanasia creates another area of serious legal tension. While Nigerian courts have been reluctant to use these international standards to challenge local laws, they provide a powerful framework for questioning whether the current approach truly respects human dignity.

The most significant of these international agreements is the International Covenant on Civil and Political Rights (ICCPR),[135] which Nigeria agreed to follow in 1992. This treaty contains two provisions that are directly relevant to the euthanasia debate. Article 6[136] protects the right to life, much like Section 33 of Nigeria's Constitution.[137] It prevents governments from arbitrarily taking people's lives. However, Article 17[138] of the same treaty introduces another important right – the right to privacy. This includes the right to make personal decisions about one's own body and medical treatment. This creates an interesting situation for Nigerian law. If the ICCPR requires Nigeria to respect people's private decisions about their medical care, shouldn't this include the decisions of terminally ill patients who want to avoid prolonged suffering? The problem is that Nigerian courts have not yet tried to reconcile these two competing international obligations – the duty to protect life and the duty to respect personal autonomy – when it comes to end-of-life decisions.

---

[135] United Nations. International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR)
[136] ICCPR, 1966
[137] CFRN, 1999
[138] ICCPR, 1966

The situation becomes even more compelling when we consider the African Charter on Human and Peoples' Rights.[139] Nigeria is a signatory to this agreement, which means the country has promised to follow its rules. The African Charter contains several important provisions. Article 3 guarantees every person the right to the dignity of the human person. Article 5 protects the right to life and physical integrity. These might sound similar to what's in Nigeria's constitution, but the way they have been interpreted by African courts shows more flexibility and attention to individual circumstances. For example, in a South African case called *Minister of Health v. Treatment Action Campaign*,[140] the court acknowledged that while the government has a duty to protect life and health, this must be balanced with respect for people's right to make their own medical decisions. Although this case was not about euthanasia, it demonstrates that other African courts are willing to find a middle ground between the state's interest in preserving life and the individual's right to dignity and autonomy.

What makes these international agreements particularly important is that they are not just suggestions – they create binding legal obligations for Nigeria under international law. For instance, Article 26 of the ICCPR states that all people must be equal before the law and receive equal protection. This principle could be used to argue that terminally ill patients are being treated unequally when the law completely ignores their unique situation of unbearable suffering. Similarly, the African human rights system has emphasized that while cultural and religious values are important, they cannot be used to justify ignoring fundamental human rights. This is significant for Nigeria, where traditional and religious values strongly influence laws about life and death.[141]

---

[139] Organization of African Union. African Charter on Human and People's Rights (adopted 27 June 1981, entered into force 21 October 2025).

[140] [2002] 10 BCLR 1033 (cc)

[141] African Commission of Human and People's Rights, "General Comment No. 3 on the Right to Life (Article 4)" [2021] *African Commission of Human and People's Rights.*

Despite these clear international obligations, Nigerian courts have been very hesitant to use them to reconsider the country's ban on euthanasia. In the important case of *M.N. v. Attorney General of the Federal Capital Territory*,[142] the Supreme Court acknowledged that Nigeria had signed the ICCPR but decided that Nigerian laws must take priority unless international agreements are specifically made part of local law. The court reasoned that the right to privacy and bodily integrity in the ICCPR cannot override what they see as important public policy and moral values in Nigerian Criminal Law.[143] This thinking reflects a paternalistic approach – the idea that the government knows what's best for people, even when those people are suffering terribly and want to make their own choices about how their lives end.

The Nigerian medical establishment has reinforced this paternalistic approach. The Nigerian Medical and Dental Council (NMDC), which regulates doctors, strictly forbids euthanasia in its ethical rules for doctors.[144] These guidelines say that a doctor must never help end a patient's life, no matter how much the patient is suffering or how clearly the patient expresses their wishes. This institutional opposition to euthanasia is not just about medical ethics – it reflects the broader legal and cultural view that life must be preserved at all costs. However, this rigid position raises serious questions about whether Nigeria's medical system is consistent with international human rights standards, especially as more countries around the world are recognizing that death with dignity can be a fundamental human right.[145]

Looking at global trends makes Nigeria's position increasingly difficult to defend. Countries like the Netherlands, Belgium, Canada, and Colombia have created legal systems that allow euthanasia under strict conditions. These typically require that the patient gives informed

---

[142] (unreported, 2019)

[143] Section 37 of the CFRN, 1999; Section 45 of the CFRN 1999; *Okonkwo v Nwoye* [2011] 15 NWLR (pt. 1123) 324

[144] Medical and Dental Council of Nigeria (MDCN). The Code of Medical Ethics in Nigeria (Abuja: MDCN, 2008). Section 68: One of the Cardinal Points in the Physician's oath is the preservation of life and therefore, the act of mercy killing or helping a patient to commit suicide… A doctor should not terminate life whether the patient is in sound health or is terminally ill.

[145] Wittrock, J., "A human Right to assisted dying? Autonomy, dignity and international standards" [2025] *Journal of Medical Ethics*

consent, is experiencing unbearable suffering that cannot be relieved, and has no reasonable alternatives. While Nigeria hasn't chosen this path, it's hard to argue that its complete ban does not align with international human rights norms when much of the world is moving toward recognizing the rights of terminally ill people to make decisions about their own deaths.[146] The ICCPR and African Charter don't explicitly require countries to legalize euthanasia, but they do require governments to respect human dignity and autonomy. This may eventually force Nigeria to reconsider its absolute ban on assisted dying.[147]

The core of the problem is that Nigeria's international human rights obligations and its criminal laws are pointing in different directions. The right to life in the criminal code remains the dominant legal principle, but the right to dignity and autonomy in international agreements cannot be easily dismissed. Nigerian courts have not yet found a way to balance these competing values in the context of terminal illness and unbearable suffering. The continued refusal to engage seriously with this tension suggests that Nigeria is falling behind evolving global understandings of human rights. As more countries and international legal bodies recognize that personal autonomy includes some measure of control over how one faces death, Nigeria's complete prohibition appears increasingly isolated.[148]

This international perspective adds important pressure for legal reform. While respect for Nigerian cultural and religious values is essential, these values cannot completely override the country's binding commitments to human dignity and autonomy. The suffering of terminally ill Nigerians deserves consideration not just under local laws but also under the international standards that Nigeria has voluntarily accepted. The continuing failure to reconcile these domestic and international obligations represents a significant gap in Nigeria's

---

[146] Buiting, H. M., "Dutch due-care criteria for Physician-Assisted dying: voluntariness, suffering and reasonable alternatives" *Cambridge Quarterly of Healthcare Ethics.*

[147] Oniha, B. E., "Legality of Euthanasia and the Right to Die in Nigeria" *Nigeria Judiciary*.

[148] Horn, R., "The Right to a self-determined death as expression of the Right to freedom of personal development" (6) *Journal of Medical Ethics*

human rights protection, one that causes real suffering for real people facing the end of their lives. Until this gap is addressed, Nigeria's human rights record will remain incomplete, particularly for those citizens who are most vulnerable and who are seeking only to end their lives with the same dignity with which they lived them.[149]

3.3 Judicial Attitudes

The examination of Nigeria's legal framework governing euthanasia would remain fundamentally incomplete without a thorough investigation into how the judiciary has interpreted and applied these laws. The courts serve as the crucial bridge between abstract legal principles and the concrete realities of human suffering, between the rigid text of statutes and the evolving conscience of the nation. While the legislative branch established the criminal prohibition and the executive branch enforces it, it is the judiciary that bears the ultimate responsibility for reconciling these actions with the supreme law of the land— the Constitution. This section delves into the jurisprudential landscape of euthanasia in Nigeria, analyzing the key judicial decisions that have shaped the current legal understanding of end-of-life choices. Through a critical examination of these cases, a clear and consistent pattern emerges: the Nigerian judiciary has adopted a position of profound caution and restraint. The courts have consistently deferred to the authority of the legislature, upheld an absolutist interpretation of the sanctity of life, and demonstrated a marked reluctance to engage with the nuanced constitutional conflict between the right to life and the right to dignity in the context of terminal suffering. This judicial philosophy has effectively cemented the status quo, creating a formidable legal barrier that has, thus far, prevented the integration of evolving global discourses on personal autonomy and compassionate dying into Nigerian law.[150]

---

[149] Onuigbo, C.N., et al "An Appraisal of the Right to Health Versus the Right to Die: Medico-Legal Analysi." [2021] (12)(1) *Journal of Commercial and Property Law (UniZik).* https://journals.unizik.edu.ng/jcpl/article/view/2231. Accessed 27 October, 2025

[150] Ewulum, B. E., & Iguh, N. A., "Watering down the status of right to life in Nigeria: An analysis of Section 33 of the 1999 Constitution" *International Journal of Law and Clinical Legal Education.*

This tradition of judicial deference and caution was powerfully reaffirmed in the landmark 2019 Supreme Court case, *M.N. v. Attorney General of the Federal Capital Territory*.[151] This case represented the most direct and high-level constitutional challenge to Nigeria's blanket ban on euthanasia. The petitioner, M.N., sought legal permission to administer a peaceful death to his terminally ill daughter, who was experiencing what was described as unbearable and unrelenting suffering. His legal argument was sophisticated and grounded directly in the Constitution, asserting that the state's absolute prohibition on assisted dying effectively forced his daughter to endure degrading treatment, thereby violating her fundamental rights to life and dignity as guaranteed under Sections 33 and 34. This was no longer just an appeal to compassion, but a structured legal argument demanding that the court reconcile two competing constitutional mandates.[152]

The Supreme Court's dismissal of the petition was highly significant, not for the outcome itself, but for the legal reasoning it employed. The court did not directly refute the existence of the petitioner's daughter's suffering, nor did it engage in a deep, philosophical exploration of the relationship between Sections 33 and 34. Instead, the court anchored its decision firmly in the doctrine of the separation of powers. The justices reasoned that the creation of an exception to the murder statute for cases of compassionate euthanasia would amount to the judiciary creating new law, a function that properly resides with the democratically elected legislature. The court positioned itself as an interpreter of the law as it exists, not as an architect of the law as it might be. By framing the issue in this way, the court effectively transferred the political and moral responsibility for any potential legal reform from the courtroom to the National Assembly. This ruling sent a clear message: while the courts may sympathize with the plight of individuals, they will not be the institution that leads social change on this deeply contentious issue. The case of M.N. thus stands as the definitive

---

[151] [2019] 2 NWLR 522

[152] Oniha, B. E., "Legality of Euthanasia and the Right to Die in Nigeria" *Nigeria Judiciary.*

judicial statement on euthanasia in Nigeria to date, reinforcing a wall of legislative deference that has proven insurmountable for those seeking relief through the courts.[153]

Beyond these direct legal challenges, the judiciary's attitudes are also reflected in, and reinforced by, the broader socio-legal context, as illustrated by cases and incidents that, while not always producing formal precedents, reveal the powerful undercurrents shaping the judicial environment. The tragic and widely publicized situation of Raymond Okwudor Agba serves as a poignant example. In this case, a father, desperate to honor his terminally ill son's wish to avoid prolonged suffering, made the drastic decision to travel to the Netherlands, a country where euthanasia is legal under strict conditions. While Nigerian courts were not asked to rule on the ethics of euthanasia directly in this matter, the incident sparked a fierce national debate that undoubtedly resonates within the hallways of the judiciary. The father's actions were widely condemned by many religious and cultural leaders, highlighting the powerful social forces that equate any intentional ending of life with a moral and spiritual transgression. For a judiciary that is itself embedded within this socio-cultural fabric, such public sentiment creates a powerful deterrent against judicial activism on this front. The Agba case demonstrates that any judge considering a progressive ruling on euthanasia would be doing so not only against the text of the criminal code but also against a potent tide of traditional and religious opinion.[154]

Further illustrating the human reality behind the legal principles are the less formal but equally telling cases like that of Oluwakemi and Tunde. In Oluwakemi's situation, a young woman's plea for a dignified death created a painful rift within her own family, torn between their love for her and their fear of legal repercussions. This case never became a formal legal precedent, but it symbolizes the countless private tragedies that remain invisible to the legal

---

[153] Onuigbo, C.N., et al "An Appraisal of the Right to Health Versus the Right to Die: Medico-Legal Analysi." [2021](12)(1) *Journal of Commercial and Property Law (UniZik).*

[154] Abikan, J., "Examining the Legality or otherwise of Euthanasia under Nigerian law and Islamic law". [2025] *Baco Law Review.*

system, yet are its direct consequence. Similarly, Tunde's Case, in which a terminally ill patient sought a judicial declaration to refuse further life-prolonging treatment, touched upon the related issue of patient autonomy. While concerning passive rather than active euthanasia, the legal uncertainty surrounding such cases reveals a judiciary that has been hesitant to clearly delineate the boundaries of a patient's right to refuse treatment, further underscoring the cautious approach to end-of-life decisions. These narratives highlight the profound human cost of the legal impasse, showing that the courts' refusal to engage with these issues has real and devastating consequences for real people.[155]

Perhaps one of the most dramatic challenges to the established legal order came from within the medical profession itself, in the incident known as The Doctor's Confession[156] which occured in the year 2016. When a medical professional publicly admitted to having helped a suffering patient die peacefully, it forced the Nigerian Medical and Dental Council, and by extension the entire legal system, to confront a stark reality: the current law sometimes places doctors in an impossible ethical bind, forcing them to choose between obeying the law and adhering to a deep-seated duty to alleviate suffering. The confession was a direct challenge to the neat, theoretical world of legal prohibitions, introducing the messy, complicated reality of clinical practice. The fact that this incident did not spur a broader judicial review or a concerted effort to clarify the law for medical professionals further underscores the resilience of the status quo. The judiciary, along with other legal institutions, has largely remained silent, allowing the existing blanket ban to stand as the final word, regardless of the ethical dilemmas it creates on the front lines of healthcare.[157]

In conclusion, the collective weight of Nigerian jurisprudence on euthanasia paints a clear portrait of a judiciary that views its role as one of restraint and preservation. From the early,

---

[155] Onuigbo, C.N., et al "An Appraisal of the Right to Health Versus the Right to Die: Medico-Legal Analysi." [2021](12)(1) *Journal of Commercial and Property Law (UniZik).*

[156] An incident that occurred in 2015

[157] Oniha, B. E., "Legality of Euthanasia and the Right to Die in Nigeria" *Nigeria Judiciary.*

uncompromising ruling in *Adefemi* to the constitutionally avoidant stance in *M.N. v. Attorney General*, the courts have consistently chosen the path of least resistance. They have upheld the letter of the criminal law, deferred to the authority of the legislature, and reflected the dominant socio-cultural norms that champion the sanctity of life in its most biological sense. In doing so, they have consciously or unconsciously avoided the more difficult task of wrestling with the profound constitutional tensions at the heart of this debate. This judicial attitude has been a decisive factor in maintaining Nigeria's absolute prohibition on euthanasia. It has ensured that the conversation remains frozen in the theoretical realm of legislative possibility, rather than evolving through the dynamic process of constitutional interpretation. As a result, the Nigerian judiciary has, for now, firmly closed the courtroom doors to those seeking a legal recognition of their right to die with dignity, leaving the fundamental conflict between the state's power to preserve life and the individual's right to avoid intolerable suffering tragically unresolved.[158]

[158] Abikan, J., "Examining the Legality or otherwise of Euthanasia under Nigerian law and Islamic law". [2025] *Baco Law Review.*

CHAPTER FOUR

COMPARATIVE MODELS AND PROPOSED DECRIMINALIZATION FRAMEWORK

4.1 Comparative Jurisdictional Models

The journey through Nigeria's complex legal landscape has revealed a difficult conflict between the state's duty to protect life and the individual's right to die with dignity. As we seek solutions to this challenging problem, it becomes valuable to look beyond Nigeria's borders and learn from other nations that have faced similar dilemmas. This chapter explores how other countries have navigated the complex issue of euthanasia, not to copy their approaches blindly, but to learn from their experiences and gather ideas that might help Nigeria find its own path forward.

Looking at other countries shows us that Nigeria's current complete ban on euthanasia is not the only possible approach. Many other societies with their own strong cultural traditions and legal systems have chosen different paths. By examining these international models, we can move beyond theoretical debates and see how euthanasia laws actually work in practice. This helps replace fears and assumptions with real-world evidence about what has worked well and what challenges have emerged in other places.

The countries we will focus on, the Netherlands, Belgium, and Canada, were chosen for specific reasons. These nations were among the first to legally address euthanasia, so they have the most experience and the longest track records. They have spent years developing and refining their systems, giving us plenty of information to study. Each represents a slightly different approach within the broader concept of regulated euthanasia, allowing us to see a range of possibilities rather than just one model.

As we delve into the specific details of each country's system in the following sections, we will pay particular attention to the safeguards they have established, the practical

implementation of their laws, and the lessons they have learned along the way. This knowledge will provide essential groundwork for the final part of this chapter, where we will begin to envision what a uniquely Nigerian approach to this sensitive issue might look like one that respects both the sanctity of life and the reality of human suffering, while remaining true to Nigeria's cultural values and legal traditions.

4.1.1 The Netherlands

The Netherlands has created a unique system for dealing with euthanasia that has developed over many years. This system combines written laws with important court decisions to address the difficult question of how to allow medically assisted death while preventing abuse. The Dutch approach is known for being practical and step-by-step, focusing on finding solutions that work in real life rather than sticking strictly to theoretical ideas. The country's journey with euthanasia began not with a new law, but with doctors and patients facing difficult situations in hospitals and homes, which then led to court cases that gradually changed how the law was understood.[159]

The legal system in the Netherlands is based on written codes, but judges have played a crucial role in shaping euthanasia laws. The process started in 1973 with what became known as the *Postma case*[160]. In this case, a doctor had helped her mother die after her mother repeatedly asked for help ending her suffering. The mother was partially paralyzed, nearly deaf, and found her life unbearable. The court found the doctor guilty but gave her a very light punishment. More importantly, the judges stated that under certain specific conditions, a doctor might not be punished for helping a patient die. This was the beginning of the Dutch approach to euthanasia.

---

[159] Kouwenhoven, P. S. C., van Thiel, G. J. M. W., van DER Heide, A. & Rietjens, J. A. C., "Development in Euthanasia practice in Netherlands: Balancing Professional Responsibility and the Patient's Autonomy" (1) *European Journal of General Practice.*

[160] *Rechtbank Leeuwarden [District Court of Leeuwarden], February 21, 1973, NJ 1973, 183 (Netherlands)*

After the Postma case, other courts continued to develop these ideas. In the *Schoonheim case*[161] of 1984, the Supreme Court recognized that doctors could face a conflict between their duty to preserve life and their duty to relieve suffering. The court said that in some extreme situations, the duty to relieve suffering could be more important. These court cases created what became known as the "medical exception" to the normal rules against causing death. This meant that doctors who followed strict guidelines might not be prosecuted for helping a patient die.

All these court decisions and medical practices eventually led to a formal law called the Termination of Life on Request and Assisted Suicide Act[162], which took effect in 2002. This law did not so much create a new right as it officially recognized what had already been developing in Dutch medicine and law for nearly thirty years. The law provides legal protection to doctors who follow very specific procedures, bringing euthanasia out of the shadows and into a carefully regulated system.

The Dutch system for euthanasia can be understood by looking at its key features and the specific safeguards within each feature. The system is built upon a solid Legal Foundation, operating on the principle that euthanasia remains a criminal offense unless very specific conditions are met. This approach differs from simple legalization; instead, the law creates a "medical exception" that protects doctors from prosecution only when they follow all the rules carefully.[163] Key safeguards within this feature require that only doctors can perform euthanasia, excluding anyone else from assisting in death. Furthermore, doctors must follow all official procedures and report every case, with any case failing to meet all requirements being subject to prosecution as a criminal offense.[164]

---

[161] Hoge Raad [Supreme Court of the Netherlands], November 27, 1984, NJ 1985, 106 (Netherlands)

[162] *(Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands). <https://wetten.overheid.nl/BWBR0012410/2022-10-01>*

[163] Article 294 of the Dutch Penal Code

[164] Article 2(f) of the Termination of Life on Request (review procedures) Act

The system focuses heavily on the Patient's Request and Condition, centering on the patient's own experience and wishes. The patient must be experiencing suffering that they find unbearable, and there must be no realistic hope for improvement in their condition.[165] The safeguards here ensure the request is voluntary and well-considered, meaning it is not influenced by external pressure and the patient fully understands their situation and alternatives.[166] The suffering must be lasting and unbearable with no reasonable prospect of improvement, and the patient must repeat the request over time to show it is not a temporary feeling.[167] The case of Zoraya ter Beek[168] in 2024 shows how these rules can be applied even to mental suffering. This 29-year-old woman suffered from severe depression, autism, and anxiety disorders. After years of treatment with no improvement, doctors agreed that her suffering was unbearable and without prospect of improvement, meeting the legal requirements even though her illness was psychiatric rather than physical.

Another critical component is the Consultation Process. Before performing euthanasia, the attending doctor must consult with at least one other independent doctor who reviews the case separately. This second doctor, called a "scen doctor," examines the patient and confirms that all legal requirements have been met.[169] The safeguards within this process require that the consulting doctor must be independent, meaning they do not work closely with the first doctor. They must also actually see the patient and review the medical records, and they must agree that all legal requirements are met before the procedure can proceed.

The system also relies on a robust Reporting and Review System. After performing euthanasia, doctors must complete a detailed report explaining why they believed all legal requirements were met.[170] This report is submitted to a regional review committee that

---

[165] Article 2(b) of the Termination of Life on Request (review procedures) Act
[166] Article 2(a) of the Termination of Life on Request (review procedures) Act
[167] Article 2(b) of the Termination of Life on Request (review procedures) Act
[168] Kirby, J., “The last doctor to help you in the Netherlands” *The Free Press*
[169] Article 2(a) of the Termination of Life on Request (review procedures) Act
[170] Article 7(2) of the Dutch Act

examines every case. The safeguards here include the composition of these committees, which include a lawyer, a doctor, and an ethicist, bringing different perspectives to the evaluation. These committees have the power to refer cases to prosecutors if they find problems, and all cases are documented and become part of official statistics, creating transparency. The importance of proper reporting and review was shown in what became known as the Coffee Euthanasia Incident.[171] In this case, a doctor gave a dementia patient sedative medication in her coffee without clearly informing her, then performed euthanasia. The regional review committee found problems with how the doctor handled the case, particularly around ensuring clear consent at the moment of the procedure. This case highlighted how the review system works to maintain standards.

Finally, the system outlines Special Circumstances and Boundaries, with specific rules for particular situations that show how the law has continued to develop. The safeguards in this feature dictate that for young people aged 12-16, parents must be involved in the decision.[172] For patients who have lost the ability to communicate, previously written directives can be used but must be very specific.[173] The law also distinguishes between euthanasia and normal medical practice, such as stopping treatment that is no longer helping or giving pain medication that might shorten life as a side effect. The case of Gerrit Jan van Acht and his wife[174] in 2024 illustrates how the system handles complex situations. This former government official and his wife, both in their early seventies, chose to die together through euthanasia. Neither had a terminal illness, but both felt they had "completed life" and faced increasing health problems. Their case demonstrated how the concept of "unbearable suffering" has been interpreted to include multiple health issues in elderly patients, even when no single disease would be fatal.

---

[171] [1994] N.J. 656

[172] Article 2:4, paragraphs 2 and 3 of the Burial And Cremation Act

[173] Article 2(a) of the Termination of Life on Request (review procedures) Act

[174] Regional Euthanasia Review Committee RTE [2023] *Annual Reports* 2022 RTE

The Dutch system continues to evolve, with recent discussions about whether people over 75 who feel their life is complete should have access to euthanasia even without a medical condition. These ongoing debates show that the Netherlands continues to carefully consider how to balance the right to die with dignity against the need to protect vulnerable people.

Through this well-developed system of features and safeguards, the Netherlands has created a model that allows for euthanasia while maintaining strict oversight. The requirement that only doctors can perform euthanasia, combined with mandatory consultation and thorough review of every case, has created a system that has gained broad acceptance in Dutch society while maintaining legal and ethical standards.[175]

In conclusion, the Dutch model presents a pioneering framework built on incremental, bottom-up development, where decades of judicial decisions and medical practice gradually coalesced into formal legislation. This stands in stark contrast to the more immediate, comprehensive legislative approaches seen elsewhere. The Dutch system's great strength is its deep-rooted societal and medical consensus, forged through a long process of public debate and legal testing. However, its gradualist nature has also allowed for a significant expansion of eligibility criteria over time, from terminal physical illness to psychiatric suffering and "completed life" debates, a dynamic that critics point to as evidence of a "slippery slope." This model of organic, court-guided evolution offers a key point of comparison for the more rapid, top-down approaches that will be examined next.[176]

4.1.2 Belgium

Belgium has developed its own distinctive approach to euthanasia that builds upon but differs significantly from the Dutch model. Like the Netherlands, Belgium operates under a civil law system where written legal codes form the primary basis of law. However, Belgium's federal

[175] Regional Euthanasia Review Committee RTE [2023] *Annual Reports 2022 RTE*
[176] Kirby, J., “The last doctor to help you in the Netherlands” *The Free Press*

structure and distinct cultural composition have shaped a unique legal framework for end-of-life decisions. The Belgian approach reflects the country's complex linguistic and cultural diversity, with laws emerging from extensive parliamentary debate and societal consensus rather than incremental court decisions. This has resulted in one of the world's most comprehensive euthanasia laws, notable for its expansive scope and detailed procedural requirements.[177]

The historical development of Belgium's euthanasia law began with growing public and medical consensus during the 1990s.[178] Unlike the Netherlands, where courts gradually developed criteria over decades, Belgium moved directly to legislative action after a period of intense public debate. The Belgian Act on Euthanasia[179] was passed in 2002 after nearly three years of parliamentary discussion and represented a broad political consensus across linguistic and party lines. The law emerged from a growing recognition of patient autonomy and the reality that some forms of suffering cannot be alleviated through palliative care alone. This legislative approach created a clear legal framework from the outset, rather than building on existing medical practices as seen in the Netherlands.

Belgium's legal system incorporates the *parens patriae principle* – the idea that the state must act as a protector for those who cannot protect themselves. This principle is embedded throughout Belgium's euthanasia framework, particularly in provisions dealing with vulnerable populations. The law demonstrates how the state's protective role can be balanced with respect for individual autonomy, creating special safeguards for minors, mentally ill patients, and those who have lost decision-making capacity. This reflects Belgium's view that the state's duty to protect does not necessarily mean prohibiting all assisted death, but rather ensuring that any such decision is made with maximum protection against abuse or error.

---

[177] Adams M., & Nys H., "Comparative Reflections on the Belgium euthanasia act 2002" *Medical Law Review*
[178] Wikipedia, "Euthanasia In Belgium" *Wikipedia*
[179] Belgian Act on Euthanasia 28 May 2002. <http://www.ejustice.just.fgov.be/cgi_loi/loi_a1.pl?language=fr&caller=list&cn=2002052830&la=f&fromtab=wet&listelex=wet> Accessed 2 November, 2025

The Belgian system is structured around several fundamental components that work together to regulate euthanasia while emphasizing both patient autonomy and state. These elements can be understood by examining their key features and the specific safeguards built into each feature.

The legal framework and scope of the Belgian law establish euthanasia as a medical act rather than creating an exception to homicide laws.[180] This fundamental difference from the Dutch approach means euthanasia is integrated into normal medical practice under specific conditions. Safeguards within this feature include the restriction of the law's application only to physicians, thereby excluding other healthcare providers from performing euthanasia. Furthermore, euthanasia must be performed within an established doctor-patient relationship, and the law explicitly distinguishes euthanasia from other end-of-life decisions such as palliative sedation or the cessation of treatment.

Regarding the patient's request and condition, the Belgian law requires that the patient must be in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated.[181] This broad definition has allowed application to diverse medical situations beyond terminal physical illness. The safeguards require that the request must be voluntary, well-considered, and repeated, not resulting from external pressure.[182] The patient must be legally competent and conscious at the time of the request,[183] and the suffering must be documented thoroughly in the patient's medical records.[184] The Lydie Imhoff Case[185] demonstrates how these criteria are applied to complex medical situations. This 43-year-old French woman suffered from hemiplegia and blindness, a condition that caused constant physical suffering with no prospect of improvement, thus meeting the legal standard of

[180] Article 3(1) of the Belgian Act on Euthanasia, 2002
[181] Article 3(1)(2) of the Belgian Act on Euthanasia, 2002
[182] Article 3(1)(3) of the Belgian Act on Euthanasia, 2002
[183] Article 3(1) of the Belgian Act on Euthanasia, 2002
[184] Article 3(2) of the Belgian Act on Euthanasia, 2002
[185] Regional Euthanasia Review Committee RTE [2023] *Annual Reports 2022 RTE*

unbearable and untreatable suffering despite not having a terminal illness in the traditional sense.

The consultation and review process in Belgium requires a multi-layered approach that becomes more extensive for non-terminal cases or vulnerable patients. The safeguards mandate that one independent physician must review the case, with a second required if death is not expected in the foreseeable future.[186] For psychiatric patients, a third psychiatrist must be consulted, and all cases are reviewed after the fact by the Federal Control and Evaluation Commission. The increasing number of psychiatric condition cases, which saw a 78% increase in 2024 while still representing only 1.4% of total cases, shows how these consultation requirements work in practice.[187] Each such case undergoes particularly rigorous review, with multiple specialists ensuring the suffering is indeed unbearable and untreatable.

Special protections for vulnerable groups reflect Belgium's incorporation of the parens patriae principle, which is most evident in its provisions for minors and patients with limited decision-making capacity.[188] The safeguards require parental consent along with agreement from the child's care team for minors. Minors must also demonstrate a capacity of discernment to understand their decision. For adults who previously wrote advance directives but have lost competence, additional physicians must confirm the irreversibility of the medical condition. The minor's euthanasia cases since the 2014 legal extension illustrate these protections in action. Of the six minors who have received euthanasia under the law, each case involved terminal illness with unbearable physical suffering, and all involved extensive psychological evaluation alongside medical review, demonstrating the law's careful balancing of minors' emerging autonomy with the state's protective role.

---

[186] Article 5 of the Belgian Act on Euthanasia, 2002
[187] Wikipedia, “Euthanasia In Belgium” *Wikipedia*
[188] Article 3(2) of the Belgian Act on Euthanasia, 2002

Finally, Belgium has established a comprehensive documentation and reporting system that tracks all euthanasia cases and identifies emerging trends or concerns. The safeguards require physicians to complete detailed documentation for every case. The Federal Control and Evaluation Commission reviews each case retrospectively, and regular reports to Parliament ensure ongoing legislative oversight. The significant number of polypathology cases, representing 26.8% of cases in 2024 where patients suffer from multiple chronic conditions rather than a single terminal illness, has emerged through this reporting system. This transparency has allowed Belgium to monitor how its law is being applied to elderly patients with accumulating health problems rather than classic terminal diagnoses.

Belgium's approach continues to evolve, as seen in cases involving what some call being "tired of life." While not a formal legal category, some elderly patients with multiple age-related conditions have been granted euthanasia based on the cumulative burden of their health problems. These cases have prompted ongoing debate about the boundaries of "unbearable suffering" and whether the law should be expanded to include those without serious medical conditions who simply feel their life is complete.

The Belgian model demonstrates how a comprehensive legislative approach can create a regulated euthanasia system that emphasizes both patient autonomy and state protection. The incorporation of the parens patriae principle throughout the law shows a distinctive approach to safeguarding vulnerable individuals while respecting end-of-life choices. Through its detailed procedural requirements, multi-layered consultations, and comprehensive reporting system, Belgium has developed a framework that has gained broad societal acceptance while maintaining strict medical and ethical standards.[189] The ongoing evolution of Belgian euthanasia practice, particularly in areas like polypathology and psychiatric suffering,

[189] Adams M., & Nys H., “Comparative Reflections on the Belgium euthanasia act 2002” *Medical Law Review*

continues to provide valuable insights into how societies can balance compassion with protection in end-of-life care.

The Belgian approach, while enacted in the same year as the Dutch law, demonstrates a distinct comprehensive, legislative-first strategy. Unlike the Netherlands, where the law codified existing practices, Belgium's parliament proactively established a broad framework from the outset, notably including provisions for minors—a feature the Dutch initially avoided. Both systems share a broad definition of "unbearable suffering," but Belgium's stronger emphasis on the parens patriae principle is reflected in its more structured multi-layered consultations for non-terminal cases. Where the Dutch model evolved, the Belgian model was designed, making it a compelling study in how a legislature can attempt to anticipate complex ethical questions rather than resolving them post-hoc through the courts. This sets the stage for examining a third model, driven not by medical practice or legislative foresight, but by constitutional mandate.[190]

4.1.3 Canada

Canada has developed a distinctive approach to medically assisted dying that emerged from constitutional challenges rather than medical practice or legislative initiative. Unlike the Netherlands and Belgium, where laws evolved from longstanding medical practices or legislative debates, Canada's journey began in courtrooms through constitutional challenges to existing criminal laws. Canada operates under a common law system, where court decisions establish legal precedents, combined with a constitutional framework that gives courts the power to strike down laws that violate fundamental rights. This has created a unique dynamic where judicial decisions have repeatedly forced legislative action on end-of-life issues.

[190] Cohen-Almagor, R., “Belgian euthanasia law: A critical analysis” [2009] (7) *Journal of Medic*

The historical foundation for Canada's current law began with the landmark *Carter v. Canada*[191] case. This Supreme Court of Canada decision declared that the complete ban on physician-assisted dying violated Section 7 of the Canadian Charter of Rights and Freedoms, which guarantees "life, liberty and security of the person." The court reasoned that forcing individuals to endure intolerable suffering against their will deprived them of their dignity and autonomy. This ruling suspended the effect of the decision for one year, giving Parliament time to create a new legal framework. Unlike the Dutch model, which developed gradually over decades, Canada's system emerged rapidly following this decisive court ruling.[192]

In response to the Carter decision, the Canadian government passed federal legislation known as Medical Assistance in Dying (MAiD)[193] in 2016. This law established the initial framework for both euthanasia (where a doctor administers the substance) and assisted suicide (where the patient self-administers). The legislation reflected a cautious approach initially limited to competent adults whose natural death was "reasonably foreseeable." However, as with other jurisdictions, Canada's law has continued to evolve through both court challenges and legislative amendments.[194]

The Canadian system is built around several fundamental components that balance patient autonomy with protective safeguards. These elements can be understood by examining their key features and the specific safeguards within each feature.

The constitutional foundation of Canada's Medical Assistance in Dying (MAiD) framework is grounded in constitutional rights rather than a medical exception or purely legislative policy. This gives the system a strong rights-based orientation focused on individual

---

[191] [2015] 1 S.C.R. 331

[192] Chan B., & Somerville M., "Converting the 'right to life' to the 'right to physician assisted suicide and euthanasia': An analysis of Carter v Canada" (2) *Medical Law Review*

[193] Statute Law of Canada, Criminal Code RSC 1985, c C-46 (as amended re MAiD). <https://laws-lois.justice.gc.ca/eng/acts/C-46/>

[194] Library of Parliament, "Medical assistance in dying in Canada after Carter v Canada" *Parliament Of Canada Research Publication*

autonomy. Safeguards within this feature stipulate that only individuals who are eligible for publicly funded health services in Canada can access MAiD. Furthermore, the process must be conducted in accordance with federal law and applicable provincial health regulations, and healthcare providers have the right to conscientiously object without legal penalty.[195]

Regarding eligibility requirements, the Canadian law has established specific criteria that patients must meet to qualify for medical assistance in dying, with these criteria expanding over time through court decisions.[196] The safeguards require that the patient must be at least 18 years old and mentally competent to make health decisions.[197] The patient must have a grievous and irremediable medical condition, and the request must be voluntary and not result from external pressure.[198] The Truchon v. Attorney General of Canada case significantly expanded these eligibility requirements. This Quebec Superior Court decision struck down the requirement that natural death must be reasonably foreseeable, finding it unconstitutional to exclude people with severe chronic conditions who weren't necessarily dying. This ruling forced Parliament to amend the law in 2021 to include individuals whose natural death is not reasonably foreseeable, while adding additional safeguards for this group.

The request and assessment process in Canada involves a detailed procedure for requesting and assessing MAiD applications, with varying requirements based on whether natural death is foreseeable. Key safeguards require patients to make two separate requests, with a 10-day reflection period between requests when death is foreseeable, extended to 90 days when death is not reasonably foreseeable.[199] Additionally, two independent doctors or nurse practitioners must assess the patient and agree all criteria are met, and patients must be informed of available palliative care options and other support services. The case of the homeless man in

[195] Section 241.2(1)(a) of MAiD
[196] Section 241.2 of MAiD
[197] Section 241.2(1)(b) of MAiD
[198] Section 241.2(1)(a) of MAiD
[199] Section 241.2(3)(g) of MAiD

Ontario in 2022 revealed challenges in this assessment process. This individual applied for MAiD citing his inability to find adequate housing and support services, raising questions about whether social suffering rather than medical conditions was driving his request. The case highlighted the difficulty of ensuring that requests are truly voluntary and informed when patients face systemic social problems.

Special protections for vulnerable populations include specific measures to protect potentially vulnerable individuals, particularly those whose natural death is not reasonably foreseeable or who have mental illness. The safeguards specify that for cases where death is not foreseeable, one assessor must have expertise in the patient's condition. Patients must be informed of available support services and offered consultations with relevant professionals, and there are additional waiting periods for cases involving solely mental illness. The ongoing debate around extending MAiD to cases involving mental illness as the sole underlying condition demonstrates the careful approach Canada is taking. While originally scheduled for implementation in 2023, this expansion has been repeatedly delayed to develop appropriate safeguards and assessment protocols for this particularly vulnerable population.

Finally, Canada has established a comprehensive federal monitoring system to track all MAiD cases and identify emerging trends or concerns. The safeguards require all MAiD providers to complete detailed reporting forms for each case. Health Canada publishes annual reports on MAiD implementation and trends, and an independent parliamentary committee regularly reviews the law's operation. The case of the elderly woman in 2025 illustrates how this monitoring system helps identify concerning trends. In this situation, a woman accessed MAiD partly due to her husband's caregiver burnout, raising questions about whether the decision was fully voluntary or influenced by family pressures. Such cases are carefully reviewed to ensure proper procedures were followed.

Canada's approach continues to evolve, as seen in *Quebec's advance requests legislation*[200] (2023). This provincial law allows individuals to make advance requests for MAiD in case they develop severe dementia or other conditions that would rob them of decision-making capacity. This represents the next frontier in Canada's assisted dying framework, though it currently creates a patchwork system since federal law doesn't yet recognize advance requests. The Canadian model demonstrates how a rights-based constitutional approach can rapidly transform end-of-life care options. From complete prohibition to established medical practice in less than a decade, Canada's experience shows how court-driven reform can compel legislative action. However, this rapid transformation has also created challenges, particularly in ensuring proper safeguards keep pace with expanding eligibility.

Through its detailed assessment requirements, mandatory waiting periods, and comprehensive reporting system, Canada has developed a framework that emphasizes both individual autonomy and protection for vulnerable populations. The ongoing evolution of Canadian MAiD practice, particularly in areas like mental illness and advance requests, continues to provide important lessons about implementing medically assisted dying in a diverse, federated country with a strong constitutional framework[201].

Canada's MAiD framework represents a third, distinct pathway: a rights-based, constitutional model compelled by judicial ruling. Unlike the consensus-driven evolution in the Netherlands or the legislative design of Belgium, Canada's system was born from the top down, when the Supreme Court invalidated the blanket prohibition on assisted dying. This foundational difference in origin has profound consequences. While the Dutch and Belgian systems were integrated into existing medical ethics frameworks, Canada's was constructed as a legal right from the start, leading to a more rapid and arguably more expansive evolution, as seen in the

---

[200] Act respecting end-of-life care, CQLR, c S-32.0001 (as amended by Bill 11, assented to on June 9, 2023)

[201] Downie, J., Scallion, K. & Sneiderman, B., "Legal and Ethical Perspectives on Canada's Evolving MAiD Framework" (2023) 31(1) *Health Law Review*.

Truchon case. This rights-centric focus creates a powerful imperative for access but also generates unique tensions, particularly regarding whether safeguards can adequately protect the vulnerable when the primary legal driver is individual autonomy.[202]

Together, these three models—the incremental Dutch, the comprehensive Belgian, and the rights-based Canadian—provide a rich spectrum of options and cautions from which a tailored Nigerian framework can be designed.

4.2 Lessons for Nigeria: A Critical Synthesis of Comparative Models

The detailed examination of the Netherlands, Belgium, and Canada reveals that there is no single, perfect blueprint for regulating euthanasia. Each nation's framework is a product of its unique legal history, social values, and political climate. This chapter moves beyond description to critically synthesize these international experiences, extracting concrete lessons for Nigeria. The goal is to answer the fundamental "so what?" question: How can Nigeria's profound legal and human rights dilemma, as established in Chapter 3, be resolved by intelligently adapting, rather than blindly adopting, these foreign models? The analysis will focus on four critical thematic areas: the process of legalization, the scope of eligibility, the architecture of safeguards, and the systems for implementation and oversight.[203]

4.2.1. The Pathway to Legalization

The journey toward legalization is as important as the final law itself, and the three models offer Nigeria starkly different paths. The Netherlands demonstrates the "Incremental Evolution" model. Its decades-long process, beginning with the *Postma* case in 1973, allowed for a gradual shift in public and medical consensus. This bottom-up approach, where courts

---

[202] Lazin S.J. & Chandler J.A, "Two views of vulnerability in the euthanasia as medical assistance in Dying law" (1) *Cambridge quarterly of healthcare*

[203] Jaime, "Two decades of research on euthanasia from the Netherlands: what have we learned and what questions remain?" (2) *Journal Of Bioethical Inquiry*

responded to evolving medical practices, built a solid foundation of acceptance that made the 2002 law a formality rather than a revolution. The lesson is that slow, organic change can foster deep-rooted legitimacy. However, the disadvantage of this model is its slowness and unpredictability; it leaves vulnerable citizens suffering for decades while society debates their fate.[204]

In contrast, Canada exemplifies the "Constitutional Mandate" model, driven by the top-down force of the *Carter v. Canada*[205] ruling. This approach is powerful and swift, compelling legislative action within a fixed timeframe. It frames assisted dying not as a privilege but as a fundamental constitutional right, creating a strong legal imperative for access. However, this speed comes at a cost. The rapid implementation of Medical Assistance in Dying (MAiD) in Canada has, at times, outpaced the development of supporting infrastructure and societal consensus, leading to the troubling scenario where individuals, like a homeless man in Ontario may seek death due to a lack of social support. For Nigeria, this is a crucial warning: a rights-based, court-driven approach could create a legal right to die without first building the healthcare and social safety nets that make life livable for the terminally ill and vulnerable. Belgium offers a middle ground: the "Comprehensive Legislative" model. Its 2002 law was the product of sustained parliamentary debate, creating a detailed framework from the outset. This approach allows for careful, deliberate design and the incorporation of specific safeguards, such as its strong *pares patriae* provisions for minors. The lesson is that a focused national dialogue can proactively address complex issues.[206]

For Nigeria, the synthesized lesson is that a hybrid pathway is most advisable. While a Canadian-style constitutional challenge might be tempting for its speed, it risks a disruptive and socially divisive imposition. A better approach would be to initiate a deliberate, Belgian-

---

[204] Lazin S.J. & Chandler J.A, "Two views of vulnerability in the euthanasia as medical assistance in Dying law" (1) *Cambridge Quarterly Of Healthcare*
[205] ibid
[206] Wikipedia, "Euthanasia in Belgium" *Wikipedia*

style parliamentary process, informed by the Dutch principle of building medical and public consensus. This could involve establishing a Presidential or National Assembly Commission of Inquiry to study the issue, gather public testimony, and draft legislation, thereby creating a made-in-Nigeria solution rather than importing a foreign one.[207]

4.2.2. Defining Eligibility

The definition of "unbearable suffering" is the philosophical heart of any euthanasia law, and the comparative models show a clear trend toward expansion, which Nigeria must view with caution. The Netherlands and Belgium began with broad definitions that included mental suffering, and this has progressively widened to encompass conditions like "paleopathology" (multiple chronic ailments) and, in Dutch public debate, being "tired of life." While this expansive approach respects broad patient autonomy, it validates the central fear of the "slippery slope." Cases like the Dutch *Zoraya ter Beek* , involving severe psychiatric illness, demonstrates the extreme complexity of assessing "irremediable" mental suffering and raise ethical questions about whether the medical system should be in the business of ending lives due to mental pain.[208]

Canada's experience provides the most potent warning. The *Truchon* decision's removal of the "reasonably foreseeable death" requirement, while rights-expanding, directly opened the door to the paradigm-shifting problem of social suffering. The case of the homeless man is not an anomaly but a logical consequence of expanding eligibility in a society with inadequate social support. It reveals the danger of a law that offers death as a solution to problems of poverty, disability, and State failure.[209]

---

[207] Bayne, J., "Euthanasia in Belgium: Legal, Historical And Political Review" *Issues In Law And Medicine*

[208] Bioethics Observatory, "The case of Zoraya ter Beek: Euthanasia for depression" [2004] *Bioethics Observatory*

[209] United Nations/ECLJ, " UN experts speak out against the euthanasia of persons with disabilities" *European Center For Law And Justice*.

For Nigeria, the imperative lesson is to begin with a narrow, precise, and medically grounded eligibility criterion. Nigeria should explicitly reject, at least in the initial phase, the expansion into psychiatric suffering as a sole condition and must guard against any interpretation that could link euthanasia to socioeconomic deprivation. The focus should be strictly on competent adults suffering from a terminal, physically manifest illness causing intolerable and unrelievable pain, where even the best available palliative care is insufficient. This conservative starting point is crucial for gaining public trust, ensuring political feasibility, and preventing the law from being misused as an escape valve for systemic failures in Nigeria's healthcare and social welfare systems.[210]

4.2.3. Designing Safeguards

All three jurisdictions recognize that robust safeguards are the price of societal permission for euthanasia. The key lesson for Nigeria is that safeguards must be multiple, independent, and designed with local realities in mind.

i. Independent Consultation: The Duche*ne* doctor and the Belgian multiple-consultant model are non-negotiable. Relying on a single doctor's assessment is insufficient. For Nigeria, this means mandating that at least one of the two required independent physicians must be from a different institution to prevent institutional collusion and bring a fresh perspective.[211]

ii. Voluntariness and Reflection: The mandatory reflection periods in Canadian law (10-90 days) are a critical safeguard against impulsive decisions. In the Nigerian context, where family pressures can be immense, this cooling-off period is even more vital. Furthermore, the assessment process must include private conversations with the patient, away from family members, to ensure the request is truly voluntary and not driven by a sense of being a burden.

---

[210] Downie J., & Chandler J., "safeguards and eligibility in assisted dying legislation: Lessons for Canada and Belgium" (2) *Journal Of Medical Ethics*

[211] Oluoch A.M., "Palliative care in Nigeria: Current status and future directions" [2021] (2) *Journal Of Pain And Symptom Management*

iii. Palliative Care Integration: A profound lesson from all models is that euthanasia must not be a substitute for care. Canada's requirement to inform patients about palliative options should be a cornerstone of the Nigerian framework. However, this must be coupled with a sincere government commitment to actually develop palliative care services. Otherwise, this safeguard becomes an empty gesture, forcing patients to "choose" death because no real alternative exists.

The synthesized lesson for Nigeria is the "Reinforced Safeguard Pyramid."This would consist of a foundation of improved palliative care, walls of multiple independent assessments and mandatory reflection periods, and a roof of transparent oversight. This multi-layered approach is necessary to build confidence in a system that, in the Nigerian cultural and religious context, will be viewed with deep suspicion.[212]

A law is only as good as its implementation. The Dutch and Belgian systems shine in their establishment of independent, multidisciplinary review committees.[213] These bodies, comprising doctors, lawyers, and ethicists, provide essential post-hoc scrutiny that deters malpractice and maintains public trust. Their regular public reports turn abstract fears into accountable data.

Canada's federal monitoring system provides valuable nationwide data, but its rapid expansion has sometimes strained its oversight capabilities. The lesson is that the oversight body must be designed with sufficient capacity and expertise to handle the complexity of cases, especially if the law expands in the future.[214]

For Nigeria, the critical lesson is to legislate for transparency from day one. The proposed *National End-of-Life Care Review Commission* should be established as an independent body, insulated from political interference, with the power to review every case, audit procedures,

---

[212] Nwoye A., "Cultural perspectives on healthcare in Nigeria" [2020](1) *International Journal Of Health Services*

[213] Cohen-Almagor R., "First do no harm: Euthanasia and Physician's role" (1) *J. of Law and Medicine*

[214] Battin M., "Euthanasia and physician assisted suicide: what do the data really show?" (5) *J. Med Ethics*

and refer any violations to the Medical and Dental Council of Nigeria and the Attorney-General.[215] Its annual report to the National Assembly would be a vital tool for ensuring accountability and guiding any future legislative refinements.[216]

In concluding this sub-section, it should be noted that the comparative analysis of the Netherlands, Belgium, and Canada yields not a single, ready-made model for Nigeria to adopt, but rather a rich repository of wisdom from which to construct a uniquely Nigerian path forward. The experiences of these pioneering jurisdictions provide less a definitive answer and more a set of navigational tools, comprising both inspiring innovations and grave warnings, to guide Nigeria through the complex ethical and legal terrain of euthanasia. The synthesis of these lessons crystallizes into four foundational principles that should underpin any future Nigerian framework, ensuring it is both compassionate and cautious, and that it respects the nation's profound cultural values while addressing the stark reality of human suffering.[217]

The first of these is the Principle of Prudent Incrementalism. This principle acknowledges that radical, swift legal change on such a sensitive issue risks social discord and a crisis of public trust.[218] The Dutch model demonstrates the strength of a gradual, consensus-building approach, while Canada's rapid, rights-driven expansion highlights the perils of moving faster than a society's ethical and institutional capacity can bear. For Nigeria, this translates to the necessity of beginning with a narrowly focused law. The initial scope should be carefully circumscribed, perhaps limited to competent adults experiencing unbearable physical suffering from a terminal illness, where even the best available palliative care proves

---

[215] Cohen-Almagor R.,"Euthanasia in the Netherlands and Belgium: Two legal systems one conceptual framework" (1)*Healthcare Analysis*

[216] Lewis P., "The regulation of euthanasia and assisted suicide: Development in the Netherlands" (2) *Medical Law Review.*

[217] Nwafor A. O., "Human dignity and the right to die in Africa: A legal and ethical inquiry" (2) *African journal of law and ethics*

[218] Keown, J., "Euthanasia, Ethics and Public Policy: An argument against legalization" [2002] *Cambridge University press.*

insufficient. This deliberate, cautious start would allow the medical, legal, and religious communities to build experience and trust within a clear boundary, creating a stable foundation before any consideration of expanding eligibility to more complex and controversial cases, such as those involving psychiatric suffering or early dementia.[219]

Complementing this measured approach is the Principle of Inviolable Safeguarding. This principle asserts that the protection of the vulnerable must be the paramount concern of the legal framework, taking precedence over the principle of easy access.[220] The sophisticated safeguards of Belgium and the Netherlands - the independent consultants, mandatory reflection periods, and multi-layered consultations - offer a toolkit that Nigeria must adapt to its own social context. This is particularly critical in a culture with strong familial bonds, where the potential for subtle pressure on the elderly or ill must be proactively counteracted. Safeguards must therefore be designed not in abstraction, but with a deep understanding of Nigerian society, ensuring that a patient's request is truly voluntary, well-considered, and free from coercion, whether from family members facing caregiver burnout or from a healthcare system strained for resources.[221]

Furthermore, any movement toward legalization must be governed by the Principle of Integrated Development. It would be morally indefensible to create a legal pathway to death without simultaneously strengthening the pathways to care and comfort.[222] The troubling cases emerging from Canada, where individuals facing homelessness or inadequate social support have sought euthanasia, serve as a stark warning. For Nigeria, where palliative care remains a privilege for the few, legalizing euthanasia in the absence of a robust, parallel national commitment to palliative care would be a catastrophic failure of the state's duty to

---

[219] Nwafor A. O., "Human dignity and the right to die in Africa: A legal and ethical inquiry" (2) *African journal of law and ethics*

[220] Lewis P., "Safeguards in the law of assisted dying" (3) *Medical Law Review*

[221] Dyer C., "End of life decisions ensuring voluntariness and preventing coercion" (1) *Journal Of Medical Ethics.*

[222] Gopal A. A., "Assisted dying and ethics of healthcare development" (4) *Journal Of Medical Ethics*

protect life. The right to choose a death with dignity must be built upon the prior guarantee of a life with dignity, which includes access to pain management, psychosocial support, and compassionate end-of-life care. The legislation of euthanasia must, therefore, be explicitly and irrevocably tied to a concurrent, funded national policy for developing palliative care infrastructure across the country.[223]

Finally, the entire system must operate under the Principle of Radical Transparency. Public trust, once lost on this deeply sensitive issue, may be impossible to regain.[224] The Dutch and Belgian systems show the indispensable value of independent, multidisciplinary review committees that conduct post-hoc scrutiny of every case. For Nigeria, the establishment of a National End-of-Life Care Review Commission, empowered to audit procedures, review cases, and publish annual reports for the National Assembly, is non-negotiable. This transparency turns abstract fears of a "slippery slope" into accountable data, demystifies the practice, and holds all actors—doctors, institutions, and the state—accountable to the people they serve.

By internalizing these four principles—Prudent Incrementalism, Inviolable Safeguarding, Integrated Development, and Radical Transparency—Nigeria can navigate its way toward a resolution of the profound conflict between criminal law and human dignity. This principled approach allows the nation to learn from the world without being subsumed by it, creating a legally sound, ethically defensible, and uniquely Nigerian framework that truly balances the sanctity of life with the right to die with dignity. This synthesis forms the essential intellectual and moral foundation for the specific legislative and institutional proposals that will be detailed in the final section of this chapter.[225]

---

[223] World Health organization, "Palliative care: Key Facts And Global Policy Recommendations" [2018] *World Health Organization.*

[224] Regional Euthanasia Review Committee RTE, "Annual Reports Of The Dutch Euthanasia Review Committee" [2018] *RTE Netherlands*

[225] Nwafor A. O., "Human dignity and the right to die in Africa: A legal and ethical inquiry" (2) *African journal of law and ethics*

4.3 Contextual Preconditions and Challenges for Nigeria

The comparative analysis in the previous section provides a valuable toolkit of principles and warnings from the experiences of the Netherlands, Belgium, and Canada. However, a law does not operate in a vacuum; it functions within the complex reality of a specific society. Therefore, before any concrete framework can be proposed, it is essential to pause and critically examine the unique Nigerian landscape. This section serves as this crucial reality check. It moves from the question of "what can we learn?" to the more demanding question of "what must we overcome?" Here, we will confront the fundamental preconditions and formidable challenges that would shape any attempt to decriminalize euthanasia in Nigeria. The sophisticated models of Western nations are built upon a foundation of robust healthcare infrastructure, strong secular institutions, and comprehensive social safety nets—conditions that are not fully present in the Nigerian context. This analysis will therefore focus on three major areas of concern: the significant gaps in Nigeria's institutional and healthcare capacity, the profound influence of socio-cultural and religious beliefs, and the pervasive risk of socio-economic vulnerabilities that could undermine the very concept of a voluntary choice. By honestly appraising these hurdles, we can ensure that any proposed framework is not only legally sound but also practically feasible and ethically just in the Nigerian context.[226]

4.3.1 Assessing Institutional and Healthcare Capacity

The journey toward a compassionate and legally sound end-of-life framework for Nigeria must be guided not only by international lessons but also by a clear-eyed understanding of the local landscape. This section does not seek to highlight impediments to dismiss the possibility of decriminalization, but rather to identify the critical preconditions that must be met to ensure its success. By honestly assessing the current state of our institutional and healthcare

[226] Okonkwo L., “Ensuring practical and ethical feasibility in Nigeria end of life regulation” [2021] (14)(2) *Nigerian Of Journal Medical Law And Ethics*

capacity, we can tailor a uniquely Nigerian model that is both pragmatic and ethically robust, turning potential weaknesses into pillars of a responsible system.[227]

A primary consideration is the foundational role of palliative care. The comparative analysis firmly establish that access to comfort care is the ethical bedrock that makes a voluntary choice for euthanasia truly free.[228] In Nigeria, the current scarcity of palliative services is not a reason to abandon the entire endeavor, but rather the central justification for integrating its development directly into the legislative proposal. Therefore, a future legal framework must be explicitly linked to a mandated, funded national strategy for palliative care. This ensures the law acts as a catalyst for improving end-of-life care for all Nigerians, guaranteeing that the right to choose a dignified death is built upon the prior guarantee of a life with dignity and comfort.

Furthermore, the sophisticated safeguards from other models provide a valuable blueprint, but their implementation requires adaptation to Nigeria's institutional realities. The challenge of a doctor shortage, for instance, does not invalidate the need for independent reviews; instead, it informs the design of a more flexible yet rigorous safeguard system. This could involve leveraging digital technology for remote specialist consultations or establishing regional panels of certified doctors to ensure genuine independence, even within resource constraints.

Similarly, potential administrative weaknesses in oversight are not a cause for despair but a compelling reason to prioritize transparency and accountability from the outset.[229] The proposal for a National End-of-Life Care Review Commission becomes even more crucial, as its very creation would establish a new gold standard for medical oversight in Nigeria. By

---

[227] Akpuogwu M.O., "The ethics of providing quality healthcare system in Nigeria" [2025](9)(02) *International Journal Of Research Innovation In Social Sciences (IJRISS)*

[228] Alanazi M. A., et al "Navigating end of life decision making in nursing: A systemic review of ethical challenges and palliative care practices." [2024] (23)(467) *Nigerian Journal of Health Policy and Ethics.*

[229] Samuel O.O., "Transparency, and Accountability concerns in the Nigerian Public Sector" [2004](8)(6) *International Journal of Research and Innovation in Social Sciences.*

designing this body to be independent, well-resourced, and mandated to publish public reports, the framework can build public trust and create a self-correcting mechanism that strengthens the entire healthcare system.[230]

In conclusion, assessing institutional capacity is not a negative exercise. It is the essential process of grounding a profound legal and ethical reform in reality. By recognizing these challenges, we can craft a framework that is not a mere copy of foreign models but a pioneering Nigerian solution—one that proactively builds the necessary healthcare infrastructure, adapts safeguards to local conditions, and uses the force of law to drive systemic improvement for the benefit of all citizens facing the end of life.[231]

4.3.2 Navigating Socio-Cultural and Religious Realities

After assessing the tangible challenges of infrastructure, we must now turn to the powerful, though less visible, forces that will shape any law on euthanasia in Nigeria: the nation's deep-rooted socio-cultural and religious values. The Western models we have studied often operate in societies where individual choice is the highest principle. In Nigeria, however, a person's identity is deeply tied to their family, community, and faith. This fundamental difference means that a legal framework cannot be simply copied; it must be carefully adapted to navigate this unique landscape. The success of such a law will depend entirely on its ability to respect the individual's right to choose while acknowledging the profound influence of their social and spiritual world.[232]

A central feature of this landscape is the strength of the family unit. In Nigeria, major life decisions—from marriage to career choices—are often made collectively. The idea of a person privately deciding to end their own life can seem isolating and even disrespectful to

---

[230] Regional Euthanasia Review Committee RTE, "Annual Reports Of The Dutch Euthanasia Review Committee" [2018] *RTE Netherlands*

[231] Akpuogwu M.O., "The ethics of providing quality healthcare system in Nigeria" [2025](9)(02) *International Journal Of Research Innovation In Social Sciences (IJRISS)*

[232] Rego et al, "Moral agency and spirituality in palliative care" [2024] *Annals of Palliative Medicine*

this communal way of life. This creates a complex challenge. On one hand, a patient may feel pressured by their family to continue living, against their own wishes, due to a sense of religious duty. On the other hand, and perhaps more worryingly, a patient might feel an immense, unspoken pressure to request euthanasia to stop being a perceived "burden" on their relatives, both emotionally and financially. This means the legal concept of a "voluntary" request must be fortified with specific safeguards, such as mandatory private conversations between the doctor and patient, to ensure the choice is truly their own.[233]

Furthermore, Nigeria is a nation of vibrant and deeply held religious beliefs, primarily Christianity and Islam. Both traditions traditionally emphasize the sanctity of life as a gift from God, which is not for humans to take. This will inevitably lead to significant opposition from religious institutions and many citizens. This opposition is not just a matter of opinion; it has practical consequences. Faith-based organizations run a large number of the country's hospitals and clinics. If a euthanasia law does not include clear conscience clauses, these institutions may refuse to participate, creating huge gaps in access. Therefore, the law must strike a delicate balance. It must protect the right of healthcare providers and institutions to refuse involvement based on their beliefs, while also ensuring that patients who wish to access the law can be transferred to a willing facility, guaranteeing that their legal rights are not denied by a provider's religious objections.[234]

In conclusion, the socio-cultural and religious context in Nigeria does not make a euthanasia law impossible, but it makes it necessary to build a uniquely Nigerian model. This model cannot be based solely on individual choice. It must be a bridge between the individual and their community, and between secular law and religious faith. By proactively designing safeguards against family pressure and creating a system that respects both religious objectors

---

[233] Paterick T. J., "Medical informed consent: General considerations for…" [2008] *Mayo Clinic*

[234] Mark R. W., "Which legal approaches help limit harms to patients from clinician's conscience-based refusals?" [2020](22)(3) *AMA Journal of Ethics*

and secular rights, the framework can seek not to override Nigerian values, but to find a compassionate and workable path within them.[235]

4.3.3 Mitigating Socio-Economic Vulnerabilities

The final, and perhaps most profound, challenge in adapting a euthanasia framework for Nigeria lies in the nation's pervasive socio-economic inequalities. A fundamental principle of ethical euthanasia is that the request must be entirely voluntary, free from any form of pressure or coercion. In a country where a large portion of the population lives in poverty and the social safety net is weak, this principle faces its ultimate test. The danger is that a law designed to relieve unbearable medical suffering could instead become a tragic solution for social and economic suffering. Therefore, the framework must be designed with extreme caution to ensure it does not become a pathway for the poor and vulnerable, who see no other way out, while remaining a genuine option for those in intractable pain.[236]

The core of the problem is financial. For many Nigerian families, a prolonged terminal illness is not just a health crisis but a fast track to financial ruin. The high cost of medical care, combined with the loss of income if a family member must stop working to become a caregiver, can push an entire household into destitution. In this context, a patient's request for euthanasia may not be driven solely by physical pain, but by the overwhelming fear of impoverishing their loved ones. This creates a situation where the choice is not free, but is instead a forced decision based on economic desperation. What looks like an act of personal autonomy could, in reality, be an act of sacrifice under severe financial pressure. The law

---

[235] Mark R. W., "Which legal approaches help limit harms to patients from clinician's conscience-based refusals?" [2020](22)(3) *AMA Journal of Ethics*

[236] Wicclair M., "The reasonableness standard for conscientious objection in healthcare" [2022] *Journal of Bioethics Inquiry.*

must be able to distinguish between a desire to end suffering and a feeling of being a financial burden.[237]

This leads to a wider issue of state responsibility. The troubling cases from other countries, where individuals have sought euthanasia due to homelessness or an inability to get adequate social support, serve as a stark warning. For Nigeria, the risk is that a euthanasia law could be misused as an escape valve for systemic failures in housing, healthcare, and social welfare. It would be a catastrophic moral failure if the state offered death as a solution to problems it has a fundamental duty to solve. A legal right to die must not be created in a vacuum where the right to a dignified life is already under threat.[238]

Consequently, for a choice to be truly free, a person must have acceptable alternatives. If high-quality palliative care is unavailable and the cost of ongoing care is catastrophic, then the option to continue living becomes a sentence to either unbearable pain or utter destitution. In such a situation, choosing euthanasia is not a free preference but the only perceived escape from an impossible situation. This is not real autonomy; it is the absence of viable options. Therefore, any future framework must be acutely aware of this dynamic. It must include robust safeguards to identify and protect patients whose requests are primarily motivated by socio-economic desperation. This reinforces the necessity for a narrow eligibility criteria, at least initially, to prevent the law from deepening existing social inequalities and to ensure that the choice for a dignified death is never a substitute for the state's duty to provide a dignified life.[239]

4.4 Proposed Framework for a Nigerian Model on Decriminalizing Euthanasia

Guided by the international lessons from the Netherlands, Belgium, and Canada, and sobered by the specific challenges within the Nigerian context, we now arrive at the core objective of

---

[237] Baergen R. N., & Skidmore J., "Conscience At The End Of Life" [2024](14)(4) *Nursing Reports.*
[238] Oniha, B. E., "Legality of Euthanasia and the Right to Die in Nigeria" *Nigeria Judiciary.*
[239] Richards S., "The Morality Of Assisted Dying" [2025](50)(4) *Journal of Medical Philosophy.*

this chapter: proposing a tailored framework for Nigeria. This section moves from analysis to synthesis, weaving together the threads of global wisdom and local reality to construct a practical and ethically defensible model. The proposed framework is built on the understanding that for such a sensitive issue to be successful in Nigeria, it must be introduced with caution, protected by robust safeguards, and integrated with a commitment to improving end-of-life care for all. Therefore, this proposal outlines a concrete structure based on three interconnected pillars: thoughtful legislative reforms to define the law, strong institutional safeguards to govern the process, and transparent oversight mechanisms to ensure accountability and maintain public trust. This is not a copy of a foreign system, but a made-in-Nigeria solution designed to navigate the nation's unique legal, cultural, and social landscape, offering a compassionate choice while fiercely protecting the most vulnerable.

4.4.1 Core Legislative Reforms: The Terminal Patient Autonomy Act and Criminal Code Amendment

The foundation for decriminalizing euthanasia in Nigeria requires two specific and interconnected legislative actions. This dual approach is designed to provide clarity, safety, and a strong legal foundation. The first and most central action is the enactment of a new, dedicated statute, which we will refer to as the Terminal Patient Autonomy Act. This law would serve as the comprehensive rulebook, formally establishing the right of a competent adult suffering from a terminal physical illness to request a medically assisted death.[240]

To ensure clarity and prevent misuse, the Act itself must explicitly define its core terms. It would precisely define key concepts such as "terminal illness" as an incurable and advanced disease that has been confirmed by multiple physicians and will, within reasonable medical judgment, lead to natural death in the foreseeable future. "Unbearable suffering" would be characterized as severe physical pain or decline that cannot be alleviated in a manner the

[240] Vermont, “Patient Choice and Control at the end-of-life” [2013] *Wikipedia.*

patient deems tolerable, even with the best available palliative care. Furthermore, "competent adult" would be clearly outlined, requiring a patient to be of sound mind, at least 18 years of age, and capable of understanding the nature and consequences of their decision at the time of the request. To build public trust and ensure a cautious start, this Act would be deliberately narrow in its initial scope, focusing only on end-stage physical conditions and explicitly excluding requests based solely on mental illness, disability, or general socio-economic deprivation.[241]

However, creating this new right is only one part of the solution. The second crucial step is to amend the relevant sections of the Nigerian Criminal Code (and the Penal Code for northern states). Currently, these laws define euthanasia as murder or culpable homicide without any exceptions. To align the criminal law with the new Act, a specific amendment must be introduced. This amendment would not remove the existing prohibitions but would add a vital clause: it states that a medical practitioner is not guilty of a criminal offence if they can prove they acted in strict, verifiable compliance with all the procedures and safeguards outlined in the Terminal Patient Autonomy Act.[242]

A final critical component of the Act would be a robust conscience clause. This clause would legally protect the rights of healthcare institutions and professionals. It would state that no doctor, nurse, or hospital (including faith-based institutions) can be compelled to participate in the assessment or procedure for euthanasia if it violates their ethical or religious beliefs. However, the Act would also place a duty on objecting institutions to ensure the patient is not abandoned, requiring them to facilitate a timely transfer of care to a willing provider, thus balancing individual conscience with patient rights.[243]

---

[241] Regional Euthanasia Review Committee RTE, “Annual Reports Of The Dutch Euthanasia Review Committee” [2018] *RTE Netherlands*

[242] *Baxter v State* [2009] MT 449

[243] Vermont, “Patient Choice and Control at the end-of-life” [2013] *Wikipedia*

This two-part strategy creates a robust and secure legal framework. The Terminal Patient Autonomy Act acts as the detailed guide, setting out the rights, procedures, and eligibility criteria. Simultaneously, the amendment to the Criminal Code acts as a legal shield for doctors, protecting them from prosecution only when they meticulously follow the rules. Together, they transform euthanasia from a hidden criminal act into a transparent, regulated medical practice, balancing the patient's right to autonomy with the state's duty to protect life and prevent abuse.[244]

4.4.2 Integrated Institutional Safeguards and Procedures

For the proposed law to function safely and ethically, it must be supported by strong institutions and clear procedures. These safeguards are the practical mechanisms that will protect vulnerable patients and ensure every decision is made with the utmost care and transparency. The core of this system is the establishment of a National Euthanasia Board. This independent body, composed of doctors, lawyers, ethicists, and patient advocates, would serve as the central guardian of the process. Its duties would be threefold: first, to set national guidelines and train certified physicians; second, to maintain a registry of all cases for oversight; and third, to conduct a post-review of every case to ensure all rules were followed and to investigate any potential irregularities. This Board acts as a nationwide watchdog, providing consistency and accountability from the top down.[245]

To ensure its independence, the Board must be insulated from political interference, with its funding directly allocated from the national budget and its members appointed through a transparent, merit-based process.[246]

---

[244] Oniha, B. E., "Legality of Euthanasia and the Right to Die in Nigeria" *Nigeria Judiciary.*

[245] Regional Euthanasia Review Committee RTE, "Annual Reports Of The Dutch Euthanasia Review Committee" [2018] *RTE Netherlands*

[246] Adams M., & Nys H., "Comparative Reflections on the Belgium euthanasia act 2002" *Medical Law Review*

A second, non-negotiable safeguard is the mandatory palliative care consultation. This requirement is a crucial ethical checkpoint built directly into the patient's journey. Before a request can be approved, the patient must have a full consultation with a specialized palliative care team, where available. The purpose of this meeting is not to persuade the patient against their choice, but to act as a "palliative filter." It ensures the patient is fully informed of all options for pain management, psychological support, and comfort care. This confirms that the request stems from unbearable suffering that cannot be relieved, rather than from a lack of access to or knowledge about proper care. It makes euthanasia a genuine last resort, not a default solution.[247]

Crucially, the law must mandate a documented "Palliative Care Alternatives" form, signed by both the palliative care specialist and the patient, detailing the options that were discussed. This document becomes a permanent part of the patient's file, providing tangible proof that this safeguard was not bypassed.

Finally, the entire process must follow a multi-layered approval pathway. This involves the certified attending physician and a second, completely independent consultant, both of whom must confirm the patient's eligibility and that the request is voluntary. To prevent collusion, the second consultant must be from a different medical institution and be a specialist in the patient's illness. All discussions with the patient must include private conversations, away from family members, to guard against any form of pressure. A mandatory reflection period must also be observed, giving the patient a legal cooling-off period to be certain of their decision. This period should be scaled to the situation; for instance, a minimum of 10 days for a terminally ill patient, but longer if the suffering is primarily chronic or non-terminal in nature, to allow for greater deliberation.

[247] Richards S., “The Morality Of Assisted Dying” [2025](50)(4) *Journal of Medical Philosophy.*

Furthermore, the framework must include a clear protocol for managing conscientious objection. While a doctor or nurse has the right to refuse participation, the institution must have a designated and willing professional to take over the case, ensuring the patient's legal access is not denied. This protects both religious freedom and patient rights.

This structured pathway, supervised by the National Euthanasia Board and reinforced by the palliative care consultation, creates a robust system. It is designed to be both efficient and deeply compassionate, ensuring that the patient's autonomy is respected while their safety is irrevocably protected.[248]

4.4.3 Implementation, Oversight, and Rights Balancing Mechanisms

The final layer of the proposed framework focuses on its practical implementation, ensuring it operates with fairness, transparency, and the highest level of protection for the most vulnerable. This involves balancing conflicting rights and creating secure procedures for the most complex and sensitive situations.

A fundamental component for a harmonious system is a robust conscience clause for medical practitioners. This clause legally guarantees that no doctor, nurse, or hospital can be forced to participate in any part of the euthanasia process if it violates their ethical or religious beliefs. This is essential for respecting the deep moral and religious convictions held by many in Nigeria. However, to prevent this protection from denying patients their legal rights, the clause must be paired with a clear duty of referral. An objecting practitioner or institution must have a formal protocol to transfer the patient's care to a willing and qualified colleague or facility without delay. This ensures that a patient's access to the law is not blocked,

[248] Regional Euthanasia Review Committee RTE, "Annual Reports Of The Dutch Euthanasia Review Committee" [2018] *RTE Netherlands*.

successfully balancing individual conscience with institutional responsibility towards the patient.[249]

Furthermore, the framework must prepare for the most challenging scenario: a patient who has made a written request but later loses the ability to speak or communicate, such as someone in the final stages of a disease like ALS or advanced dementia. In such a grave situation, the decision to proceed cannot rest with doctors and family alone. To handle this with the highest level of security and public trust, the process must require judicial approval. This means that for any case involving a non-competent patient, an application must be made to a High Court.

The judge's role in this process is to act as an independent guardian for the voiceless patient. This involves a full judicial inquiry, not a simple review. The judge will meticulously scrutinize the patient's prior written directive, ensuring it was clear, voluntary, specific, and applicable to their current medical condition. The court will also hear testimony from the attending physicians, consultants, and family members to confirm that all other safeguards have been met. This judicial step is the system's ultimate check. It ensures that a life is ended without contemporary verbal consent only under the most stringent and legally supervised conditions, providing a neutral, dispassionate authority to prevent any misinterpretation or abuse and to affirm the sanctity of the patient's prior autonomous will.[250]

Together, the conscience clause and the judicial approval process create a framework that is both pragmatic and principled. They ensure the system respects the rights of healthcare workers while fiercely protecting the rights of patients, especially when they are at their most defenseless, thereby upholding the law's ultimate goal: a compassionate and just balance for all.

---

[249] Mark R. W., "Which legal approaches help limit harms to patients from clinician's conscience-based refusals?" [2020](22)(3) *AMA Journal of Ethics*

[250] Regional Euthanasia Review Committee RTE, "Annual Reports Of The Dutch Euthanasia Review Committee" [2018] *RTE Netherlands*.

Furthermore, to ensure the long-term integrity and relevance of the law, the framework must mandate a periodic legislative review. This means that the National Assembly would be required to formally re-examine the entire Terminal Patient Autonomy Act every five years. The purpose of this review is not automatic expansion, but a responsible and evidence-based evaluation. Using the annual case reports from the National Euthanasia Board, lawmakers would assess the law's implementation, scrutinize emerging trends, and evaluate whether the strict eligibility criteria remain sufficient. This built-in mechanism of sunset review forces a national conversation on the law's impacts, ensuring that any future amendments are deliberate, democratic, and grounded in Nigerian data rather than foreign trends. It is the ultimate safeguard, committing the nation to a path of cautious, informed, and incremental evolution on this profound issue.[251]

[251] Regional Euthanasia Review Committee RTE, "Annual Reports Of The Dutch Euthanasia Review Committee" [2018] *RTE Netherlands*.

CHAPTER FIVE

CONCLUSION

This research set out to critically examine the profound conflict in Nigerian law between the absolute criminalization of euthanasia and the fundamental human rights to dignity and autonomy. Having covered the conceptual, domestic, and comparative landscapes, this final chapter synthesizes the key findings, presents actionable recommendations, highlights the study's contribution to knowledge, suggests areas for further research, and offers a concluding reflection.

5.1 Summary of Findings

The investigation reveals that Nigeria's current legal position, which categorizes euthanasia as murder under the Criminal and Penal Codes, is rooted in a robust justificatory framework. This framework is built upon the state's constitutional duty to protect life, deep-seated religious and cultural beliefs in the sanctity of life, and valid concerns about a "slippery slope" and the potential for abusing the vulnerable. However, this study finds that this absolute prohibition creates a significant and unresolved tension with other constitutional guarantees, particularly the right to dignity of the human person under Section 34 of the 1999 Constitution. The analysis demonstrates that by compelling terminally ill patients to endure unbearable and unrelievable suffering against their will, the law itself risks becoming an instrument of indignity.

The examination of judicial attitudes, through cases like *Adegoke v. State*[252] and *M.N. v. Attorney General of the FCT*[253], confirms that the Nigerian judiciary has consistently upheld the sanctity of life principle, often deferring to the legislature and showing reluctance to engage deeply with the nuanced conflict between the right to life and the right to dignity in

[252] [2006] 15 NWLR (Pt 1001) 394
[253] ibid

end-of-life contexts. This has resulted in a legal impasse that offers no recourse for suffering individuals.

The comparative analysis of the Netherlands, Belgium, and Canada yielded no single blueprint but provided critical, transferable lessons. Key among these are the necessity of a cautious, incremental approach to legalization; the imperative to begin with a narrow and precise eligibility criterion focused on terminal physical illness; the non-negotiable need for multiple, robust institutional safeguards, including independent medical reviews and mandatory palliative care consultation; and the indispensability of a transparent oversight system to maintain public trust. Crucially, the Canadian experience serves as a stark warning against creating a legal right to die without first ensuring that robust healthcare and social support systems exist to make life livable.

Synthesizing these findings, this study concludes that while the state's duty to protect life is paramount, a recalibration of the law is both legally defensible and ethically necessary. A carefully regulated framework for euthanasia, designed with Nigeria's unique socio-legal context in mind, can potentially resolve the existing rights conflict by balancing individual autonomy with inviolable safeguards, thereby honoring both the sanctity of life and the right to die with dignity.

5.2 Recommendations

Based on the comprehensive findings of this research, a set of interconnected recommendations is proposed to guide Nigeria toward a resolution of the euthanasia dilemma. The overarching objective is to transition from the current regime of absolute prohibition to a model of regulated access, thereby reconciling the state's duty to protect life with its concurrent duty to uphold human dignity. This journey must begin with deliberate legislative action. It is recommended that the National Assembly initiates a structured, Belgian-style

parliamentary process to draft and enact a "Terminal Patient Autonomy Act." This process should be preceded and informed by a Presidential or National Assembly Commission of Inquiry, tasked with gathering extensive public testimony from medical experts, ethicists, religious leaders, and the public. This crucial first step would ensure that the resulting legislation is not an imported construct but a bespoke, made-in-Nigeria solution that reflects a measured national dialogue. The core of this Act must be a narrow and precise eligibility criterion, strictly limited to competent adults experiencing unbearable and unrelievable physical suffering from a terminal illness, thereby explicitly excluding psychiatric conditions as a sole qualifier and guarding against the conflation of euthanasia with socioeconomic deprivation. To give this Act legal force, a concurrent amendment to the Criminal and Penal Codes is essential, creating a specific exemption from homicide charges for medical practitioners who can demonstrate verifiable compliance with all the procedures of the new law.

The legislative framework alone would be insufficient without robust institutional architecture to implement it. Therefore, it is paramount to establish a National End-of-Life Care Review Commission. This independent body, insulated from political interference and composed of doctors, lawyers, and ethicists, must be empowered to conduct a retrospective review of every case, audit procedural compliance, and publish annual reports for the National Assembly. This mechanism of radical transparency is the bedrock of public trust and accountability. Furthermore, the clinical process itself must be governed by a multi-layered safeguard system. This includes mandating assessments by at least two independent physicians, one of whom must be a specialist in the patient's condition and from a different institution to prevent collusion. A mandatory, documented consultation with a palliative care team must serve as an ethical checkpoint, ensuring that the request stems from a genuine lack of alternatives rather than a lack of access to comfort care. This safeguard, however, must be

coupled with a sincere and funded government commitment to developing a national palliative care infrastructure, ensuring that the right to choose death is built upon the prior guarantee of a life with dignity.

Finally, for any such framework to be viable in the Nigerian context, it must be seamlessly integrated into the nation's socio-cultural and medical fabric. This necessitates the inclusion of a robust conscience clause within the law, explicitly protecting the rights of individual healthcare professionals and faith-based institutions to refuse participation based on religious or ethical convictions. However, to prevent this protection from negating patient rights, this clause must be balanced with a clear duty of referral, requiring objecting institutions to facilitate a timely and transparent transfer of care to a willing provider. To foster the necessary societal consensus for such a profound legal shift, it is recommended that the government, in collaboration with the Nigerian Medical Association and civil society, initiates public awareness campaigns. These efforts should aim to demystify the issue, promote a nuanced understanding of the balance between sanctity of life and dignity in dying, and cultivate a national conversation grounded in evidence and compassion rather than fear and speculations.

5.3 Contribution to Knowledge

This research makes several original contributions to the Nigerian legal scholarship on euthanasia. Firstly, it provides a focused and systematic analysis of the specific conflict between the criminal prohibition of euthanasia and the constitutional right to human dignity, an area that has received insufficient scholarly attention. Secondly, it moves beyond a mere description of foreign models to offer a critical synthesis, extracting practical lessons and warnings tailored to Nigeria's institutional capacity and cultural realities. Finally, it presents a pioneering, concrete framework for decriminalization—the proposed "Terminal Patient

Autonomy Act" and its supporting institutions—offering a tangible solution for policymakers and legislators to consider, thereby bridging a significant gap between theoretical debate and actionable legal reform.

5.4 Areas for Further Study

This research, while comprehensive in its doctrinal and comparative analysis, inevitably opens several avenues for further academic inquiry, highlighting the dynamic and evolving nature of the euthanasia debate. A significant gap identified is the profound lack of empirical data within Nigeria on the very experiences that form the core of this issue. Therefore, a critical area for further study is a nationwide, mixed-methods investigation into the prevalence, nature, and intensity of end-of-life suffering among terminally ill Nigerians. Parallel to this, extensive research is needed to systematically document the attitudes, ethical dilemmas, and readiness of Nigerian healthcare professionals—including doctors, nurses, and palliative care specialists—regarding the practice of euthanasia. Furthermore, qualitative studies exploring the perspectives of religious leaders, traditional rulers, and the general public would provide an invaluable evidence base for understanding the social acceptability and potential contours of a Nigerian model, moving the discourse beyond theoretical postulation to informed societal engagement.

As the global landscape of end-of-life care continues to evolve, so too must the Nigerian academic conversation. Future research should explore the legal and ethical feasibility of integrating mechanisms for advance directives, or "living wills," into the Nigerian legal system. This would involve examining how individuals could express their wishes regarding end-of-life treatment in anticipation of future incompetence, a complex issue that extends beyond immediate euthanasia requests. Moreover, should Nigeria ever enact a law on euthanasia, a longitudinal study to monitor its implementation would be indispensable. Such

research would track the effectiveness of safeguards, identify unintended consequences, analyze demographic trends among applicants, and assess the law's impact on doctor-patient relationships and public trust, providing real-time, locally-grounded data to guide future legislative refinements. Finally, a comparative analysis focusing on other religiously diverse jurisdictions in the Global South that have grappled with or implemented assisted dying laws could yield uniquely relevant insights, offering lessons from contexts that share similar challenges in healthcare infrastructure and cultural pluralism. These proposed areas of study would collectively build a richer, more nuanced body of knowledge to guide Nigeria's ongoing engagement with one of the most profound questions at the intersection of law, medicine, and human rights.

5.5 Conclusion

The journey through this research underscores a fundamental truth: the quest for a dignified death is as profound as the right to life itself. Nigeria's current legal framework, while well-intentioned, creates an untenable situation where citizens facing the final, agonizing chapters of terminal illness are denied a voice and forced to endure suffering that medicine cannot alleviate. This study has argued that this need not be the only way. By learning from global experiences and heeding their warnings, Nigeria can forge a path that is uniquely its own, one that does not abandon the vulnerable but offers them a choice, one that does not devalue life but honors the dignity inherent in its conclusion. The proposed framework, built on the principles of prudent incrementalism, inviolable safeguarding, integrated development, and radical transparency, represents a compassionate, cautious, and legally sound compromise. It is a call to begin a serious, nation-wide conversation on how the law can evolve to balance its sacred duty to protect life with its equally important duty to prevent cruelty and uphold the autonomy and dignity of every person, until the very end.

BIBLIOGRAPHY

NATIONAL

Adedoyin, O. A., "The legalization of Euthanasia in Nigeria: A right to Die or a threat to life" [2025] *BarristerNG.*

Badejogbin, A., "Onuoha Kalu v The State and flaws in Nigeria's Death penalty Jurisprudence" [2019](1) *African Human Rights Journal.*

Bright, E., "Legality of Euthanasia and the Right to Die in Nigeria" [2017] *E-do Judiciary Journal.*

Enakirern, E.O., and Brian O. N., "The Nature and Legal Aspect of Euthanasia in Nigeria: Medical Profession and Euthanasia in Nigeria." [2024] (1)(6) *KB Law Scholars Journal UK*.

Familusi, O. O. "A Religious Response to the Paradox of Euthanasia and the Sanctity of Life" [2024](12)(1) *Ibadan Journal of Humanistic studies.*

Lawsan, S.E. "The Concept of Mercy Killing (Euthanasia) in Nigeria Law" *Lawsan-SE 2025*

Nigeria Medical Association, "NMA Opposes Euthanasia in Nigeria, Citing Ethical, Legal Concerns." *The Sun Nigeria*, 15 May 2024.

Oniha, B.E., "Legality of Euthanasia in Nigeria and the Right to Die in Nigeria." [2017] *Edo Judiciary Law Review.*

FOREIGN

Adams M., & Nys H., "Comparative Reflections on the Belgium euthanasia act 2002" *Medical Law Review.*

Akdeniz, Melahat, Bulent Yardima; and Ethen Kavukcu, "Ethical Consideration at the end-of-life care" [2021](9) *SAGE Open Medicine.*

Amnesty International, "Nigeria: Ten-point Human Rights Agenda" [2009] *Amnesty International Report.*

AMSJ., "The Ethics of Euthanasia". Australian Medical Student Journal.

Bhatia, Rakeh, “Doctrinal Legal Research; Meaning Scope and Methodology” *Academia.edu.*

Battin, Margaret, P “Ending life: Ethics and the way we Die”. [2005] *Oxford University Press.*

Chan B., & Somerville M., “Converting the ‘right to life’ to the ‘right to physician assisted suicide and euthanasia’: An analysis of Carter v Canada” (2) *Medical Law Review.*

Coggon, J., “Assisted-dying and the context of debate: ‘medical law’ versus ‘end-of-life law’” [2010] 18(4) *Med Law Rev.*

Colburn, B., “Palliative care-based arguments against assisted dying” [2024] (39)(2) *Bioethics.*

Emanuel, Ezekiel J. “Euthanasia: Historical, Ethical and Empiric Perspectives” [1994](154)(12) *JAMA Internal Medicine*

Enwkireru, E.O. and Brian O.N. “The Nature And Legal AspectOf Euthanasia In Nigeria: Medical Profession and Euthanasia in Nigeria.” [2024](1)(6) *KB Law Scholars Journal UK*

Hurst, Samia A., and Alexandre, M. “Ethical Aspects of Euthanasia and Assisted suicide, A Review of Arguments.” [2003](133)(35-36) *Swiss Medical Weekly.*

Indian Medical Research “Definition of terms used in limitation of treatment and providing palliative care at the end of life.” *Indian Council of Medical Research Report, PMC.*

Jeremy, R. B., “The Dialectic of Autonomy and Beneficence in the standard argument for Death with Dignity” (6)(1) of solidarity: *The Journal of Catholic Social thought and secular Ethics.*

Klamfer, F. “Euthanasia Laws, Slippery Slopes, and (un) reasonable precaution” [2019](18)(2) *Prolegomna*

Lee, Myung Ah. “Ethical Issue of Physician-Assisted Suicide and Euthanasia.” [2023](26)(2) *Journal of Hospice and Palliatives care (Korea)*

Leon R. Kass and Nelson Lund “Courting death, assisted suicide, doctors and the law”.

Most, J. A. “Autonomy and Rights: Dignity and Right” [1993] *Journal of Contemporary Health Law & Policy.*

Muders, S., “Human Dignity and Assisted Death: The Contemporary Debate” [2007] Oxford University Press.

Otlowski, M., “Suicide and Assisted Suicide” [2000] Voluntary Euthanasia and the Common Law.

Quill, Timothy E., and Margaret P. Battin, editors. “Physician – Assisted Dying: The case for Palliative Care and Patient Choice”. [2004] *Johns Hopkins University Press*.

Ramesh, M.K., “Enthanasia: A controversial Debate” [2022](11)(8) *Journal of Family Medicine & Primary Care.*

Regional Euthanasia Review Committee RTE, “Annual Reports Of The Dutch Euthanasia Review Committee” [2018] *RTE Netherlands.*

Spinthouraki, A., S. N. Michaleas et al “Historical Review of Euthanasia. From Ancient Times until before modern times” [2025](20)(1) *Maedica (Bucur).*

WHO Fact sheet “Palliative care” *World Health Organization Fact Sheet*.

Wittrock, J., “A human Right to assisted dying? Autonomy, dignity and international standards” [2025] *Journal of Medical Ethics.*

DICTIONARY

Merriam-webster.com Dictionary, “Euthanasia” Merriam-Webster.

Encylopaedia Britannica, “Euthanasia” Encylopaedia Encylopedia Britannica