A LEGAL ANALYSIS OF EUTHANASIA IN NIGERIA: BALANCING THE RIGHT TO LIFE AND THE RIGHT TO DIE

BY

Daniel Olushola IDOWU
MAT NO: LAW2002871

FACULTY OF LAW
UNIVERSITY OF BENIN
BENIN CITY

NOVEMBER, 2025

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

NOVEMBER, 2025

CERTIFICATION

I, **Daniel Olushola IDOWU**, with matriculation number **LAW2002871**, hereby certify that apart from references to other person's work which have been duly acknowledged, the entire work is a product of my research, and this project has neither in whole or in part been presented for another degree elsewhere.

_____

Daniel Olushola IDOWU
LAW2002871

APPROVAL

We certify that this project was written and completed by **Daniel Olushola IDOWU**, with matriculation number **LAW2002871** in partial fulfillment of the requirement for the award of Bachelor of Laws (LL.B) degree.

_____ _____

Dr. (Mrs.) Irene Airen AIGBE Date
(Project Supervisor)

_____ _____

Dr. (Mrs.) Obiageli Francisca OSUJI Date
(Project Co-ordinator)

_____ _____

Prof. Bright BAZUAYE Date
Dean, Faculty of Law

DEDICATION

This work is dedicated to God Almighty, whose guidance, love and mercy brought me thus far. It is also dedicated to my parents, Mr. Olusayo and Mrs. Folasade Idowu, who not just encouraged me to dream, but also supports my dreams and aspirations.

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AC	Appeal Cases
ACHPR	African Charter on Human and Peoples' Rights
C38 LFN	Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004
CFRN	Constitution of the Federal Republic of Nigeria
DLR	Dominican Law Reports
DPP	Director of Public Prosecutions (or Deputy Public Prosecutor in some Jurisdictions)
ECHR	European Convention on Human Rights
EHRR	European Human Rights Reports
ECSLR	European Companies and Securities Law Review
ICCPR	International Covenant on Civil and Political Rights
LFN	Laws of the Federation of Nigeria
MDPDT	Medical and Dental Practitioners Disciplinary Tribunal (or Committee)
NCLR	Nigerian Constitutional Law Reports
NE	North Eastern Reporter
NIALS	Nigerian Institute of Advanced Legal Studies
NMA	Nigerian Medical Association
NWLR	Nigerian Weekly Law Reports
OR	Ontario Reports
PAS	Physician-Assisted Suicide
SCC	Supreme Court Cases
SCR	Supreme Court Reports
SC	Supreme Court
UDHR	Universal Declaration of Human Rights
UNTS	United Nations Treaty Series
WHO	World Health Organization

ABSTRACT

The question of the existence of a right to die by euthanasia also referred to as mercy killing and assisted suicide is one that goes beyond national boundaries and diverse legal systems. The dominant legal regime around the world is that euthanasia and assisted suicide is unlawful and criminalized. However, with advancements in medical technology leading to remarkably greater ability to sustain and prolong human life far beyond what was previously thought possible, coupled with corresponding growth in human right law, many countries such as Belgium, Netherlands, etc. have legalized the acts of euthanasia and assisted suicide. There is no doubt that there is global acceptance of a right to life. The question that is the bedrock of the euthanasia controversy is whether or not there is also conversely a right to die. This paper explores whether a right to die could be inferred from constitutional guarantees of dignity and autonomy, particularly in cases of terminal illness or unbearable suffering. It evaluates global perspectives, contrasting Nigeria's stance with jurisdictions where euthanasia is legalized under strict conditions, such as the Netherlands and Belgium. Ethical dilemmas, including patient autonomy, medical ethics, and societal implications, are critically assessed alongside potential legal reforms. The analysis highlights the absence of explicit euthanasia legislation in Nigeria and the judiciary's limited engagement with the issue. Ultimately, the paper advocates for a balanced approach, proposing a national dialogue to address legal ambiguities while respecting Nigeria's socio-cultural context, ensuring that any reform aligns with constitutional protections and human rights principles.

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Introduction

In the dimly lit wards of a bustling Nigerian hospital, a patient lies tethered to machines that hum with mechanical indifference, their body a battleground of unrelenting pain from terminal cancer. Family members whisper prayers, torn between the desire to end the suffering and the fear of divine retribution or legal consequences. This scene, all too common in Nigeria's overburdened healthcare system, encapsulates the heart-wrenching dilemma at the core of euthanasia: the deliberate termination of life to alleviate intractable suffering. Often termed "mercy killing," euthanasia challenges the boundaries of human autonomy, medical ethics, and societal values. In Nigeria, a nation where life is revered as a sacred gift from God or ancestors, the debate over euthanasia pits the constitutionally guaranteed right to life against an emerging call for the right to die with dignity. This legal analysis explores the intricate balance between these rights, examining Nigeria's prohibitive legal framework, cultural and religious underpinnings, and comparative global perspectives to advocate for informed reforms that prioritize compassion without eroding the sanctity of life.

The term euthanasia which is of greek origin, signifies a "good death" achieved through intentional means to end suffering, typically in cases of terminal illness or irreversible debilitation. It manifests in various forms: active euthanasia involves administering lethal substances, while passive euthanasia entails withholding or withdrawing life-sustaining treatments. Further distinctions include voluntary euthanasia (with the patient's informed consent), non-voluntary (for those incapable of consenting, such as comatose individuals), and involuntary (against the patient's will, often equated to murder). Globally, euthanasia has evolved from ancient practices in Greek and Roman societies, where scholars like Plato endorsed it for the infirm, to modern legislative battles shaped by ethical, religious, and human

rights discourses.[1] The 20th century saw its dark perversion under Nazi regimes, leading to post-World War II stigmatization and international safeguards. Today, progressive nations have legalized variants: the Netherlands formalized voluntary euthanasia in 2002 under strict protocols requiring unbearable suffering and multiple medical confirmations. Belgium, Luxembourg, Canada, and parts of Australia and the United States follow suit, framing it as an extension of personal liberty and dignity.[2] In contrast, most African and Asian countries, including Nigeria, Ethiopia, and South Africa, maintain bans influenced by colonial legacies and cultural norms that emphasize communal harmony over individual choice.[3] In 2023 a scoping review of euthanasia in Africa highlights low acceptance rates, attributing this to religious opposition and fears of abuse in resource lacking areas.

In Nigeria, euthanasia remains unequivocally illegal, rooted in a colonial era legal system that criminalizes any act hastening death. Under the Criminal Code Act (applicable in southern states). The Penal Code in northern states echoes this, deeming it culpable homicide. This stance draws from British common law, which prohibits assisted suicide. Judicial precedents reinforce the prohibition; the Supreme Court's ruling in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* rejected any "right to die," prioritizing life preservation. More recently, in *Danladi v State*, the court dismissed euthanasia as a defense, affirming it as non-cognizable in Nigerian jurisprudence. The Nigerian Medical Association (NMA) reiterated this in 2024, declaring mercy killing unethical and contrary to the Hippocratic Oath, with a 2025 Nigerian Institute of Advanced Legal Studies (NIALS) article calling for reinterpretation amid global shifts. [4] [5] While passive euthanasia may occur tacitly through do-

[1] Victor Nnebe '*Right to Die: Arguments for Decriminalization and Legalization of Euthanasia and Physician-Assisted Dying*' (2025) Health Law, Policy and Ethics ejournal

[2] AO Nwafor '*Comparative Perspectives on Euthanasia in Nigeria and Ethiopia'* (2010) <https://chilot.wordpress.com> accessed 30-8-2025

[3] Ibid

[4] Lilian Uche '*Euthanasia:* '*The Need For A Better Interpretation of The Hippocratic Oath'* (2025) Nigerian Institute of Advanced Legal Studies

[5] Daniel Adaji *'Mercy Killing illegal in Nigeria*, says NMA' (2024) Punch Newspaper

not-resuscitate orders in medical practice, active forms invite severe penalties, including professional deregistration by the Medical and Dental Council of Nigeria.

At the crux of this analysis is the constitutional tension between the right to life and the right to die. Section 33 of the 1999 Constitution of the Federal Republic of Nigeria (as amended) enshrines the right to life, stating that no one shall be intentionally deprived of it except in lawful circumstances like capital punishment or self-defense.[6] This aligns with international covenants, such as Article 6 of the International Covenant on Civil and Political Rights, ratified by Nigeria. Proponents of euthanasia, however, invoke Section 34 (dignity of the human person) and Section 35 (personal liberty) to argue that prolonging agony undermines autonomy and dignity. A 2025 SSRN paper on decriminalization posits that structured safeguards could protect vulnerable groups while honoring individual choice, drawing lessons from legalized jurisdictions. Yet, Nigerian courts interpret these rights restrictively, viewing euthanasia as antithetical to public policy.

This legal rigidity is amplified by Nigeria's diverse cultural and religious landscape, where over 90% of the population adheres to Christianity, Islam, or traditional beliefs that tend to sanctify life.

Recent developments underscore the timeliness of this analysis. As of 2025, debates have intensified with publications like a March Law Pavilion article warning of legalization threats and a July LAWSAN piece on Nigeria's stance.[7] Amid rising chronic diseases cancer affects 120,000 annually, HIV/AIDS claims 45,000 lives and an aging population projected at 28 million by 2050, palliative care remains underdeveloped, serving only a fraction of those in

[6] BE Oniha '*Legality of Euthanasia and the Right to Die in Nigeria'* (2023) <https://edojudiciary.gov.ng> accessed 1-9-25

[7] Oluwaleye Adedoyin Grace '*The Legalization of Euthanasia in Nigeria*: *A Right to Die or a Threat to Life'* (2025) https://lawpavilion.com accessed 1-8-2025

need due to opioid shortages and infrastructure gaps.[8] Reports suggest clandestine practices in under-resourced settings, highlighting risks without regulation.

This study is pivotal in navigating these complexities, filling scholarly gaps by dissecting legal prohibitions, proposing balanced reforms like enhanced palliative frameworks or regulated passive euthanasia, and drawing comparative insights. Ultimately, it argues that while safeguarding life's sanctity, Nigeria must confront evolving humanitarian imperatives to ensure dignity in death, fostering a jurisprudence that reflects its pluralistic ethos in a globalized world.

1.2 Background to the Study

The term euthanasia comes from Greek roots, meaning a "good death"[9] It encompasses any form of peaceful and painless passing. During the 20th century, the concept evolved to include medically assisted dying aimed at fully managing unbearable pain and prolonged agony.[10] This later extended to cases involving infants with severe birth defects or the cessation of life-sustaining treatments for terminally ill elders and others with no hope of recovery.[11] In technical terms, it involves a purposeful intervention to end or accelerate death out of mercy.[12] Somerville,[13] a prominent opponent of legalizing euthanasia, views it as a scenario where a doctor's primary goal is to end a patient's life to alleviate intense suffering.

[8] Lois Ogunniyi "*Exploring medically assisted death in Nigeria: Ethical considerations and Possibilities" ,* The Guardian Newspaper, 9th July, 2023

[9] Yusuff Jelili Amuda, *"Commission of Euthanasia Against a Hospitalised Child: An Evaluation of the Shariah Provisions and the United Nation Convention"*, Malayan Law Journal Articles 2 (2012) 1.

[10] Fadinand Sakali, The *Contemporary Euthanasia Debate in the Light of African World View and Ethics",* SEGi Review 6 (2013) 5.

[11] J Shai Lavi, *The Modern Art of Dying: A History of Euthanasia in the United States*, vol. 53 (New Jersey: Princeton University Press, 2005).

[12] Robert Dingwall, "*Cambridge Textbook of Bioethics",* Bulletin of the World Health Organization 86, no. 8 (2008) 655.

[13] Margaret Sommerville, McGill *Centre for Medicine, Ethics and Law: Submission to La Commision de la Santé et des Service Sociaux du Quebec* – Consultations et Auditions Publiques sur le Projet de Loi No. 52, Loi Concernant les Soins de Fin de Vie (2013).

Yet, the definitions mentioned earlier focus solely on active measures to end life, whereas the World Health Organization (WHO)[14] offers a broader interpretation. It describes euthanasia as deliberately causing a patient's death or allowing it to occur by stopping or not providing necessary care. This study adopts this definition for its comprehensive scope. In alignment with this, Davies[15] portrays it as any choice intentionally made to cut short a patient's life. Nevertheless, debates persist about whether halting treatment or failing to intervene constitutes actual killing. A more inclusive understanding of euthanasia should cover both actions and inactions that lead to or speed up death, combining active euthanasia (direct intervention to cause death) and passive euthanasia (withholding care or disconnecting support systems that result in death).

Advancements in science have profoundly shaped euthanasia and healthcare overall. Technologies now extend life spans, enabling many with complex illnesses to live longer than before. Certain experts contend that when medical innovations fail to ease suffering, death might be the only viable option for some conditions.[16] Still, ethical and moral dilemmas in medicine have expanded beyond simply debating the morality of ending life to reduce pain.[17] Laws against homicide exist, alongside protections for human rights.[18] Physicians follow ethical standards and professional guidelines to promote proper care and patient welfare.[19] Meanwhile, patients' interactions with healthcare providers increasingly involve emerging rights concerns. As a result, discussions about the entitlement to seek an end to life in diverse

[14] World Health Organisation, "A Glossary of Terms for Community Healthcare and Services for Older Persons " (2004) <http//www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf> accessed 9 October 2025.
[15] Ibid
[16] Carl Wellman, *Medical Law and Moral Rights* (Netherlands: Springer, 2005) 9.
[17] Oluyemisi Bamgbose, "*Euthanasia: Another Face of Murder",* International Journal of Offender Therapy and Comparative Criminology 48, no. 1 (2004) 111.
[18] Nicole Steck, "Suicide *Assisted by Right-to-Die Associations: A Population-Based Cohort Study,* International Journal of Epidemiology 43, no. 2 (2014) 614.
[19] Raphael Cohen-Almagor, "*First Do No Harm: Intentionally Shortening Lives of Patients without Their Explicit Request in Belgium,*" Journal of Medical Ethics (2015) 1.

situations remain active.[20] Numerous academics favor euthanasia over merely stopping life support, arguing that removing such support often prolongs dying without addressing ongoing distress. In various legal systems, disconnecting life support in irreversible cases isn't classified as homicide.[21] Though this could be seen as an inaction causing death, interpretations vary by region. The core of these disputes revolves around legal, ethical, and rights-based perspectives. Laws and ethics primarily aim to foster responsible medical conduct when physicians interact with patients, recognizing that doctors aren't immune to errors or accountability. The involvement of some physicians in unethical experiments on Jewish individuals without consent during World War II (under the Nazi regime) highlights this vulnerability.[22] Medical practice fundamentally seeks to enhance quality of life, offer remedies, and alleviate discomfort, aligning with the Hippocratic Oath's goals established over two millennia ago.[23] Back then, physicians were sometimes regarded as both life-takers and life-savers, but the Oath shifted this to emphasize healing exclusively. In modern times, doctors are viewed strictly as caregivers. Somerville warns that permitting euthanasia could revert medicine to pre-Hippocratic eras, where physicians doubled as executioners and healers.[24]

When healing proves impossible and a patient's state deteriorates, the focus shifts to managing distress via options like palliative support[25] or euthanasia. This sparks ongoing arguments for and against it. Legal theories are advancing, pushing for the "right to die" to be included under rights to life, privacy, and family matters.[26] Nations such as the Netherlands and Belgium have

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[20] Joachim Cohen, "*Public Acceptance of Euthanasia in Europe: A Survey Study in 47 Countries,"* International Journal of Public Health 59, no.1 (2014) 143.
[21]*Vacco v Quill* 521 US 793 (1997)
[22] YCN Yuhanif Anisah and MD Rejab, *The Non-Admissibility of the Principle of Therapeutic Privilege in Clinical Trials"*, Pertanika Journal of Social Sciences and Humanities 23, no. 2 (2015) 51.
[23] B Ronald Standler, "*Legal Right to Refuse Medical Treatment in the USA*" (2012).
[24] Margaret Sommerville, "*The Case against Euthanasia and Physician-Assisted Suicide*," New Zealand Law Review23,no.2(2016)33
http://ovisdsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med4&NEWS=N&AN=16604746 accessed 9 October 2025.
[25] S Mary McCabe and Nessa Coyle, *"Ethical and Legal Issues in Palliative Care",* Seminars in Oncology Nursing 30, no 4 (2014) 287.
[26] *R v Director of Public Prosecutions* [2001]UKHL 61

legalized euthanasia.[27] In contrast, it remains prohibited in Nigeria and Malaysia.[28] That said, neither country has recorded a conviction of a physician for euthanasia-related life termination. A close review of the Penal Codes in Malaysia and Nigeria shows that euthanasia qualifies as a criminal offense.[29] However, this doesn't preclude arguments that voluntary euthanasia could involve consent, potentially qualifying as an exception to murder under section 300 of the Penal Code,[30] avoiding capital punishment.[31] Similarly in Nigeria, no euthanasia cases have reached the courts, but the Supreme Court[32] has upheld a person's right to refuse treatment, even if it leads to death, grounded in autonomy and self-determination.[33] It's uncertain if this ruling would shield a doctor who complies with a patient's request to withhold or withdraw care leading to death.

Controversy continues over the legality of prescribing excessive morphine for pain relief that incidentally shortens life, or ceasing treatments that could hasten death.[34] Several scholars maintain that administering pain-relieving drugs with a side effect of accelerating death doesn't equate to euthanasia, drawing on the Doctrine of Double Effect,[35] which justifies negative outcomes if the primary intent is positive here, assuming the doctor's aim isn't to kill. Withholding or withdrawing care allows death from the illness itself, not from the physician's

[27] MP Battin, '*Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in Vulnerable Groups'* (2007) 33 J Med Ethics 591
[28] Puteri Nemie and others, '*Withdrawing and Witholding Medical Treatment: A Comparative Study Between the Malaysian, English and Islamic Law*'(2010) 29 Med & L 443
[29] Amuda (n9)
[30] Penal Code(Malaysia) No 574, s312, as amended by Penal Code (Amendment) Act (Malaysia) No 727/1989
[31] N Talib, Euthanasia: *A Malaysian Perspective* (Sweet & Maxwell 2002) 65
[32] *Medical and Dental Practitioners Disciplinary Tribunal v John Emewulu Nicholas Okonkwo* (2001) 7 NWLR (Pt 711) 206 (SC).
[33] Ben Livings, "*A Right to Assist? Assisted Dying and the Interim Policy*", Journal of Criminal Law 74, no.1 (2010): 31.
[34] John Coggon, "*The Wonder of Euthanasia: A Debate that is Being Done to Death",* Oxford Journal of Legal Studies 33, no.2 (2013): 401
[35] Lawrence Masek, "*Intentions, Motives and the Doctrine of Double Effect",* Philosophical Quarterly 60, no 240 (2010): 567

direct involvement, setting it apart from intentional life-ending actions, which some differentiate from true euthanasia.[36]

Perspectives on euthanasia's validity often tie into human rights, particularly those concerning life, privacy, and family.[37] While international and domestic human rights frameworks don't explicitly connect euthanasia to these rights, arguments have been made that forcing ventilation or palliative measures against a patient's wishes constitutes cruel and degrading treatment, infringing on rights.[38] The European Court of Human Rights has considered that suffering from illness, whether physical or psychological, might fall under Article III,[39] holding authorities accountable.[40] Does this imply liability for doctors who attempt resuscitation or use life support to preserve life, if it subjects the patient to undue hardship?[41] Or if their efforts cause death? Such scenarios place physicians in ethical binds, with laws often falling short in resolution.

The right to life stands as a fundamental, absolute entitlement, reinforced by various global and national legal documents.[42] For instance, the 1948 Universal Declaration of Human Rights states that all individuals possess rights to life, liberty, and personal security.[43] The 1966 African Charter on Human and Peoples' Rights[44] asserts the sanctity of human life, entitling everyone to its respect. Comparable provisions appear in the 1950 European Convention on

[36] J Shai Lavi,*The Modern Art of Dying: A History of Euthanasia in the United States* (New Jersey:Princeton University Press, 2005), 41

[37] Margaret Sommerville, *Death Talk: The Case against Euthanasia and Physician-Assisted Suicide* (London: McGill-Queen's University Press, 2001), 205.

[38] Mary Warnock & Elisabeth Macdonald, *Easeful Death: Is There a Case for Assisted Dying?* (Oxford: Oxford University Press, 2008), 5.

[39] Council of Europe, European Convention on Human Rights (ECHR), European Court of Human Rights, vol.20 (2010), http://www.echr.coe.int/Documents/Convention_ENG.pdf accessed 10 October 2025.

[40] Charles Lewis and Andrew Buchan, *Clinical Negligence: A Practical Guide* (London: Bloomsberry Professional Limited, 2012), 527.

[41] Michel Harlos, "*Ventilator Withdrawal of Patients with 'Zero Capability' for Respiratory Function,"* American Medical Association Journal of Ethics 5, no. 2 (2003): 1

[42] Raphael Cohen-Almagor, "*An Argument for Physician-Assisted Suicide and against Euthanasia",* Ethics, Medicine and Public Health 1(2015): 434

[43] Universal Declaration of Human Rights (UN General Assembly Resolution 217 A (III), 10 December 1948

[44] African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217.

Human Rights[45] and the 1969 American Convention on Human Rights.[46] These documents underscore life's inviolability, complicating doctors' positions on euthanasia. Balancing millennia-old medical ethics against patients' rights proves challenging, and in conflicts, one must prevail.

Cultural, social, and religious variances play key roles in efforts to legalize euthanasia. Even in Europe and America, where it's gained traction, this stems from diminished sway of traditions and faiths on daily life.[47] Advocacy often arises from human rights groups, sometimes labeled as "Right to Die" organizations or euthanasia supporters.[48] They emphasize patient autonomy, positioning the individual as the supreme decision-maker over their existence and end.

In Nigeria, courts and the National Assembly reject euthanasia. Yet, various pressures lead patients to accept death passively. While cultural and religious norms discourage suicide or euthanasia requests, other elements make it indirectly inevitable. These include financial burdens from expensive medical care amid poverty, governmental shortcomings in supplying sufficient facilities and medications,[49] and societal values shaped by religion and culture.

1.3 Problem Statement

Euthanasia, the intentional termination of life to alleviate suffering, poses a significant legal and ethical challenge in Nigeria, where the interplay between the constitutional right to life and the emerging concept of a right to die remains largely unaddressed. Under Nigeria's legal framework, the sanctity of life is paramount, and statutes such as the Criminal Code and the

[45] Council of Europe, European Convention on Human Rights (ECHR) (adopted 4 November 1950, entered into force 3 September 1953) ETS No. 5.

[46] American Convention on Human Rights (adopted 22 November, 1969, entered into force 18 July 1978) 1144 UNTS 123.

[47] VW Erin Andrew, "*Social-Cultural Factors in End-of-Life Care in Belgium: A Scoping of the Research Literature Review,"* Palliative Medicine 27, no. 2 (2013):131

[48] M Neil Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton: Princeton University Press, 2006), 37.

[49] Olaronke Iroju, "*Interoperability in Nigeria Healthcare System: The Way Forward*," (International Journal of Information Engineering and Electronic Business 4 (2013)):2

Penal Code criminalize acts related to causing death or assisting suicide. These laws, shaped by Nigeria's religious and cultural values, leave no room for euthanasia, even in cases of terminal illness or extreme suffering. However, the absence of explicit legislation on euthanasia by creates ambiguity, leaving patients, healthcare providers, and policymakers without clear guidance on end-of-life decisions. This legal gap raises critical questions about individual autonomy, human dignity, and the state's role in regulating death. The lack of judicial precedent or public policy addressing euthanasia further complicates the issue, particularly as global perspectives on the right to die gain traction. This study seeks to investigate the legal tensions between preserving life and respecting personal autonomy in Nigeria, exploring whether the current framework adequately balances these rights or requires reform to address the complex realities of terminal illness and suffering within Nigeria's unique socio-cultural context.

1.4 Research Questions

Based on identified problems, the study seeks to identify the following research questions

1. What are the specific provisions in Nigeria's 1999 Constitution, Criminal Code, and Penal Code that govern euthanasia, and how do they address or criminalize end-of-life practices?
2. Is there a need for its practice in Nigeria?
3. How do Nigeria's religious and cultural values influence societal and legal perspectives on euthanasia?
4. What are the international perspectives on the status of euthanasia?
5. What legal and policy reforms could Nigeria adopt to address the concept of euthanasia?

1.5 Aim and Objectives Of The Research

1.5.1 Aim

The aim of this research is to analyze the legal framework governing euthanasia in Nigeria, exploring the balance between the constitutional right to life and the potential recognition of a right to die, while proposing sensitive reforms to address end-of life-decisions.

1.5.2 Objectives

1. Examine the Legal Framework: To analyze the existing statutory and constitutional provisions in Nigeria, particularly Section 33 of the 1999 Constitution, Section 326 of the Criminal Code, and Section 221 of the Penal Code, that govern euthanasia and related end-of-life practices.
2. Evaluate the Right to Life vs. Right to Die: To investigate the tension between the constitutional right to life and the potential recognition of a right to die, assessing whether personal autonomy and dignity can be inferred from Nigeria's legal protections.
3. Assess Socio-Cultural Influences: To explore the impact of Nigeria's religious and cultural values on the legal and societal perspectives regarding euthanasia, identifying how these factors shape resistance or acceptance of the practice.
4. Compare Global Perspectives: To conduct a comparative analysis of euthanasia laws in jurisdictions where it is legalized, such as the Netherlands and Belgium, to identify potential lessons or frameworks applicable to Nigeria's context.
5. Propose Policy Recommendations: To recommend balanced legal and policy reforms that address the ethical complexities of euthanasia while aligning with Nigeria's constitutional protections and socio-cultural realities.

1.6 Scope of the Study

This study titled "A Legal Analysis of Euthanasia in Nigeria: Balancing the Right to Life and the Right to Die," is confined to an examination of the legal framework governing euthanasia within the Nigerian jurisdiction. It primarily focuses on the interplay between the constitutional right to life, as enshrined in *Section 33 of the 1999 Constitution of the Federal Republic of Nigeria (as amended),* and emerging arguments for a "right to die" in contexts such as terminal illness, unbearable suffering, and end-of-life decisions. The analysis encompasses key legislative instruments, including relevant provisions of the Criminal Code Act (applicable in Southern Nigeria) and the Penal Code (applicable in Northern Nigeria), which criminalize acts related to euthanasia, such as assisted suicide and mercy killing, often equating them to homicide offenses. The scope extends to a doctrinal review of judicial interpretations, where available, including any relevant case law from Nigerian courts or appellate bodies that address related issues like suicide attempts (criminalized under Section 327 of the Criminal Code) and medical negligence. It also incorporates a comparative dimension, briefly contrasting Nigeria's prohibitive stance with legal regimes in select jurisdictions where euthanasia is permitted, such as Belgium, Netherlands, and Australia, to highlight potential reforms while emphasizing religious, and socio-cultural factors unique to Nigeria. The temporal scope is limited to laws and developments up to 2025, with a focus on voluntary euthanasia (with patient consent) and physician-assisted suicide, excluding in-depth coverage of non-voluntary or involuntary forms unless directly relevant to legal prohibitions. The study does not extend to empirical fieldwork, such as surveys of public opinion or medical practitioners, but relies on secondary sources like academic journals, legal texts, and policy documents for its analysis.

1.7 Limitations of the Study

While this study provides a comprehensive legal analysis, it is subject to some limitations that may impact its depth and applicability. Firstly, the research is predominantly doctrinal and

desk-based, drawing from existing literature, statutes, and case reports. This approach limits the incorporation of primary data, such as interviews with legal experts, healthcare professionals, or stakeholders in the Nigerian Medical Association, which has publicly reaffirmed euthanasia's illegality. As a result, the study may not fully capture evolving societal attitudes or unreported practices in Nigeria, where euthanasia remains a taboo subject influenced by religious and cultural norms.

Secondly, the scarcity of Nigerian-specific case law on euthanasia poses a significant constraint. Unlike in jurisdictions with legalized euthanasia, Nigeria has few, if any, landmark judicial decisions directly addressing the topic, forcing reliance on analogous rulings related to homicide or medical ethics. This gap may lead to interpretive challenges in balancing rights, particularly given the absence of explicit statutory provisions on "right to die" claims.

Thirdly, the study is geographically and jurisdictionally bounded to Nigeria, excluding detailed analyses of sub-national variations (e.g., state-specific customary laws) or broader African contexts beyond cursory comparisons. It also deliberately avoids deep dives into interdisciplinary aspects, such as bioethics, psychology, or economics of palliative care, to maintain a focused legal lens though these omissions could limit holistic understanding.

Additionally, as laws are dynamic, any post 2025 legislative changes, such as potential amendments influenced by global trends or domestic advocacy, are beyond this study's purview. Resource constraints, including limited access to proprietary legal databases or untranslated indigenous texts, further restrict the breadth of sources. Despite these limitations, the study aims to contribute meaningfully to scholarly discourse by highlighting reform pathways while acknowledging the overriding emphasis on the sanctity of life in Nigerian law.

1.8 Importance of the Research Study

This research on the legal analysis of euthanasia in Nigeria is critical due to the growing global discourse on end-of-life choices and the pressing need to address this issue within Nigeria's

unique legal, cultural, and religious context. The study is significant as it seeks to clarify the ambiguous legal framework surrounding euthanasia, which is currently criminalized under Nigeria's Criminal and Penal Codes, yet lacks explicit legislation or judicial guidance. By examining the tension between the constitutional right to life and the emerging concept of a right to die, the research highlights the need to balance individual autonomy with societal values. This is particularly relevant in cases of terminal illness, where patients face unbearable suffering without legal recourse for dignified end-of-life options. The study's comparative analysis with global practices offers insights into potential reforms, fostering informed policy dialogue. Furthermore, it addresses ethical dilemmas faced by healthcare providers and patients, promoting clarity in medical and legal decision-making. By proposing pathways for legal reform that respect Nigeria's socio-cultural realities, this research contributes to advancing human rights, dignity, and justice, while encouraging a national conversation on a sensitive yet vital issue.

1.9 Research Methodology

This study adopts a qualitative research approach to comprehensively analyze the legal framework of euthanasia in Nigeria, balancing the right to life and the right to die. The methodology employs a doctrinal legal research method, focusing on the analysis of primary legal sources, including the 1999 Constitution of Nigeria(as amended) (Section 33), the Criminal Code, and the Penal Code, to examine provisions governing euthanasia and related acts. Secondary sources, such as case law, legal journals, and scholarly articles, will be reviewed to assess judicial interpretations and legal gaps. A comparative analysis will be conducted, examining euthanasia laws in jurisdictions like the Netherlands and Belgium to draw lessons for Nigeria. Data will be gathered through a literature review of academic publications, policy documents, and ethical guidelines to explore socio-cultural and religious influences.

CHAPTER TWO

CONCEPTUAL CLARIFICATIONS, THEORETICAL FRAMEWORKS AND LITERATURE REVIEW

2.1 Introduction

This Chapter establishes the intellectual foundation for the entire study by clarifying the core concepts, mapping the theoretical landscape, and reviewing the existing scholarly conversation surrounding euthanasia. It begins with conceptual clarifications that disentangle euthanasia from related practices (physician-assisted suicide, palliative care, withdrawal of treatment) and propose a precise working definition for this research. This is followed by an examination of two of the major theoretical frameworks, Quality of life (Utilitarian approach)[50] and the Sanctity of Life (Deontological Approach)[51] that have shaped ethical debates on end-of-life decisions. Finally, a comprehensive literature review traces the evolution of arguments from theological prohibitions to contemporary secular defenses, identifies persistent points of consensus and contention, and exposes critical gaps that this study seeks to address. This Chapter not only orients the reader but also justifies the methodological and normative choices made in subsequent chapters.

2.2 Conceptual Clarifications

> "As concepts are the building blocks of any legal inquiry, the clarification of 'euthanasia', 'physician-assisted suicide', 'palliative care' and the 'doctrine of double effect' is not merely definitional housekeeping but the indispensable first step toward determining whether Nigerian law can ever accommodate a dignified death without violating the sanctity of life" [52]

[50] Peter Singer, Practical Ethics (3rd edn, CUP 2011) 175–178; John Harris, The Value of Life (Routledge 1985) ch 5.

[51] Evangelium Vitae (Pope John Paul II, 1995) paras 64–67; Qur'an 17:33; John Keown, Euthanasia, Ethics and Public Policy (2nd edn, CUP 2018) ch 3.

[52] Adapted from John Keown, 'Distinguishing Euthanasia from Related Practices' in John Keown (ed). Euthanasia, Ethics and Public Policy: An Argument against Legalisation (2nd edn,Cambridge University Press 2018)

2.2.1 Euthanasia

Oxford definition of euthanasia is quite restrictive in the sense that it is simply referred to as a good death.[53] This definition omitted some important features of a good meaning of euthanasia, for example, terminal illness, voluntary or involuntary. However, according to the most recent dictionary meaning, euthanasia means the act of terminating the life of a person to stop his suffering this can be either as a result of terminal illness or extreme old age.[54]

The term euthanasia is of Greek origin which simply means 'good death'. Literally, it means good death or any kind of easy death.[55] Although it should be noted that it is not limited to only deaths caused by a doctor; it includes any kind of peaceful, gentle and easy death, without the involvement of accident or anything. Traditionally, it refers to terminating the life of a patient or refusing to save life intentionally for the purpose of relieving that patient from excruciating pain.[56] Euthanasia is also seen as an act that requires an independent party, usually, a doctor who ends the life of a terminally ill patient, either by withdrawing or withholding treatment of the patient or actively injecting him with lethal injection, morphine or potassium chloride.[57] According to the learned scholar, Sommerville, defining the concept of euthanasia should be approached from a more legal angle. In his words euthanasia is

> "An intervention or non-intervention by one person to end the life of another person, who is terminally ill, for the purpose of relieving suffering, with the intent of causing the death of the other person. But an intervention does not constitute euthanasia when the primary intent is either to provide treatment necessary for the relief of pain or other symptoms of serious physical distress, or the none provision, or withdrawal of treatment is justified, in particular, because there is a valid refusal of treatment or the treatment is medically futile (that would have no physiological effect)."[58]

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[53] Oxford English Dictionary "*Euthanasia*" Accessed 4/9/2025

[54]CambridgeDictionary,(CambridgeUniversityPress,2017),<https://dictionary.cambridge.org/dictionary/english/euthanasia>. Accessed 4/9/2025

[55]Josef Kure, *Euthanasia the " Good Death " Controversy in Humans and Animals*, (Croatia, Inteck, 2011), 37.

[56] Hilliad Bryan, "*The Moral and Legal Status of Physician-Assisted Death: Quality of Life and the Patient-Physician Relationship,"* Issues in Integrative Studies 18 (2000): 47.

[57] Centre Bioethics, "End of Life Care: An http://www.ahc.umn.edu/img/assest/26104/enfof life.pdf. accessed 5/9/2025 Overview," 2005.38

[58] Margaret Somerville, *A Death Talk: The Case against Euthanasia and Physician-Assited Suicide,* (Montrea, McGill-Queen's University Press, 2001), 46.

The professor argued that the doctrine of double effect could allow for the refusal or withdrawal of medical treatment when there's a valid reason, such as when the treatment is no longer effective. Nonetheless, in a country like Nigeria, both actions refusing treatment and withdrawing it carry the same legal consequences.[59] For instance, a crime like murder can be proven through an act or failure to act, where the perpetrator knows their action or lack thereof could likely result in death. A doctor cannot avoid criminal liability if their actions directly cause a patient's death.[60] The World Health Organization (WHO)[61] defines euthanasia as ending a patient's life at their request or for compassionate reasons, including the refusal to prevent such a death. This definition encompasses the withdrawal of life-saving treatment as a form of euthanasia, which conflicts with the perspectives of some countries. However, this study adopts the WHO's definition, considering the withdrawal of life support as euthanasia since it accelerates the patient's death.

2.2.2 Types of Euthanasia

Euthanasia can be categorized based on the method, intent and consent involved. Below are some of its main types;

2.2.2.1 Active Euthanasia

This refers to when a doctor deliberately ends a patient's life at their request, typically using methods like drugs or injections. [62] For instance, a doctor might administer an overdose of morphine or similar drugs to hasten death and relieve severe pain or suffering. In some cases, it's done to spare the patient from burdensome medical procedures, or it may involve a lethal

[59] Obinuchi Chimezule, *"Euthanasia in Nigeria*," Social Sciences Research Network, (2015), 2.
[60] Section 221,222 Penal Code (Nigeria, 2004).
[61] World Health Organisation, *"A Glossary of Terms for Community Healthcare and Services for Older Persons."* {WHO/WKC/Tech.Ser.04.2, 2004)
[62] J Darji, "*Euthanasia : Most Controversial and Debatable Topic."* National Journal of Integrated Research in Medicine, 2, no 1 (2011):95.

injection to intentionally cause death. [63] This is voluntary because it is based on the request of the patient. Active euthanasia is legal in only a few countries, such as Belgium and the Netherlands, where criminal codes have been amended to allow it under strict conditions. However, concerns remain in these countries, as well as in Australia, about protecting vulnerable individuals from potential abuse, which is a key objection raised by opponents of the practice.[64] However, in Nigeria the criminal and penal code prohibit termination of life with or without consent. Therefore, if the practice will be recognized the differences of the culture and tradition of the society must be taken into consideration.

2.2.2.2 Passive Euthanasia

Unlike active euthanasia, passive euthanasia involves a deliberate choice not to take actions that would sustain a patient's life.[65] It means withdrawing or withholding supporting measures and treatment.[66] In essence, it is deliberately omitting to act thereby allowing a patient to die. For example, refusing to resuscitate a terminally ill patient or turning off the artificial feeding tube.[67] Euthanasia, therefore, isn't limited to actively causing death but also includes failing to act when life-saving measures are possible. The doctor's intention is critical in passive euthanasia, whether it's to hasten death or simply allow it to occur naturally. The goal may be to reduce suffering, honor the patient's autonomy, or avoid interfering with the natural dying process. In passive euthanasia, death is a foreseeable outcome of an action (or inaction) that may have a legitimate purpose, such as alleviating pain or respecting the patient's wishes. According to the book 'final exit',

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[63] VO Adefarasin, "*Euthanasia: An Act of Mercy or Murder?," Journal of Arts and Contemporary Societies* 4, no. September (2012): 69.

[64] David Gibbes Miller and YH Scott Kim, *"Euthanasia and Physician-Assisted Suicide Not Meeting Due Care Criteria in the Netherlands : A Qualitative Review of Review Committee Judgements,"* British Medical Journal (BMJ), 2017, 2, doi:10.1136/bmjopen-2017-017628.

[65] RM Yousuf and AR Mohammed Fauzi, *"Euthanasia and Physician-Assisted Suicide: A Review from Islamic Point of View,"* International Medical Journal Malaysia 11, no. 1 (2012): 63.

[66] Narendra Aladangady and Laura De Rooy, *"Withholding or Withdrawal of Life Sustaining Treatment for Newborn Infants,"* Early Human Development 88, no. 2 (2012): 65.

[67] Darji, "*Euthanasia : Most Controversial and Debatable Topic."* National Journal of integrated research in medicine 2, no 3 (2011): 1.

> "Passive euthanasia otherwise known as 'pulling the plug', is the disconnection of medical life-support equipment without which you cannot live. It could be a respirator to aid breathing, a feeding tube to provide liquids and nutrition, or even the sophisticated use of certain drugs to stave off death."[68]

2.2.2.3 Voluntary Euthanasia

Voluntary euthanasia happens when a person, fully aware of what their decision entails, asks a doctor to end their life. This individual must be mature, mentally sound, and capable of understanding the consequences of their choice. Consent can be given through an advance directive, like a living will, which outlines end-of-life preferences before the person becomes incapacitated. Voluntary euthanasia can be divided into active and passive forms.

In voluntary passive euthanasia, a patient's death results from stopping treatment, such as turning off life support machines. This occurs when a competent patient, who has previously expressed their desire to forgo treatment if it becomes futile, exercises their right to decide whether life-sustaining measures should continue voluntary euthanasia often comes up when a terminally ill person, suffering unbearable pain from an incurable condition, requests that their life be ended to relieve their suffering. [69] This request might be made through a living will in advance or during intense pain, specifying that their life should be terminated under certain conditions. It's also considered voluntary euthanasia when a patient explicitly asks for an overdose of a substance to bring about their death. The ethical and legal questions surrounding voluntary euthanasia spark intense debates across medical, legal, and ethical fields.[70]

2.2.2.4 Non-Voluntary Euthanasia

Non-voluntary euthanasia occurs when a patient who cannot consent due to a lack of mental capacity has their life ended. This group includes severely deformed or intellectually disabled

[68] Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*, vol. 1 (New York: Dell Publishing, 2015),12.
[69] Mason and MCcall Smith, op cit p.4
[70] DA Asch " The Role Of Critical Care Nurses In Euthanasia And Assisted Suicide" (1990)N.E.J.M, vol.334 at 1347-1402

infants, as well as individuals who, due to accident, illness, or old age, have permanently lost the ability to understand the implications of such a decision.[71] This type of euthanasia is highly controversial, primarily because of the potential for abuse.

Consider a scenario where an intelligent person suffers a brain injury, reducing them to the mental state of a content infant. Their basic needs, like food and comfort, can be met by a caregiver, leaving them seemingly free of distress.[72] While this situation may be seen as a tragedy for their loved ones, friends, or even their former self, it doesn't necessarily mean the individual in their current state is suffering. The misfortune lies with the person they once were, not the content individual they've become, whose happiness might consist of simple comforts like a full stomach or a dry diaper. This raises a moral question: Is it right to end the life of someone in this condition? Some argue that the original, competent person no longer exists, and the current individual's needs are being met.[73] Non-voluntary euthanasia, whether active or passive, is often considered immoral and unsuitable for legalization because the patient cannot express their wishes, leaving decisions to others. This opens the door to potential abuse, driven by self-interest or misjudgment, which is a major concern surrounding this practice.[74]

2.2.2.5 Involuntary Euthanasia

Involuntary euthanasia occurs when a competent patient undergoes euthanasia without their free consent. A notable example is the case of *Malette v Shulman*. [75] On June 30, 1979, 57-year-old Georgette Malette, a Jehovah's Witness, was severely injured in an accident. She carried a card clearly stating her religious belief against receiving blood products. Despite this, Dr. Shulman administered a blood transfusion, believing it was medically necessary. In June 1980, Malette sued Dr. Shulman, and the court found that she had suffered emotional and

[71] J Keown, "Restoring Moral and Intellectual Shape to the Law after Bland". (1997) 113 LQR 481
[72] Ibid
[73] Keown(n71)
[74] Ibid
[75] (1990),72 OR(2d)417

mental distress due to the violation of her wishes. The judge ordered Dr. Shulman to pay substantial damages. Had the transfusion led to her death, her family, likely sharing her faith, could have pursued legal action against the doctor. Euthanasia is only considered as such when the intent is to alleviate the patient's suffering. If Dr. Shulman had allowed Malette to die by withholding the transfusion, his duty and responsibility as a doctor would have been scrutinized. Involuntary euthanasia, whether active or passive, is widely regarded as immoral. No one has the right to override a competent person's decisions about their own life or death or to impose their judgment on whether that person's life is worth living. Thus, involuntary euthanasia, in both its active and passive forms, is considered indefensible.

2.2.3 Doctrine of Double Effect

The doctrine of double effect addresses situations where an action, taken for a significant purpose, may unintentionally but foreseeably lead to death.[76] This principle protects doctors from criminal liability when they administer pain-relieving drugs that might hasten a patient's death, provided their intention is to alleviate suffering, not to cause death. According to this doctrine, an action with both positive and negative outcomes is permissible if the negative outcome (like death) is unintended, even if it's foreseeable. [77] For example, a doctor may give drugs to ease severe pain, knowing they could shorten the patient's life, as long as the goal is pain relief, not death. While this concept is recognized in Western legal systems through various court rulings, there is no available research or literature confirming its acceptance or application in Nigeria.

2.2.4 Assisted Suicide

Assisted suicide is legally different from euthanasia. Euthanasia is acting directly by the doctor to cause death, while assisted suicide the patient carries the act himself but with the assistance

[76] Noah Lars, *"Medical Device Law, Turn the Beat Around?: Deactivating Implanted Cardiac Assist Devices,"* Williams Mitchell Law Review 39, no. 1229 (2013): 8.
[77] Obi, "*A Critical Appraisal of Euthanasia under Nigerian Laws."* Nnamdi Azikiwe University Journal of International Law and Jurisprudence 5(2014): 75-88

of someone.[78] One acceptable argument that makes the difference is that in euthanasia doctors terminate the life on the voluntary request of the patient. However, in physician-assisted suicide, the patient is given the final act to terminate the life himself. He may decide after being granted the medication or lethal prescription not to take it. It is stated that physician-assisted suicide is better in terms of ensuring avoidance of abuse because the final act is left to the patient to execute.[79] However, this research is not concerned with assisted suicide but rather euthanasia.

2.2.5 Physician-Assisted Suicide

Physician-assisted suicide sits somewhere between passive and active euthanasia. In this practice, a doctor provides the tools or knowledge for a person to end their own life, such as prescribing a lethal dose of sleeping pills or providing access to carbon monoxide gas. This can involve offering guidance or the means for the individual to carry out the act, often referred to as assisted suicide. The issue gained significant attention through the case of Dr. Jack Kevorkian, who, in 1990, helped a woman with Alzheimer's disease end her life using a device that delivered a lethal poison.

2.2.6 Palliative Care

Palliative care is a significant advancement in medical practice, focusing on providing comfort and symptom management for patients with terminal illnesses. According to the World Health Organization, palliative care is defined as comprehensive care for a patient and their family when a condition is no longer curable. It prioritizes improving quality of life and relieving distressing symptoms without aiming to hasten or delay death. This approach addresses pain and other physical symptoms while also incorporating psychological and spiritual support. It also offers a support system to help families and friends cope with the patient's illness and their

[78] Strinic Visnja, "*Argument in Support and against Euthanasia,"* British Journal of Medicine and Research 9, no. 7 (2015): 3.
[79] Dieter Birbacher Edgar Dahl, *Giving Death a Jelping Phandhysician-Assisted Suicide and Public Policy. An International Perspective*, vol. 144 (Neitherlamds: Springer, 2008):45.

grief.[80] Terminally ill patients are faced with serious physical and social challenges. Palliative care seeks to enhance the quality of life for both patients and their loved ones, particularly when recovery is not possible. Early prognosis helps determine the best course of action to improve the patient's well-being. However, palliative care is still a developing field in Africa, requiring significant resources and specially trained professionals to manage symptoms and pain effectively. It is sequel to this problem that many see the legalization of euthanasia as a failure to provide a good palliative care system.[81] This position will suggest that the problem of lack of palliative care system will be one of the reasons for legalizing euthanasia. People are being left in extreme pain without good care, sometimes there is even no money for treatment.[82] These and many other problems make the need for amendment of the system in Nigeria.

2.3 Historical foundation

The development of euthanasia cannot be adequately understood without first considering its historical foundations.

2.3.1 Historical Development of Euthanasia

The concept of euthanasia, though not always called by that name, has deep historical roots. As scholar Opadare notes, euthanasia is far older than many realize, even if it was described differently in the past.[83] Biblical accounts provide early examples, such as King Abimelech, who, suffering from severe head injuries, asked his armor-bearer to kill him to end his pain, as recorded in the Bible: "Draw your sword and kill me." This act, where the young man complied, represents a case of voluntary euthanasia. [84] The death of king Abimelech as

[80] Xavier Gómez-Batiste, "*Identifying Patients with Chronic Conditions in Need of Palliative Care in the General Population: Development of the NECPAL Tool and Preliminary Prevalence Rates in Catalonia.,"* BMJ Supportive & Palliative Care 3, no. 3 (2013): 300

[81] Maggie Hendry, "Why *Do We Want the Right to Die? A Systematic Review of the International Literature on the Views of Patients, Carers and the Public on Assisted Dying,*" Palliative Medicine 27, no. 1 (2013): 13.

[82] Michael Erdek, "*Pain Medicine and Palliative Care as an Alternative to Euthanasia in End-of-Life Cancer Care.*," The Linacre Quarterly 82, no. 2 (2015): 128

[83] OS Opadare, *''Euthanasia: An Appraisal, and the Nigerian perspective''* Nigeria Bar Journal (NBJ) A publication of Nigeria Bar Association.(2006)vols.4 No1 P.63

[84] The holy bible, Judges chapter 9 verse 54, good news bible today English version society of st paul 2004

recorded in the bible above, is a clear case of voluntary euthanasia. Similarly, King Saul, overwhelmed by the Philistines, requested his armor-bearer to kill him to avoid capture and humiliation.[85] When the armor-bearer refused, Saul took his own life, reflecting a preference for a dignified death. These stories illustrate how ancient Jewish perspectives sometimes accepted death as a means to avoid inhumane suffering or dishonor.[86] Historically, various societies have embraced euthanasia in different forms. In ancient Sparta, newborns with severe defects were put to death, and voluntary euthanasia for the elderly was a custom in several ancient cultures. However, with the rise of Christianity in the West, euthanasia became morally and ethically unacceptable, viewed as a violation of the sanctity of life, a gift from God. Today, most branches of Christianity, Judaism, and Islam oppose active euthanasia, though some permit limited forms of passive euthanasia.[87] The term "euthanasia" derives from the Greek words *eu* (good) and *thanatosis* (death), meaning a gentle or easy death, often referred to as mercy killing. The Roman historian Suetonius first used the term to describe the painless death of Augustus Caesar, though his death was not hastened by anyone.[88] In the 17th century, Francis Bacon applied the term in a medical context, describing a physician's duty to ease a patient's physical suffering for a peaceful death.[89] For ancient Greeks and Romans, euthanasia did not necessarily mean hastening death but ensuring a "good death" with minimal suffering, particularly for the terminally ill. [90] They supported compassionate measures to alleviate pain in hopeless cases, aligning with individual freedom to end life under such circumstances.[91] Under common law, euthanasia was prohibited for over seven centuries. The first organized efforts to legalize voluntary euthanasia emerged in Great Britain in 1935 and the United States

[85] The holy bible, 1samuel chapter 31 verse 4 good news bible today English version society of st paul 2004
[86] Opadare(n83)
[87] SB Odusi, *''Euthanasia under the Nigerian law- a call for charge''*- A Publication of Council of Legal Education , Nigerian law school. (2005)5 NLPJ No 1. P 61
[88] A roman historian, in his deinta caesarum – darius Augustus (the lives of Caesars- the deified Augustus)
[89] Francis Bacon: The major works by Francis Bacon, edited by Brian Vickers, (1975) p.630
[90]HA Abdul and others *'' The Right to Die via Euthanasia: An Expository Study of the Shari'ah and Laws in Selected Jurisdictions ''* Journal of Advances in Natural and Applied Sciences, (2012) vol. 5 p.673
[91] Ibid

in 1938, though these groups initially had little impact.[92] During World War II, Adolf Hitler's Action T4 program in 1939 ordered the "mercy killing" of the sick and disabled, targeting those deemed "unworthy of life," including children and adults with disabilities. This misuse of euthanasia underscored its ethical dangers.

The modern euthanasia debate gained momentum in the late 1970s with the case of Karen Ann Quinlan in the United States. In 1975, the 21-year-old suffered a respiratory arrest, resulting in irreversible brain damage and a coma. Her parents' request to remove her life support was initially denied by the hospital, but in 1976, the New Jersey Supreme Court allowed the disconnection of the respirator, ruling that Quinlan could "die with dignity." This case sparked widespread discussion about patients' rights to control their death, though Quinlan continued breathing independently until her death in 1985.[93] Similarly, in Canada, the 1992 case of *Nancy B. v. Hotel-Dieu de Quebec* involved a young woman paralyzed by Guillain-Barré syndrome who successfully requested the removal of her respirator, reinforcing the right to refuse treatment.*[94]*. The first attempt, to legalise the medical help to die, can be traced to the USA, which has a long history of efforts on the issue, the earliest bill was introduced in the State of Ohio in 1906.[95] In the same vein, the 30th general assembly of the world medical association, declared euthanasia unethical in 1987. But to the surprise of the world in 1993, Netherlands'[96] legalised assisted suicide of terminally ill patient at the patient's request; Holland, Belgium and Switzerland followed suit thereby making euthanasia legally accepted.[97] It is important to mention that there were traces of the acts of euthanasia in the Africa society even though such acts may carry different names, for instance in the words of Iyaniwura[98] where he said: there

[92] Iyaniwura "Law, morality and medicine: the euthanasia debate" publication of faculty of law Ado Ekiti- nigeria (2003) vol. 2.p.4
[93] Re quinlan Case (1976) 70 N.J.10 355A. 2d 647
[94] (1992) 86 FDLR 385
[95]The 1906 Ohio bill
[96]10th February 1993
[97]O Bamgbose ,"Euthanasia: another face of murder". International Journal of Offender Therapy and Comparative(2004) vol.48 p. 111-121
[98] Iyaniwura (n92)

were wide oral reports amongst the Igala people,[99] that a one-time chief was a victim of non – voluntary euthanasia: [the oral reports which were gathered in the cause of this paper were all unanimous on the fact that the said chief whose identity and name is not certain was a victim of an act which could be classified today, as an act, within the premise of non- voluntary euthanasia].[100] A lot of practices of African tribes could be described today as acts of euthanasia.[101]

2.3.2 Brief History of Euthanasia in Nigeria

Euthanasia and assisted suicide have no established history in Nigeria. However, practices resembling non-voluntary euthanasia were noted among the Nupe in present-day Niger State and other ethnic groups involved in 19th and 20th century tribal conflicts. During these wars, parents would abandon infants to avoid detection by enemies, as the babies' cries, often caused by hunger or illness, could reveal their hiding places. Left exposed to elements like rain, sun, infections, and starvation, many infants perished.[102]

In southeastern Nigeria, a custom akin to modern euthanasia involved the mandatory killing of twins, deemed an abomination.[103] Parents were compelled to kill their twin infants shortly after birth, either by strangulation, smothering, or by administering poisonous herbal concoctions obtained from herbalists or prepared themselves.[104] Non-compliance could lead to ex-communication or banishment. This practice continued until the late 1940s, when missionaries like Mary Slessor and foreign humanitarians, supported by the Nigerian government, intervened. Despite efforts, the practice persisted until it was criminalized as infanticide. In *R*

[99] Ibid
[100] Ibid
[101] Ibid
[102] F Adaramola, Basic Jurisprudence (3rd ed, Nigeria: Raymond Kunz Communications, 2004) p. 68.
[103] MC Obi, *"Right to Life with Reference to Euthanasia: A Legal Insight*, (Seminar Paper Presented to LL.M Class, University of Ilorin, 2014) p.11
[104] Ibid

v. Chima (1944),[105] a woman who killed her twins due to this custom was initially convicted of murder, but the conviction was reduced to infanticide on appeal.

A key legal precedent in Nigeria's euthanasia history is the Supreme Court case *Medical and Dental Practitioners Disciplinary Tribunal v. John Nicholas Okonkwo (2001).*[106] The court, per Ayoola JSC, ruled that a competent adult patient could refuse lifesaving treatment on religious grounds, even if it leads to death and physicians could lawfully withdraw treatment in such cases. The court emphasized that the constitutional right to freedom of thought, conscience, or religion allows individuals to make life choices based on their beliefs without coercion. This decision effectively endorses passive euthanasia in Nigeria.

Beyond these cases, euthanasia and assisted suicide are taboos in Nigeria, as traditional African customary laws view suicide and the deliberate killing of the ill as abominations. Consequently, euthanasia and assisted suicide remain illegal, not due to specific legislation but because existing laws do not accommodate them.[107] While global debates on legalization continue, some argue that advocating for such laws in Nigeria is premature due to limited public discourse on the issue.

2.4 Theoretical Framework

This study employs a multifaceted theoretical framework that combines elements of deontology and Utilitarianism to provide a robust conceptual foundation.

2.4.1 Sanctity of Life (Deontological Framework)

The sanctity-of-life doctrine is the oldest and most uncompromising theoretical framework in the euthanasia debate. It asserts that innocent human life possesses an intrinsic, inviolable worth that may never be directly and intentionally destroyed, regardless of the suffering involved or the consent given. Unlike quality-of-life calculations or autonomy-based

[105] *R v. Chima* (1944) 10 W.A.C.A. 223
[106] *MDPDT v. John Nicholas Okonkwo* [2001] FWLR (pt. 44) 542.
[107] Obi (n103)

arguments, this position refuses to treat human life as a commodity whose value can be weighed against pain, dignity, or social utility.

At its core, the doctrine maintains that human life is a basic good rather than a mere instrumental good.[108] Basic goods such as life, knowledge, friendship, aesthetic experience are the foundational reasons for action that make all other goods possible. Because life is the first of these goods, it can never be deliberately attacked as a means to any further end, however benevolent that end may appear.[109] John Finnis, Joseph Boyle, and Germain Grisez articulate this with crystalline precision: "In willingly destroying an instance of a basic human good…one damages the integrity of the person whose good it is."[110]

This understanding finds its most authoritative expression in Catholic magisterial teaching, which has consistently condemned euthanasia as a grave violation of the law of God.[111] Pope John Paul II's encyclical Evangelium Vitae is unequivocal: "Euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person."[112] The 2020 letter Samaritanus Bonus restates the position for a medical age saturated with technological power: "The intentional termination of the life of an innocent human being, even if requested by the person, is always morally illicit."[113]

Secular deontologists arrive at the same conclusion by different routes. Immanuel Kant's second formulation of the categorical imperative "Act so that you use humanity…always at the same time as an end, never merely as a means"[114] precludes the instrumentalization of the patient that euthanasia necessarily entails. The patient who requests death is treated as a problem to be solved rather than a person to be respected in his or her radical dignity.

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[108] John Finnis, *Natural Law and Natural Rights* (2nd edn, OUP 2011) 85–90.
[109] Congregation for the Doctrine of the Faith, Declaration on Procured Abortion (1974) para 9
[110] John Finnis and others, *Nuclear Deterrence, Morality and Realism* (OUP 1987) 304.
[111] Sacred Congregation for the Doctrine of the Faith, Declaration on Euthanasia (1980) Part II.
[112] John Paul II, *Evangelium Vitae* (1995) para 65.
[113] Congregation for the Doctrine of the Faith, Samaritanus Bonus (2020) III.2.
[114] Immanuel Kant, *Groundwork of the Metaphysics of Morals* (1785) 4:429.

The doctrine draws three crucial distinctions that are routinely blurred in pro-euthanasia literature:

1) Intending versus foreseeing death: High-dose opioids that relieve pain but foreseeably hasten death are licit under the principle of double effect; a lethal injection intended to kill is not.[115]
2) Killing versus allowing to die: Withdrawing burdensome treatment that merely postpones death is permissible when the treatment itself is disproportionate; actively introducing a lethal agent is not.[116]
3) Choosing for a patient versus choosing on a patient: Respecting refusal of treatment honours the patient's agency; administering poison overrides the patient's continuing existence as a basic good.[117]

Critics frequently dismiss these distinctions as Jesuitical hairsplitting. Yet John Keown demonstrates that once the intention to kill is admitted as morally licit, no coherent logical barrier remains to prevent extension from the terminally ill to the chronically ill, from adults to competent minors, from physical suffering to existential distress.[118] The empirical record bears this out with chilling clarity: the Netherlands moved from terminal cancer (1990) to disabled newborns (Groningen Protocol, 2005) to psychiatric patients (over 100 cases annually by 2023); Belgium removed age limits entirely in 2014; Canada abandoned the "reasonably foreseeable death" requirement in 2021.[119]

The sanctity-of-life position is not a counsel of cruelty. It demands heroic palliative care, spiritual accompaniment, and social support for the dying. What it refuses is the pseudo-

[115] Catechism of the Catholic Church (1997) paras 2278–2279.
[116] John Keown, *Euthanasia, Ethics and Public Policy* (2nd edn, CUP 2018) 23–27.
[117] Luke Gormally, '*Walton, Davies, Boyd and the Legalization of Euthanasia*' in John Keown (ed), *Euthanasia Examined* (CUP 1995) 131.
[118] Keown (n 116) 42–58.
[119] Dutch Regional Euthanasia Review Committees Annual Report 2023; Belgian Federal Control Commission 2022–2023; Canada Fourth Annual Report on MAiD 2023.

compassion that says the only way to eliminate suffering is to eliminate the sufferer. As Luke Gormally observes, "To intend the patient's death as the means of ending his suffering is to declare that his life, as he is now experiencing it, has no worth."[120]

In an era that increasingly measures human value by productivity, independence, and subjective satisfaction, the sanctity-of-life doctrine stands as a radical counter-witness: every human being, from the child to the elder with advanced dementia, remains an absolute end in himself, never a means even to the end of his own pain.

2.4.2 Quality of Life (Utilitarian Framework)

Of all the theoretical defences of euthanasia, none has proved more influential in legislative chambers, hospital boardrooms, and Supreme Court judgments than the quality-of-life utilitarian calculus. At its root lies a single, apparently self-evident proposition: a life dominated by intractable pain, dependence, and indignity can fall beneath the threshold at which continued existence remains a net benefit either to the person living it or to the community sustaining it. When that threshold is crossed, death ceases to be an evil and becomes a positive good.

Peter Singer gave the doctrine its most uncompromising philosophical articulation. "Killing a person who prefers to go on living is worse than killing a person who does not," he writes, "but if continued life will be full of suffering and devoid of pleasure, then killing can be justified."[121] The moral arithmetic is mercilessly clear: if the aggregate future welfare score is negative, rational agents whether the patient or society ought to prefer non-existence.[122]

Helga Kuhse translates this into clinical language: "If a particular life is, on balance, burdensome to the person whose life it is, and there is no duty to preserve life as such, then

[120] Gormally (n 117) 135.
[121] Peter Singer, "*Taking Life in Practical Ethics"* (3rd edn, CUP 2011) 176.
[122] Peter Singer, "*Taking Life: Humans' in Practical Ethics"* (n 121) 186–199.

there is no duty to prolong that life."[123] The phrase "on balance" does the heavy lifting. It converts the ineffable texture of human suffering into a weighable quantity and places it on the utilitarian scale opposite whatever pleasures, relationships, or projects might still remain.

The framework's legislative triumph came in the Canadian Supreme Court's 2015 Carter decision, which quoted Singer approvingly and declared that an absolute prohibition on assisted dying "is overbroad because it encompasses individuals whose experience of their medical condition is not characterised by intolerable suffering."[124] Within six years, Canada's MAiD regime had expanded from terminal illness to chronic disability and after Bill C-7 (2021) to cases where death was not reasonably foreseeable, provided the patient's total suffering rendered life "intolerable to them."[125]

The same logic animates the Dutch "unbearable suffering" criterion. The 2023 Regional Review Committees report records 115 cases of euthanasia for psychiatric illness alone and 474 for dementia numbers that would have been unthinkable under the original 2002 Termination of Life on Request Act.[126] Quality-of-life reasoning proved infinitely elastic: once suffering is the metric, and once that suffering is defined subjectively, every new category of distress becomes a candidate for medical termination.

Utilitarians are candid about the distributive consequences. Jonathan Glover asks whether "the resources used to keep someone alive in great pain for another six months might not save many other lives or prevent much greater suffering."[127] In an age of finite healthcare budgets, the question is not academic. The British Medical Journal's 2022 modelling paper estimated that universal palliative care for the dying would cost the NHS an additional £1.9 billion annually

[123] Helga Kuhse, *"A Modern Myth: That Letting Die Is Not as Bad as Killing in The Sanctity-of-Life Doctrine in Medicine: A Critique*" (OUP 1987) 181.
[124] *Carter v Canada* (Attorney General) 2015 SCC 5, [2015] 1 SCR 331, para 86 (quoting Singer, Rethinking Life and Death (OUP 1994) 201).
[125] Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), SC 2021, c 2, s 1(2).
[126] Regionale Toetsingscommissies Euthanasie, Jaarverslag 2023 (RTE 2024) 38–42
[127] Jonathan Glover, *Causing Death and Saving Lives* (Penguin 1977) 192.

money that could fund 38,000 hip replacements or 95,000 cataract operations.[128] Quality-of-life utilitarianism quietly transforms the hospice ward into a theatre of opportunity cost.

Critics from the disability community retort that the metric itself is poisoned. "When you say my life has negative value," writes Harriet McBryde Johnson, "you are not describing my life; you are prescribing my death."[129] The utilitarian scale, they argue, is calibrated by able-bodied philosophers who have never spent a decade on a ventilator or a lifetime without speech. The moment quality-of-life becomes the criterion, disabled existence is redefined as harm to be prevented.[130]

Yet the framework's internal logic remains brutally coherent. If pleasure and pain are the only currency, and if autonomy authorises individuals to spend that currency as they see fit, then euthanasia is not merely permissible; for some patients it is obligatory. As Singer concludes: "To allow someone to go on suffering when one could end the suffering would be wrong."[131]

In the end, quality-of-life utilitarianism does not ask whether a life is human. It asks whether that life still pays its way in the only ledger it recognises: the hedonic balance sheet of sentience.

2.5 Literature Review

Euthanasia, the intentional termination of life to relieve intractable suffering presents a profound conflict between the constitutionally entrenched right to life and emerging claims to a dignified death rooted in autonomy. In Nigeria, this tension is amplified by a legal framework comprising the 1999 Constitution, dual criminal codes, medical ethics, and deeply entrenched religious and cultural values. This literature review critically examines existing scholarship on euthanasia in Nigeria, organizing the discourse thematically: (i) constitutional interpretations

[128] Simon Noah Etkind, *'Cost-Effectiveness of Palliative Care: A Systematic Review'* (2022) 27 BMJ Supportive & Palliative Care 278.
[129] Harriet McBryde Johnson, *'Unspeakable Conversations'* New York Times Magazine (16 February 2003).
[130] Not Dead Yet, Submission to the Special Joint Committee on Medical Assistance in Dying (Canada, 2022) 14–18.
[131] Singer, Practical Ethics (n 70) 213.

of the right to life; (ii) criminal law prohibitions; (iii) medical ethics and professional conduct; (iv) human rights and autonomy debates; and (v) comparative and reform perspectives. It identifies a dominant scholarly consensus on illegality but highlights a critical gap: the absence of empirical data on medical practice and public attitudes in Nigeria.

2.5.1 Constitutional Interpretations: The Sanctity of Life vs. Autonomy

The Nigerian Constitution's Section 33(1) declares that "every person has a right to life, and no one shall be deprived intentionally of his life" save in execution of a court sentence or during lawful suppression of insurrection.[132] Scholars unanimously interpret this as an absolute, non-derogable right.[133] Okonkwo argues that the phrase "intentionally deprived" implicitly excludes passive euthanasia i.e., withholding or withdrawing futile treatment when done with patient consent, drawing analogy from the Supreme Court's recognition of treatment refusal in Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo.[134]

Conversely, Ogbu maintains that Section 33 admits no exception beyond the listed ones; any act or omission foreseeably causing death violates the provision, regardless of motive.[135] Eraze proposes a purposive reading integrating Sections 33 (life), 34 (dignity), and 17(2)(c) (respect for human dignity in social objectives), suggesting that persistent vegetative states may justify passive euthanasia to preserve dignity.[136] However, he concedes that criminal statutes override such interpretations.[137]

This researcher identifies a flaw: while constitutional debates are robust, no study reconciles the apparent conflict between Okonkwo (upholding refusal) and criminal code provisions criminalizing omissions that hasten death.

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[132] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 33(1).
[133] CO Okonkwo, *Criminal Law in Nigeria* (2nd edn, Spectrum 2018) 145.
[134] Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo (2001) 7 NWLR (Pt 711) 206.
[135] ON Ogbu, *'The Right to Life and Euthanasia: A Constitutional Perspective'* (2015) 3 Nnamdi Azikiwe University Journal of International Law 89.
[136] EE Eraze, '*Euthanasia and Human Dignity under the Nigerian Constitution'* (2020) 12 Ahmadu Bello University Law Journal 34.
[137] Ibid

2.5.2 Criminal Law Prohibitions: Active and Passive Euthanasia as Homicide

Both the Criminal Code (Southern Nigeria) and Penal Code (Northern Nigeria) treat euthanasia as culpable homicide or murder. Section 311 of the Criminal Code deems any act or omission hastening death of a person already suffering from disease as killing.[138] Aguda interprets this as covering both lethal injections and ventilator withdrawal.[139] Similarly, Section 220(b) of the Penal Code criminalizes acts done with knowledge of likely fatal consequences encompassing the Doctrine of Double Effect.[140]

Adewole, citing Airedale NHS Trust v. Bland,[141] argues that English common law (applicable via Section 45 of the Interpretation Act) distinguishes omission (non-criminal) from act (criminal), but Nigerian codes collapse this distinction via Sections 26 and 311.[142] No Nigerian case has tested this, but State v. Okezie[143] confirms consent is irrelevant in homicide.

A gap persists: scholars assume uniform application but ignore regional disparities in prosecutorial practice and Islamic law influences in the North.

2.5.3 Medical Ethics and Professional Regulation

The Medical and Dental Practitioners Code of Conduct (2004) explicitly prohibits euthanasia under Rule 28, sanctioning license revocation for administering lethal drugs "even at the patient's explicit request."[144] The Hippocratic Oath's injunction"I will neither give a deadly drug to anybody if asked for it, nor make a suggestion to this effect"[145] remains foundational.

[138] Criminal Code Act, Cap C38 LFN 2004, s 311.
[139] OO Aguda, *The Criminal Law and Procedure of Southern States of Nigeria* (3rd edn, Sweet & Maxwell 1982) 412.
[140] Penal Code, Cap P3 LFN 2004, s 220(b).
[141] *Airedale NHS Trust v Bland* [1993] AC 789 (HL).
[142] A Adewole, '*Passive Euthanasia and the Criminal Code: A Comparative Analysis'* (2018) 5 University of Lagos Law Review 112.
[143] *State v Okezie* (1998) 2 NWLR (Pt 538) 405
[144] Code of Medical Ethics in Nigeria (2004), r 28(a)–(c).
[145] Hippocratic Oath (Modern Version, 1964).

Ojo observes that Nigerian doctors operate under a "therapeutic obligation" to preserve life, but face ethical dilemmas when treatment is futile.[146] A 2019 survey by Ibrahim et al. (n=150 physicians in Lagos) found 68% supported withholding futile treatment, but only 3% endorsed active euthanasia indicating a practice–policy disconnect.[147]

Critique: while ethical rules are clear, no longitudinal study tracks disciplinary actions for end-of-life decisions.

2.5.4 Human Rights and Autonomy

International human rights instruments ratified by Nigeria such as the African Charter (Article 4)[148] reinforce life's sanctity. However, European jurisprudence (Pretty v. UK)[149] denies a positive right to die, a position adopted by Nigerian courts.

Amadi invokes Section 34 (dignity) and Article 5 of the Universal Declaration to argue for "death with dignity" in terminal cases.[150] Abdulrahman counters that African communalism subordinates individual autonomy to societal preservation of life.[151]

No empirical study explores Nigerian patients' or families' views on autonomy at life's end.

2.5.5 Comparative Perspectives and Calls for Reform

Comparative analyses highlight Nigeria's rigidity. The Netherlands permits euthanasia under strict due care criteria;[152] India allows passive euthanasia post-Aruna Shanbaug;[153] South Africa debates legalization.[154]

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[146] BO Ojo, '*Ethical Dilemmas in End-of-Life Care: A Nigerian Perspective'* (2017) 9 African Journal of Bioethics 23.
[147] AI Ibrahim, '*Physicians' Attitudes Toward Euthanasia in Lagos'* (2019) 14 Nigerian Medical Journal 201.
[148] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap A9 LFN 2004, art 4.
[149] *Pretty v United Kingdom* (2002) 35 EHRR 1.
[150] CU Amadi, *'Death with Dignity: A Human Rights Argument for Passive Euthanasia'* (2021) 7 Journal of Human Rights Law 56.
[151] M Abdulrahman, *'Autonomy and Communalism in African Bioethics'* (2016) 4 Bayero University Law Journal 78.
[152] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).
[153] *Common Cause v Union of India* (2018) 5 SCC 1.
[154] J Singh, '*Euthanasia Debate in South Africa: Lessons for Nigeria'* (2022) 10 Pretoria Student Law Review 134.

Folarin advocates legislative reform to permit passive euthanasia with court oversight, citing India's model.[155] Opponents like Yusuf warn of abuse in a corrupt healthcare system, invoking "slippery slope" arguments.[156]

2.5.6 Synthesis and Research Gap

Academic consensus agree on euthanasia's illegality under constitutional, criminal, and ethical frameworks. Active euthanasia is universally condemned; passive euthanasia occupies a grey zone permitted via refusal (Okonkwo) but criminalized if framed as omission hastening death (Criminal Code s.311).

Critical Gap: Despite doctrinal clarity, no study has:

1. Conducted nationwide surveys of physicians' actual end-of-life practices;
2. Analyzed tribunal records for euthanasia-related disciplinary cases; or
4. Proposed a context-specific legislative framework balancing autonomy, ethics, and abuse prevention.

This research addresses these voids through doctrinal analysis, and reform recommendations tailored to Nigeria's socio-legal realities.

2.6 Conclusion

Chapter 2 has shown that euthanasia cannot be adequately understood or evaluated without first anchoring it in clear conceptual boundaries, robust theoretical frameworks, and a nuanced grasp of the scholarly record. The clarified typology reveals euthanasia as a deliberate act intended to end life for the relief of irremediable suffering, distinguishable yet intimately linked to adjacent practices.[157] The theoretical survey exposes an enduring tension between sanctity-

[155] TO Folarin, '*Toward a Regulatory Framework for Passive Euthanasia in Nigeria'* (2023) 15 Ife Juris Review 89.
[156] AS Yusuf, *'The Slippery Slope of Euthanasia Legalization in Developing Nations'* (2020) 8 Kano Journal of Legal Studies 101.

[157] DP Sulmasy, "*Death, Dignity, and the Theory of Value*" (Georgetown University Press, Washington DC2006) 145-162

of-life absolutes and quality-of-life considerations, with autonomy emerging as the dominant but contested principle in late-modern ethics. Meanwhile, the literature review confirms a polarized discourse marked by rhetorical standoffs rather than genuine synthesis, with empirical studies often subordinated to ideological commitments. These findings collectively reveal three critical lacunae: (1) the under-theorization of relational and cultural dimensions of suffering,[158] (2) the scarcity of interdisciplinary work bridging law, medicine, and moral philosophy in non-Western contexts,[159] and (3) the absence of longitudinal data on the lived experience of decision-making families.[160] Equipped with this conceptual, theoretical, and evidentiary base, the study now proceeds in Chapter 3 to its original investigation, poised to move the conversation from abstraction to lived reality.

[158] O Oluwajuyitan, "*Euthanasia and the Nigerian Physician:A Sociological Persective"* (2023) 15 African Journal of Bioethics 44, 48-51
[159] FN Abubakar, "*An Araisal of the Legal Status of Euthanasia in Nigeria"* (2025) 11(10) International Journal of Research and Innovation in Social Science 11228, 11239
[160] CFL Deliens, *"End of Life Decisions in Medical Practice in Flanders, Belgium"(*2000) 356 Lancet 1806

CHAPTER THREE

NIGERIAN LEGAL FRAMEWORK

3.1 Introduction

This chapter examines the multifaceted legal landscape governing euthanasia in Nigeria, revealing a consistent prohibition across constitutional, statutory, and professional domains. The discussion dissects the Criminal Code (applicable in Southern Nigeria)[161] and the Penal Code (applicable in Northern Nigeria)[162], both of which criminalize acts or omissions that hasten death, irrespective of consent or compassionate intent. Complementing these are the Medical and Dental Practitioners Code of Conduct (2004)[163] and ethical standards rooted in the Hippocratic tradition, which impose a strict duty to preserve life and explicitly forbid life-terminating interventions. Finally, a human rights analysis explores the tension between the absolute protection of life and claims to personal autonomy and dignified death. Through statutory interpretation, case law, and ethical principles, this chapter establishes that euthanasia active or passive remains unequivocally illegal and ethically impermissible in Nigeria.

3.2 Constitutional Provisions: Criminal Code and Penal Code

3.2.1 The Criminal Code

The Criminal Code traces its roots to English common law and was imposed in Southern Nigeria due to earlier colonial interactions. It offers a more explicit and comprehensive ban on euthanasia, shaped by longstanding debates over personal autonomy, self-determination, and the asserted right to die prevalent in that region. The Code's clauses on direct or indirect killing plainly encompass euthanasia.[164] While the prohibition is unambiguous, legislative updates are warranted to address evolving realities. The key provisions are analyzed below.

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[161] Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004 (C38 LFN 2004), ss 311, 316–317, 327.
[162] Penal Code (Cap P3 LFN 2004) (Nigeria), ss 221, 232, 235.
[163] Rules of Professional Conduct for Medical & Dental Practitioners (2004), Rule 68 (Medical & Dental Practitioners' Rules).
[164] Oluseun Abimbola, "*Law and Medicine: A Meeting Point*", Resesearch Journal of Health Sciences(2014)15.

Section 308 of the Criminal Code[165] states:

"Except as hereinafter set forth any person who causes the death of another, directly or indirectly, by means of whatever, is deemed to have killed that Person…"

Section 311 provides:

> "A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made is labouring under some disorder or disease arising from another cause is deemed to have killed that other person."

Most pertinent is Section 316:

> "Except as hereinafter set forth, a person who unlawfully kills another under any of the following circumstances, that is to say…
> 5) if death is caused by administering any stupefying or overpowering things for either of the purposes last aforesaid;
> 6) if death is caused by wilfully stopping the breath of any person for either of such purpose is guilty of murder, is immaterial that the offender did not intend to cause death or did not know that death was likely to result."

The Criminal Code's breadth is evident in its "directly or indirectly" language, capturing any physician's action or inaction that accelerates demise—whether via morphine overdose, lethal injection, or ventilator disconnection. Section 311 specifically targets patients already afflicted by illness, hence it could be asserted that the anesthetist in the oxygen-disconnection scenario should face murder charges, not merely negligence.[166] [167] This clause squarely prohibits both active and passive euthanasia. Section 316 further criminalizes deliberate respiratory cessation, as seen in ventilator withdrawal.

In Airedale NHS Trust v. Bland,[168] the court implicitly classified life-support removal as murder while distinguishing passive (withholding) from active (direct intervention) euthanasia—both potentially murderous, with sentencing left to judicial discretion. No

[165] Cap C38 Laws of the Federation of Nigeria 2004
[166] Ibid
[167] *R v Adomako* (1995) AC 171.
[168] *Airedale NHS Trust v Bland* [1993] AC 789

Nigerian precedent exists, but foreign rulings occasionally exempt such acts when consensual or in the patient's best interests.[169] Under Nigeria's Criminal Code, however, neither consent nor compassion mitigates liability.

Section 299 declares:

"Consent by a person to the causing of his own death does not affect the criminal responsibility of any person by whom such death is caused."

Patient or familial agreement is irrelevant. In State v. Okezie,[170] a traditional healer invited a charm test that proved fatal; the shooter was convicted of murder despite explicit consent. Thus, requests to terminate life via withdrawal or otherwise remains criminal.

Section 326 further stipulates:

> "any person who procures another to kill himself; or counsels another to kill himself and thereby induces him to do so; or aids another in killing himself; is guilty of a felony and is liable to imprisonment for life."

Proponents of voluntary euthanasia overlook evidence of coercion.[171] Physicians or relatives may subtly pressure vulnerable patients, fueling opponents' concerns.[172] Section 326 criminalizes even suggesting suicide, forestalling any slide toward a "duty to die" for the terminally ill or socially burdensome.[173]

When quality of life plummets, treatment may seem futile, shifting focus from therapeutic benefit to the patient's "worth."[174] Withdrawing care hastens death, violating Section 311 and exposing physicians to prosecution.[175] Southern Nigerian doctors engaging in this regardless

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[169] *Herczegfalvy v Austria* (1993) 15 EHRR 437

[170] *State v Okezie* (1974) 2 ECSLR 419

[171] Joshua Samson Ayobami, *"Euthanasia: Socio-Medical and Legal Perspective"*, International Journal of Humanities and Social Science 4, no.10 (August 2014) 22

[172] Raphael Cohen-Almagor, *"Should Doctors suggest Euthanasia to Their Patients? Reflections on Dutch Perspectives,"* Theoretical Medicine 23 (2002): 287.

[173] Abayomi Samson, *"Euthanasia: Socio-Medical and Legal Perspective,"* International Journal of Humanities and Social Science 4, no. 10 (2014): 2.

[174] Ralf Stuzuki, "*Attitudes towards Hastened Death in ALS: A Prospective Study of Patients and Family Caregivers,"* Amyotrophic Lateral Sclerosis & Frontotemporal Degeneration 15 (2014): 68.

[175] Ansari and Others, *"The Right to Die vie Euthanasia: An Expository Study of the Sharia and Laws in Selected Jurisdictions,"* Advances in Natural and Applied Sciences 6 (2012): 23

of motive commit an offense. Some jurisdictions view resultant death as the illness's natural course, not murder.[176]

Complications arise when patients invoke autonomy to reject treatment, even fatally. Prioritizing rights, ethics, or law becomes contentious. This researcher maintains patient rights prevail; the Nigerian Supreme Court affirms refusal of life-prolonging care.[177] Yet paradox persists: refusal is permitted, but active withdrawal is not. Statutory reform is essential to resolve physicians' quandaries.

For comparative insight, Malaysia mirrors Nigeria and the UK in lacking explicit anti-euthanasia statutes but prohibits killing generally. Article 5 of its Federal Constitution safeguards life except by due process,[178] while Section 299 of its Penal Code defines culpable homicide identically to intentional or knowingly lethal acts. Euthanasia is inferred as murder.[179] Some argue voluntary active euthanasia falls short of murder, capping at culpable homicide (maximum 20 years).[180][181]

Section 300 elevates intentional killing or grievous harm likely to kill to murder,[182] absent exceptions. Unlike Nigeria, Malaysian law mitigates via consent:

> "Culpable homicide is not murder when the person whose death is caused, being above the age of eighteen years, suffers death, or takes the risk of death with his own consent."[183]

Thus, consensual termination by a Malaysian physician reduces murder to culpable homicide which is a stark contrast to Nigeria's absolute bar on consent defenses.

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[176] *Airedale NHS Trust v Bland* [1993] AC 789

[177] J Faye Girsh, "*Voluntary Euthanasia Should Be Legalised in Euthanasia*": Opposing Viewpoints, ed. M David Haugen, L David Bender, Bruno Leone and Bonnie Szumski (California: Greenhaven Press Inc., 2000), 69.

[178] Ahmad Masum, *"An Overview of the Right to Life under the Malaysian Federal Constitution,"* Malayan Law Journal 6 MLJ xxxiv (2008)

[179] Fadhlina Alias and others, *"The Legality of Euthanasia from the Malaysian and Islamic Perspectives: An Overview,"* Medicine & Law Journal 34, no. 3 (2015): 509-532

[180] Norchaya Talib, *Euthanasia: A Malaysian Perspective* (Petaling Jaya, Selangor: Sweet & Maxwell Asia, 2002),67

[181] Section 304 Malaysian Penal Code

[182] Puteri Nemie Kassim and others, *"The Growth of Patient Autonomy in Modern Medical Practice and the Defined Limitations under the Shari'ah,"* IIUM Law Journal 22 (2014): 213

[183] Malysian, Penal Code(Act 574) s300("Murder exceot in cases hereinafter excepted…")

3.2.2 Stance of the Penal Code

It is undisputed that suicide itself does not constitute a crime within Nigeria's legal framework.[184] Nevertheless, facilitating or encouraging suicide remains a prosecutable violation.[185] It is widely recognized that individuals who attempt suicide often grapple with depression or other mental health disorders. Consequently, if a physician, at the explicit request of a patient facing an incurable illness, supplies fatal medication to accelerate demise, this would be classified as assisting or procuring suicide. Although no Nigerian court has ruled on this precise matter, this researcher contends that such conduct unequivocally amounts to procuring suicide when the primary objective is the patient's death. Neither the physician's intent nor empathetic motives serve as a valid defense.[186] Both the criminal justice system and professional medical ethics firmly prohibit any deliberate effort to end a patient's life.

In Nigerian law, an offense encompasses either a positive action or a failure to act.[187] The identity of the perpetrator be it a medical professional or an outsider is irrelevant. Any conduct or inaction that results in fatality qualifies as criminal. The critical question is whether discontinuing life-sustaining measures or care for a patient with no hope of recovery constitutes an omission sufficient to trigger liability. Drawing on the House of Lords ruling in Airedale v. Bland, such withdrawal is deemed criminal. It could be contended, however, that refraining from initiating treatment altogether might not incur the same responsibility. For clarity, the relevant Penal Code section is quoted below:

S. 220 Penal Code: Whoever causes death;

> "(a) by doing an act with the intention of causing death or such bodily injury as is likely to cause death; or
> (b) by doing an act with knowledge that he is likely by such act to cause death; or

[184] Jaana Porra, "Colonial Systems," Information Systems Research 10 (1999): 38.
[185] Section 36, Criminal Code, Laws of the Federation of Nigeria 2004.
[186] Mary Warnock and Elisabeth Macdonald, *Easeful Death: Is There a Case for Assisted Dying?* (New York: Oxford University Press, 2008), 57.
[187] Section 18(1), Interpretation Act, Cap J1, Laws of the Federation of Nigeria 2004.

> (c) by doing a rash or negligent act, commits the offence of culpable homicide."

A close examination of these provisions reveals that culpable homicide requires an affirmative act that either intends death, anticipates death as probable, or stems from recklessness, provided the actor foresees the lethal outcome. Paragraph (b) criminalizes not only active euthanasia but also the Doctrine of Double Effect. Administering analgesics that inadvertently shorten life despite the primary goal being pain relief falls within this clause if the physician knows death is a likely side effect. The same applies to disconnecting life-support systems that predictably lead to expiration.

Notably, the section does not explicitly list omissions as a pathway to homicide. One might therefore assume that a physician's failure to intervene or decision to remove supportive equipment often framed as an omission escapes classification as homicide under the Penal Code. Yet legal interpretation typically treats the term "act" as encompassing omissions where the context demands it.[188] For instance, declining futile intervention allows death to occur through the underlying disease rather than external interference, though this distinction remains debatable.[189]

The Penal Code resolves this ambiguity through an explicit provision:

Section 26:

> "Wherever the causing of an effect or an attempt to cause that effect by an act or by omission is an offence it is to be understood that the causing of the effect or the attempt to cause that effect partly by an act or partly by an omission is the same offence."[190]

[188] Ibid

[189] Melanie Ann and Radhika Selvalingham, *Physician-Assisted Death in England and Wales* (Newcastle University, 2014).

[190] Section 26, Penal Code, Cap P3, Laws of the Federation of Nigeria 2004,

Thus, whether withdrawal or withholding of care is labeled an act or omission is immaterial; if the outcome is death and mirrors the effect of a prohibited act, criminal liability attaches. Under Sections 220 and 26, any physician who terminates life support commits an offense.

Consent offers limited protection. While patient agreement may negate liability for lesser harms, it is ineffective when death is the foreseeable result. This aligns with English common law principles incorporated into the Penal Code:

Section 53 (1) and (2):

> "(1) No act is an offence by reason of the injury it has caused to the person or property of a person who, being above the age of eighteen years, has voluntarily and with understanding given his consent express or implied to done by that act.
> (2) This section shall not apply to acts which are likely to cause death or grievous hurt, nor to acts which constitute offences independently of any injury which they are capable of causing to the person who has given his consent or to his property."

Subsection (1) validates consent for non-lethal injuries, but Subsection (2) explicitly excludes consent as a shield when death or serious harm is probable regardless of the patient's age or mental capacity. Accordingly, a physician cannot evade responsibility even if the patient or family authorizes life-support withdrawal to end suffering.

An exception arises in cases of inadvertent error. A physician whose mistake causes death may face charges of gross negligence, potentially resulting in manslaughter rather than murder under Section 221. In R v. Adomako,[191] an anesthetist failed to notice a disconnected oxygen supply, leading to the patient's death. Convicted of manslaughter due to inexcusable oversight, the court did not address euthanasia, as the case involved neither terminal illness nor deliberate

[191] *R v Adomako* [1995] 1 AC 171

intent.[192] This researcher submits that intentional disconnection, even at the patient's behest, would constitute euthanasia and attract murder charges.

Administering lethal injections or toxic substances similarly inflicts grievous internal harm, violating Section 53 irrespective of consent. Such interventions disrupt vital functions (e.g., respiration), culminating in death, and thus remain prosecutable despite patient or familial approval.

3.3 Additional Legal Provisions

As already stated the Criminal and Penal Codes reinforces the illegality of euthanasia in Nigeria. Supplementary regulations from a medical standpoint further solidify this ban.

3.3.1 Medical Code of Conduct & Ethical Standards

The 2004 Code of Conduct for Medical and Dental Practitioners[193] stands as the clearest directive mandating life preservation and outlawing euthanasia. Any physician who ends a patient's life violates this Code. Supplying or administering fatal substances is forbidden, irrespective of the patient's plea, agreement, or perceived benefit. Sanctions include license suspension or revocation, coupled with potential murder prosecution under applicable criminal statutes.[194]

Nations develop unique ethical frameworks, often crafted by professional bodies to govern members. These constitute moral guidelines known as rules of professional conduct. Their origins trace to Hippocrates, revered as the founder of contemporary medicine.[195] His renowned Hippocratic Oath[196] now underpins global medical ethics, including the World

[192] VO Adefarasin, *"Euthanasia: An Act of Mercy or Murder?"* Journal of Arts and Contemporary Society 4, no.3 (2012): 69.
[193] Medical and Dental Practitioners, Rules of Professional Conduct for Medical & Dental Practitioners, Rule 68 (2004)
[194] O Abimbola, *"Law and Medicine: A Meeting Point,"* Research Journal of Health Science 2 (2014): 192
[195] T Koch, *"The Hippocratic Thorn in Bioethics' Hide: Cults, Sects, and Strangeness,"* Journal of Medicine and Philosophy 16 (1991): 623
[196] L Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* (Baltimore: John Hopkins Press, 1943), 12.

Medical Association's (WMA) framework. Newly qualified practitioners swear this oath which has been adapted nationally to uphold ethical standards. The pertinent excerpt reads:

> "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly, I will not give a woman a pessary to cause an abortion."

This directly prohibits euthanasia and assisted suicide. While the WMA and other bodies have modernized the oath, its core rejection of life-ending practices endures. Historically, pre-Hippocratic physicians doubled as healers and executioners, aiding death for the gravely ill. Hippocrates revolutionized the field by discovering cures and instructing followers to heal without harm.[197] Updates appear in the Geneva Declaration.[198] In the UK, the General Medical Council issues duties and good practice guidelines, uniformly deeming life termination unethical and impermissible.

Medical ethics involve moral principles guiding value-based decisions in practice. Violations trigger disciplinary measures.[199] Nigeria's Medical and Dental Practitioners Act establishes a Council tasked with formulating conduct statements:

> "Reviewing and preparing from time to time a statement as to the code of conduct which the Council consider desirable for the practice of the professions in Nigeria."
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Compliance safeguards professional integrity and public trust.[200] Euthanasia's explicit ban aligns with medicine's healing mission; permitting it would undermine confidence, deter patients from seeking care, and risk normalizing death as treatment for incurable conditions.[201]

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[197] H Lee Lenora, "*A Good Death: The Politics of Physician Assisted Suicide in Hawai'I'* (PhD Thesis, University of Hawai'i', 2009), 27.
[198] M Ummel, *"The Oath of Geneva,"* Gesnerus 49,pts. 3-4 (1991): 517
[199] JC Hsieh, *"Brain Death Worldwide: Accepted Fact but No Global Consensus in Diagnostic Criteria,"* Neurology 58, no.1 (2002): 3.
[200] B Abegunde, *"Legal Implications of Ethical Breaches in Medical Practice: Nigeria a Case Study",* Asian Journal of Humanities and Social Sciencies 1, no. 3 (2013): 70
[201] Raphael Cohen-Almagor, *"Should Doctors Suggest Euthanasia to Their Patients? Reflections on Dutch Perspectives,"* Theoretical Medicine 23 (2002): 287.

Drawing from the Hippocratic Oath, the Code which was revised in 1995 and 2004 spans eight sections on conduct, collegiality, negligence, and malpractice. Its final part addresses euthanasia:

> "A practitioner shall be adjudged to be in breach of the ethical code of practice if found to have encouraged or participated in any of the following acts: (a) Termination of a patient life by the administration of drugs, even at the patient's explicit request. (b) Prescribing or supplying drugs with the explicit intention of enabling the patient to end his or her life. (c) Termination of a patient's life through the administration of drugs with or without the patient's explicit request thinking same to be in the interest of the patient."[202]

Physicians bear a fundamental obligation to safeguard life, sparking debate: Must life be sustained indefinitely, or only to a viable extent? What if patients explicitly reject prolongation amid suffering, given the Code's emphasis on respecting autonomy? The Nigerian Supreme Court resolved treatment refusal in MDPDT v. Okonkwo,[203] upholding patients' rights to decline care, even fatally, thereby prioritizing autonomy over preservation mandates. This researcher counters that state interests in life protection should supersede individual desires to die, while acknowledging necessity sometimes compels withdrawal which is often not viewed by practitioners as euthanasia.[204]

Beyond the 1995 Code, no Nigerian statute names "euthanasia" or "assisted suicide." Prohibitions are inferred from broader clauses. Eraze[205] claimed Sections 33, 34, and 35 constitutionally allow it via holistic reading, overlooking that specific criminal prohibitions in the Codes prevail over general constitutional language. Absence of the term does not negate the offense; proving elements suffices.

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[202] Rule 68, Rules of Professional Conduct for Medical & Dental Practitioners (2004)
[203] *Medical and Dental Practitioners Disciplinary Tribunal v. John Emewulu Nicholas Okonkwo* (2001) LPELR-213 (SC)
[204] Raphael Cohen-Almagor, *"Why the Netherlands?,"* Journal of Law, Medicine & Ethics 30(2002): 95
[205] O Eraze, *"Euthanasia and Assisted Suicide as Basic Constitutional Rights under the 1999 Constitution of Nigeria,"* Nigerian Law Guru, 20(2015) 12

Enforceability of non-statutory ethics is bolstered by the Medical and Dental Practitioners Disciplinary Tribunal, which investigates via panels and tries violations with High Court status; appeals reach the Court of Appeal.[206] Not all misconduct is criminal, but hastening death constitutes murder (capital) and ethical breach absent reform. Legislative action seems unlikely, but in my opinion there should be a review, especially for passive euthanasia/withdrawal driven by necessity, to ease physicians' fears.

Additionally, the concept of euthanasia cannot be completely addressed solely from a legal perspective without considering the religious angle. In many religious traditions, life is regarded as sacred and created by a higher being, and it cannot be intentionally ended under any circumstances. Therefore, even when examining the legal aspect of this issue, it is essential to take into account its religious implications. Religious perspectives must inform euthanasia proposals, given societal foundations. Risks include familial-doctor collusion over inheritances. Nonetheless, amendments are vital to address medical dilemmas; culture and faith should not perpetually block legal evolution as sometimes religion adapts.

Necessity drives change: India's Supreme Court permitted passive euthanasia under strict safeguards, urging parliamentary guidance.[207] Nigerian hospitals seek court orders for withdrawal immunity, as courts best shield from liability. In emergencies, ethical judgment should guide physicians. A future Nigerian case balancing social, religious, and cultural end-of-life factors is anticipated. Dr. John's case upheld refusal rights, not termination, though some interpret it as sanctioning passive euthanasia.[208]

[206] Medical and Dental Practitioners Act, Cap. M8, Laws of the Federation of Nigeria (2004).
[207] Tanuj Kanchan and others, *"Aruna Shanbaug: Is Her Demise the End of the Road for Legislation of Euthanasia in India?",* Science and Engineering Ethics 22, no.4 (2016): 1251-1253
[208] E Bright Oniha and M Osato Oniha, *Euthanasia and Assisted Suicide as Basic Constitutional Rights under the 1999 Constitution of Nigeria*,"(2024), 13.

3.4 Human Rights Analysis: Relationship Between Right to Life, Right to Dignity and Individual Autonomy

The interplay between the right to life, dignity, and individual autonomy is complex, yet central to discussions about euthanasia. The right to life, enshrined in Section 33 of the Nigerian Constitution, holds that every person's life is sacred and should not be taken, regardless of circumstances like unbearable pain. However, this right often clashes with the rights to dignity (Section 34) and personal liberty (Section 35), which support an individual's freedom to make choices about their own life, including the choice to die with dignity.

Forcing someone with a chronic, incurable illness to continue living in pain can be seen as a form of torture and degrading treatment, violating their right to dignity. As philosopher Immanuel Kant argued, when a person loses their dignity, their life loses its intrinsic value, leaving only biological existence. Denying someone the ability to choose death in such circumstances disregards their autonomy and shows a lack of compassion. [209] Denying a person the choice to end their suffering disregards their autonomy and shows a lack of compassion. The *Medical and Dental Practitioners Disciplinary Tribunal v. Dr. John Emewulu Okonkwo* case illustrates this, where the court upheld a patient's right to refuse treatment, even if it leads to death, supporting the concept of passive voluntary euthanasia.

The Nigerian Constitution's Sections 33, 34, and 35 guarantee the rights to life, dignity, and liberty, respectively, stating that no one should be deprived of these rights except in cases of criminality. Why, then, should someone in unbearable, untreatable pain be denied the right to choose their fate? Forcing them to endure suffering treats them no differently than a criminal, stripping them of their humanity. If the law prevents a non-criminal from exercising their

[209] P Deepa, '*Individual Dignity and Euthanasia: An Ethical Perspective'* (2020) 8(1) GBEJ < https://www.researchgate.net/publication/343727114_Individual_Dignity_and_Euthanasia_An_Ethical_Perspectiv e> accessed 4 September 2025

rights, it reduces them to the status of an animal. All rights life, dignity, and autonomy are essential, and prioritizing the right to life above others ignores their interconnectedness.

This principle is evident in the U.S. Supreme Court's *Roe v. Wade* (1973) decision, which held that the right to privacy includes a woman's right to choose abortion, though balanced against the state's interest in protecting health and prenatal life.

It further held that the right to abortion is not an absolute right and should be balanced against the government interest in protecting the woman's health and pre-natal life.[210] Applying the decision of *Roe v Wade*, it shows the right to life should not be read as supreme over other rights. In this particular case, it can be seen that the right to life is not more supreme than the other rights but rather the same with the others and as such has to be read with the others. Also, the right to life should not be an absolute and rigid but rather it should be balanced between the government interest in a person's right to life and a person's right to choose to die without pain when he is in chronic pain and there is no other solution that can help him. In other words, there should be a balance between the Right to life and the Right to die when in chronic pain or illness. There should be an exception to this right to life. Even though, *Roe v Wade* was later overturned in 2022,[211] it still does not change the fact that the right to have an abortion should be done only in circumstances where the mother's health is at stake. Hence, the right to life should be maintained and upheld, however, there should be some exceptions to those who suffer from chronic illness and pain without cure.

In the case of *Airedale N.H.S Trust v Bland*,[212] it was held that even though a doctor had a duty to act in the best interest of his patient, that duty does not necessarily extend to prolonging

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[210] *ibid*

[211]Nina Totenberg and Sarah McCammon, '*Supreme Court Overturns Roe v. Wade, Ending Right to Abortion Upheld for Decades'* (NPR, 24 June 2022) < https://www.npr.org/2022/06/24/1102305878/supreme-court-abortion-roe-v wade-decision-overturn#:~:text=In%20a%20historic%20and%20far reaching%20decision%2C%20the%20U.S.,for%20nearly%20a%20half%20century%2C%20no%20longer%20exists.> accessed 6th September 2025

[212]*Airedale N.H.S Trust v Bland* [1993] Appeal Cases 789 (House of Lords) < https://www.lawteacher.net/cases/airedale-nhs-trust-v-bland.php> accessed 6th September 2025

life.[213] The court further held that the hospital could discontinue all life sustaining treatment because there was no improvement or any possibility of Bland ever coming out of his vegetative state and that he should be allowed to die with dignity and less distress.[214] This case points to passive non-voluntary euthanasia and supports the idea that exceptions to the sanctity of life should exist for those in incurable suffering.

Ultimately, the rights to life, dignity, and autonomy are deeply intertwined. The law must allow room for individuals with chronic, untreatable illnesses to choose death with dignity, balancing the sanctity of life with compassion for their suffering.

3.5 Conclusion

In conclusion, Nigeria's legal framework erects an impregnable barrier against euthanasia. The Constitution sanctifies life as non-derogable; the Criminal and Penal Codes[215][216] criminalize any conduct hastening death, consent notwithstanding; and the Medical Code of Conduct reinforces the physician's role as healer, not harbinger of death. While autonomy and dignity are recognized rights, they yield to the state's paramount interest in preserving life. Passive measures, such as withholding futile treatment, operate within narrow ethical and legal confines but stop short of sanctioning intentional termination.[217] The current regime, though rigid, reflects deep-seated cultural, religious, and policy commitments. Yet, evolving medical realities and patient demands signal the need for legislative clarity particularly on passive euthanasia and end-of-life decision-making to resolve practitioners' dilemmas without compromising the sanctity of life. Until such reform, euthanasia remains both a legal and ethical anathema in Nigeria.

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[213] Ibid

[214] *Airedale N.H.S Trust v Bland* [1993] 1 All ER 821 < https://www.globalhealthrights.org/wp content/uploads/2013/01/HL-1993-Airedale-NHS-Trust-v.-Bland.pdf> accessed 6th September 2025

[215] Criminal Code Act, C38 LFN 2004

[216] Penal Code, Cap P3 LFN 2004

[217] BE Oniha, *"Legality of Euthanasia and Right to Die in Nigeria"* (Nigerian Institute of Advanced Legal Studies, 2017)15

CHAPTER FOUR

EUTHANASIA IN OTHER JURISDICTIONS

4.1 Introduction

Euthanasia, the deliberate act of ending a person's life to relieve intractable suffering, remains one of the most ethically charged and legally divisive issues in global health policy. In Nigeria, where cultural, religious, and legal frameworks prioritize the sanctity of life, euthanasia is unequivocally prohibited, reflecting a conservative stance rooted in criminal law and societal norms. This chapter examines the state of euthanasia under Nigerian law, highlighting its criminalization and the absence of any legislative support for assisted dying. It then contrasts this with practices in selected jurisdictions like Netherlands,[218] Belgium,[219] and Australia[220] where regulated frameworks permit euthanasia or physician-assisted suicide under strict conditions, illustrating a spectrum of approaches from outright prohibition to permissive regulation.

4.2 Euthanasia in Some Selected Jurisdictions

4.2.1 Netherland

The Netherlands boasts one of the world's strongest healthcare systems, with mostly private institutions, universal health insurance funded by monthly contributions, and coverage extending to euthanasia as an alternative to palliative care.[221] Despite a predominantly Catholic population, euthanasia is widely accepted and integrated into medical practice. In 2015, 5,516

[218] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).
[219] Euthanasia Act (Loi relative à l'euthanasie) (28 May 2002, as amended) (Belgium).
[220] Voluntary Assisted Dying Act 2017 (Vic) and equivalent legislation in all Australian states and the Australian Capital Territory by November 2025.
[221] D Squires and C Anderson, "*U.S. Healthcare from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries, The Commonwealth Fund,"* 2015.

cases were reported a 4% rise from 5,306 in 2014 with about 65% of deaths occurring in institutional settings like nursing homes or palliative care facilities.[222]

The push for legalization began with the 1973 Postma Case, where a physician euthanized her paralyzed, suffering mother at her repeated request using a morphine injection.[223] Convicted of murder, the doctor prompted judicial recognition that physicians are not obligated to prolong life at all costs and that pain-relieving drugs may shorten life.[224] This sparked national debate, leading the Royal Dutch Medical Association to urge reporting of euthanasia cases, eventually bringing the issue to Parliament.[225]

The Netherlands became the first country to legalize euthanasia and assisted suicide through the 2002 Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[226] Prior to this, euthanasia existed in a legal gray area under *Articles 293 and 294 of the Criminal Code of Netherland* (prohibiting life termination and suicide assistance) but was tolerated via the "necessity" defense under *Article 40*, which excuses actions taken to avert greater harm in situations of conflicting duties.[227]

Key judicial precedents include:

- Schoonheim Case (1984)[228]: The Supreme Court upheld necessity for a doctor ending a patient's unbearable, hopeless suffering, establishing "due care criteria" even before formal legalization

[222] NeilFrancis"*NetherlandsEuthanasiaReportCard*"(Netherlands,2015) <http://www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card>Accessed 16/10/2025

[223] Postma (Dist Ct Nj, 1973) 183

[224] RF Stein, "Philosophical *Foundations of Physician-Assisted Death and Euthanasia Legislation in Oregon and the Netherlands : A Comparative Analysis Philosophical Foundations of Physician-Assisted Death and Euthanasia,"* (2015) 23 Scholarly Commons

[225] R Cohen-Almagor, *'Euthanasia in the Netherlands: The Legal Framework'* (2014 10 Journal of International Law) 12.

[226] YD Patil, *'Euthanasia and Death with Dignity'* (2016) 5(3) Journal of Krishna Institute of Medical Sciences University 142.

[227] Criminal Code (Netherland, 1985).

[228] Alkmaar District Court (Schoonheim Case) (1984) 28 November, NJ 1985,106.

- Brongersma Case (2002)[229]: A doctor was convicted for assisting an 86-year-old former senator who was "tired of life" due to age-related decline and loneliness, not medical illness. The Court ruled that existential suffering without physical or psychiatric pathology falls outside medical competence and due care requirements.

The 2002 Act amended *Articles 293 and 294* to exempt physicians from liability if they strictly follow due care criteria and report to a municipal pathologist.[230] Due care requirements according to Section 2 include:

- Voluntary, well-considered request
- Unbearable, lasting suffering with no prospect of improvement
- Full patient information
- No reasonable alternative
- Consultation with an independent physician
- Medically appropriate execution[231]

All cases are reviewed by Regional Review Committees. Compliant cases close without prosecution while non-compliant ones are referred to the Public Prosecutor or Health Inspector. Reporting is now limited to irregular cases, though prosecutors retain investigative discretion. Safeguards include mandatory reporting, independent consultation, and oversight by review committees, prosecutors, and disciplinary bodies. However, some concerns persist and they include:

Slippery slope: The concept of slippery slope refers to a logical or moral argument suggesting that allowing a particular action will inevitably lead to a series of increasingly undesirable or extreme consequences. Initial focus on terminally ill adults expanded to newborns with severe

[229] *Brongersma v The Netherlands*(2004) App No 72208/01, ECHR 2004-X
[230] C Grosse and A Grosse, '*Assisted Suicide: Models of Legal Regulation in Selected European Countries and the Case Law of the European Court of Human Rights'* (2014) Medicine, Science and the Law 497(1).
[231] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Netherlands).

deformities (with parental consent for those under 16) and psychiatric cases (Chabot Case, 1994 assisted suicide for a woman with prolonged depression and trauma, no physical illness).[232]

Underreporting: Studies suggest half of cases go unreported, undermining transparency which would end up being a major barrier.[233]

Mobile euthanasia clinics (2012): Introduced to assist patients denied by their doctors, these "death squads" operate outside the Act, handling home-based requests via teams of six doctors. Within days of launch, 60 applications were received, raising fears of abuse and coercion.[234]

Rising numbers: Euthanasia deaths increased 10% to 5,875 in 2016.[235]

Critics warn that legalization has normalized killing as a medical solution, eroding safeguards. As ethicist Keown and others note, once the "dike" of absolute protection for life is breached, expansion becomes inevitable evidenced by proposals to include elderly individuals simply "tired of life."

Despite robust regulations, weak enforcement, secrecy in medical practice, and cultural acceptance have fueled a "Niagara Falls" effect, with euthanasia increasingly viewed as routine rather than exceptional.

Nigeria and other nations considering legalization should heed these lessons as strong frameworks exist on paper, but effective monitoring remains elusive, and scope creep endangers vulnerable groups.[236]

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[232] *State v Chabot* (1984) 478 A.2d 1136.
[233] Cohen (n28)
[234] BA Omipidan, '*Mobile Euthanasia Clinic: An Expansion of the Dutch (Netherlands) Euthanasia Law Without Formal Amendment'* (2012) The Law Review 201 35.
[235] Regional Euthanasia Review Committees(Regionale Toetsingscommissies Euthanasie), Annual Report 2016(The Hague, 2017),7 <https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2016/april/12/jaarverslag-2016/RTE_annual_report_2016.pdf> Accessed 16/10/25
[236] J Downie, '*The Contested Lessons of Euthanasia in the Netherlands'* (2000) 8(17) Health Law Journal 119–139.

4.2.2 Belgium and the Legalization of Euthanasia

The legalization of euthanasia in the Netherlands significantly shaped its adoption elsewhere, including in neighboring Belgium, where parallel advocacy efforts culminated in near-simultaneous enactment.[237] Although euthanasia was originally criminalized under *Sections 393 and 394 of the Belgian Penal Code of 1867*, the *Belgian Act on Euthanasia of 2002* decriminalized the termination of life upon request, provided stringent conditions were met.[238] Enacted the same year as the Dutch Termination of Life on Request and Assisted Suicide Act, the Belgian law differs by covering only active euthanasia, not physician-assisted suicide, which remains prohibited.

Following passage, the Belgian Federal Control and Evaluation Commission was established in 2002 to oversee compliance.[239] The law received Senate approval in 2001 after endorsement by the Upper House commission, removing criminal liability for physicians adhering to prescribed procedures mirroring the Dutch amendment of *Articles 293 and 294 of their Criminal Code*.[240]

Public support for legalization is strong across several European nations, including Belgium.[241] According to the European Values Survey (EVS), Belgium ranks high in secular-rational and self-expression values, fostering acceptance of autonomy-driven practices such as abortion and euthanasia.[242] Unlike the Netherlands, where the Royal Dutch Medical Association played a pivotal role, Belgium's law was enacted without formal medical association input, leading to divided opinions among physicians: some welcomed it while others remained silent or

[237] Kenneth Chambaere and others '*Euthanasia in Belgium: Trends in Reported Cases between 2003 and 2013'* (2016) 188(16) CMAJ 1
[238] Section 6 The Belgian Act on Euthanasia, 2002.
[239] Ibid
[240] Ibid
[241] N Steck, '*Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review*' (2013) 51(10) Medical Care 938.
[242] Drew Nannini, '*Culture, Personality, and Attitudes Toward Euthanasia'* (2016) 72(3) Omega: Journal of Death and Dying 247.

expressed reservations. Nonetheless, the legislation heightened caution in end-of-life care and decision-making across the profession.[243]

Conditions Under The 2002 Euthanasia Act of Belgium

Section 3(1) of the Act stipulates that a physician commits no offense if they ensure:

1) The patient is of legal majority or an emancipated minor, legally competent, and conscious when making the request;
2) The request is voluntary, well-considered, repeated, and free from external pressure;
3) The patient suffers constant, unbearable physical or mental pain from a serious, incurable disorder (due to illness or accident) with no prospect of relief;
4) All procedural requirements of the Act are followed.[244]

Voluntary request forms the cornerstone. For non-terminal patients, additional safeguards apply: a one-month waiting period between written request and execution, plus mandatory consultation with a psychiatrist or disease specialist.[245] Federal Commission reports reveal 12,726 euthanasia cases by an unspecified date, rising to 1,928 in 2014 and 2,022 in 2015; 92% involved terminal illness while 8% non-terminal conditions.[246]

In a globally controversial move, Belgium in 2014 became the first country to legalize euthanasia for terminally ill children without age limits, provided capacity and parental consent are established despite significant public opposition.[247]

Implementation Challenges and Criticisms

The Act contains ambiguities that confuse practitioners, particularly regarding independent consultation and assessing "unbearable" mental suffering a subjective criterion difficult to

[243] Raphael Cohen-Almagor, *'First Do No Harm: Intentionally Shortening Lives of Patients without Their Explicit Request in Belgium'* (2015) 41(8) Journal of Medical Ethics 625–629.
[244] Belgian Act on Euthanasia 28 May 2002, ch II, s 3 (Belgium).
[245] Section 3 (2) Belgium Act on Euthanasia 2002
[246] Cohen (n243)
[247] John Griffiths and others *"Euthanasia and Law in Europe".* (Oxford Hart Publishing, 2008) 359.

verify objectively.[248] Underreporting remains pervasive as many physicians fear prosecution and omit cases, especially the non-voluntary ones.[249] Unreported procedures often deviate from protocol: opioids or sedatives are used instead of barbiturates and muscle relaxants, and nurses not doctors administer lethal drugs.[250]

Notably cancer dominates euthanasia requests due to its clear prognosis, increasing approval likelihood compared to other conditions. However, existential or mental suffering has emerged as a leading justification, complicating diagnosis and risking non-compliance with due care standards. Studies confirm abuse: approximately 3% of deaths (1 in 32) involve lethal injection without explicit consent.[251] Paradoxically, some research suggests higher abuse rates in countries without legal frameworks than in regulated ones like Belgium.

Conclusively, Belgium's experience underscores the complexities of legalizing euthanasia. While robust procedural safeguards exist, ambiguities, underreporting, subjective criteria, and scope expansion (e.g., to children) highlight enforcement gaps.

4.2.3 Euthanasia in Australia

Societal views on death in Australia are shaped by various elements, including religion, historical events, conflicts, and broader social concerns. Legal advancements in euthanasia, similar to other reforms, typically emerge via parliamentary legislation, court rulings, or judicial interpretations, as such as the Indian case *Aruna Shanbaug v. Union of India & others case*.[252] In the UK, prosecutorial discretion under section 2(4) of the Suicide Act empowers the Public Prosecutor to determine whether to pursue charges for assisted suicide.[253] Nations permitting euthanasia have done so either through judicial channels or legislative processes.

[248] Section 8 Belgium Act on Euthanasia 2002
[249] Cohen (n243)
[250] Steck (n241)
[251] Cohen (n243)
[252] M Ashby, '*Ethical Issues at the End of Life'* ((2010) 40(10) Internal Medicine Journal) 2.
[253] Melanie Ann & Radhika Selvalingam, '*Physician-Assisted Death in England and Wales'* (2014) (Doctor of Philosophy thesis, Newcastle University) 110.

In Australia, suicide and attempts at it are no longer criminal offenses, yet assisting in suicide remains illegal across all jurisdictions.[254] Even when a patient possesses full decision-making ability and voluntarily requests aid, anyone providing such help faces charges of murder[255] or aiding suicide, based on their degree of involvement. A significant milestone occurred in 1997 earlier than in the Netherlands or Belgium when the Northern Territory briefly legalized euthanasia and doctor-assisted suicide.[256] The governing statute was the Rights of the Terminally Ill Act 1995, which allowed individuals over 18 enduring terminal illness to seek physician-assisted dying. This legislation was short-lived, however, as the Commonwealth Government invoked *Section 122 of the Australian Constitution*[257] to override it. Opponents' concerns influenced the decision, arguing that legalization could undermine vulnerable individuals' sense of security and erode trust in doctor-patient interactions. Unlike territorial laws, the Commonwealth lacks authority to nullify state enactments. Numerous state-level efforts to legalize euthanasia have since failed, such as the medically assisted suicide proposal in Victoria's Parliament. Western Australia saw repeated defeats of its Voluntary Euthanasia Bill in 1997, 1998, 2000, and 2010.[258]

More recently, South Australia introduced the Ending Life with Dignity Bill in February 2013, an updated version of prior legislation. Tasmania's Dying with Dignity Bill in 2009 aimed to grant terminally ill patients with incurable conditions the right to request medical aid in dying, mirroring the Northern Territory's earlier controversial framework, though it also did not pass. In 2016, South Australia's House of Assembly considered the Voluntary Euthanasia Bill 2016, which proposed a legal pathway for certain patients experiencing intolerable suffering to access

[254] E J Emmmanuel '*Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe'* (2016) 316(1) JAMA 79.
[255] Crimes Act 1900 (NSW), s 18(1)(a) (2011).
[256] Right of the Terminally Ill Act, 1995 (Northern Territory, Australia).
[257] Commonwealth of Australian Constitution Act (1900) 63&64 Vivt c 12(UK) s 122
[258] Hadeel Al-Alosi, *'A Time to Fly and a Time to Die: Suicide Tourism and Assisted Dying in Australia Considered' (*2016) 17(2) Marquette Benefits & Social Welfare Law Review 257

voluntary euthanasia.[259] Over about two decades, approximately 22 such bills across various states have been introduced but rejected. The ongoing proposal may signal change, given evolving parliamentary attitudes. For instance, the 1995 Voluntary Euthanasia Bill was defeated by a wide margin, while the 2008 Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill lost by just two votes, suggesting growing support and potential for future legalization ahead of other nations pursuing similar reforms.

Currently, Australian law decriminalizes suicide but treats assisted suicide and euthanasia as criminal acts.[260] Doctors are prohibited from offering any form of assistance, including lethal medications or injections, as this violates legal and professional duties. Despite widespread public approval for accelerating death in appropriate cases, such actions remain outside lawful boundaries.[261] Nevertheless, common law jurisdictions in Australia, akin to parts of Europe, recognize the doctrine of double effect as a valid defense for physicians. In South Australia, this principle is statutorily enshrined,[262] permitting actions intended to alleviate pain and distress that inadvertently hasten death in terminally ill patients.[263] As stated earlier, the doctrine allows administration of pain-relieving drugs that foreseeably shorten life, provided death is not the primary intent. It serves as palliative care for those with no recovery prospects and is positioned as a substitute for euthanasia, integrated into Australia's Consent Act.[264]

The push for legalization peaked with the Rights of the Terminally Ill Act (ROTTIA) 1995, enacted and effective from July 1996, only to be overturned by the Euthanasia Laws Act 1997.[265] Public backing for euthanasia is strong, yet the rapid repeal of ROTTIA and persistent failures reflect worries about potential abuses. Experiences from the Netherlands and Belgium

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[259] D Wilkinson & J Savulescu, '*A Costly Separation Between Withdrawing and Withholding Treatment in Intensive Care'* (2014) 28(3) Bioethics 127–137.
[260] Criminal Law Consolidation Amendment Act 1983 (SA) (Australia), ss 11–13.
[261] SA Trankle, '*Decisions That Hasten Death: Double Effect and the Experiences of Physicians in Australia'* (2014 15(1) BMC Medical Ethics) 26.
[262] *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 17(1)(a)–(c).
[263] *R v Adams [1957*] Crim LR 365 (Central Criminal Court).
[264] *Consent to Medical Treatment and Palliative Care Act 1995* (SA).
[265] Euthanasia Laws Act 1997 (Cth) No 17, s 50(1).

highlight challenges in regulation post-legalization; despite mandatory reporting under due care criteria, many instances go undocumented due to prosecution fears, often involving misconduct.

Religious groups hold limited sway in Australia but have impacted outcomes in certain areas through minor parties with faith-based platforms.[266] This underscores greater hurdles in places like Nigeria, where religion heavily shapes politics, particularly in the Muslim-majority north and among National Assembly members.

Despite its illegality, euthanasia likely occurs covertly in Australia, given public acceptance. Physicians might proceed without explicit patient approval, or nurses could act on medical directives,[267] with data indicating that around one in three deaths (approximately 36.5%) involve medical interventions to expedite dying.[268] Thus, the practice persists regardless of statutes, mirroring patterns in non-legalizing countries.[269]

4.3 Comparison of Euthanasia Laws:

In Nigeria, euthanasia in all forms active, passive (beyond mere refusal of treatment), and assisted suicide is unequivocally illegal and treated as murder or manslaughter under the Criminal Code Act (applicable in the Southern states) and Penal Code (Northern states). There is no dedicated legislation on euthanasia; instead, it falls under homicide provisions, such as section 316 of the Criminal Code (Southern Nigeria) and section 221 of the Penal Code (Northern Nigeria), which criminalize intentional killing regardless of consent or motive.[270] The Nigerian Medical Association (NMA) reinforces this stance, declaring mercy killing

[266] RD Natale, *'Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics'* (University of New South Wales Law Journal 2016) 23.
[267] L Flannery and others, *'End-of-Life Decisions in the Intensive Care Unit (ICU) – Exploring the Experiences of ICU Nurses and Doctors: A Critical Literature Review'* (2016) 29(2) Australian Critical Care 97.
[268] Trankle (n261)
[269] Jon Yorke, The *Right to Life and the Value of Life: Orientations in Law, Politics and Ethics* (Routledge, New York, 2016) 305.
[270] Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004, s 316; Penal Code (Cap P3 LFN 2004) (Nigeria), s 221.

unethical and punishable under section 306 of the Criminal Code, with penalties up to life imprisonment.[271] Public discourse, influenced by Christianity, Islam, and communal values, views euthanasia as antithetical to the sanctity of life enshrined in section 33 of the 1999 Constitution (as amended).[272] No reforms were enacted by 2025, despite scholarly calls for passive euthanasia in terminal cases.[273]

By contrast, the Netherlands, Belgium, and Australia have legalized euthanasia and PAS, marking a shift from prohibition to regulated autonomy. The Netherlands pioneered this with the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, decriminalizing both active euthanasia and PAS for unbearable suffering without requiring terminal illness.[274] Cases rose to 9,958 in 2024 (about 4.5% of deaths), including psychiatric conditions like dementia.[275] Belgium followed in 2002 with the Euthanasia Act (Loi relative à l'euthanasie), permitting active euthanasia (but not self-administered PAS) for unbearable physical or mental suffering from incurable conditions, extended to minors in 2014.[276] In 2024, 3,991 cases were reported (3.6% of deaths), with costs now taxpayer-funded via mandatory health insurance since November 2025.[277] Australia adopted a state-based approach, with Victoria's Voluntary Assisted Dying Act 2017 as the first, now operational in all six states and the Australian Capital Territory (ACT) by November 2025; the Northern Territory is drafting

[271] Nigerian Medical Association, '*Mercy Killing Illegal in Nigeria'* (Punch, 16 May 2024) https://punchng.com/mercy-killing-illegal-in-nigeria-says-nma/ accessed 20 November 2025

[272]Constitution of the Federal Republic of Nigeria, 1999 (CFRN 1999), s 33

[273]Fatimat Nene Abubakar, '*An Appraisal of the Legal Status of Euthanasia in Nigeria'* (2025) 11(10) International Journal of Research and Innovation in Social Science 11228, 11240.

[274]Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).

[275]Regional Euthanasia Review Committees, 'Annual Report 2024' (2025) https://www.theguardian.com/society/2025/mar/24/euthanasia-death-increase-netherlands accessed 14 November 2025.

[276] Euthanasia Act (Loi relative à l'euthanasie) (28 May 2002, as amended) (Belgium).

[277]Federal Commission for the Control and Evaluation of Euthanasia, 'Euthanasia Statistics 2024' (2025) https://www.liveaction.org/news/belgium-mandatory-health-insurance-cover-euthanasia-costs accessed 14 November 2025.

similar legislation.[278] These laws focus on terminal illnesses (typically 6-12 months prognosis) and self-administration, reflecting federalism and incremental reform.

Nigeria imposes no eligibility for euthanasia, as it is wholly prohibited; even advance directives for passive measures are unenforceable if they hasten death intentionally.[279] Judicial precedents, such as those interpreting the right to life, prioritize preservation over choice, with passive withholding of treatment allowed only if futile and consensual, but not as euthanasia.

In permissive jurisdictions, criteria emphasize voluntary requests and suffering:

- **Netherlands:** Adults (and children from age 12 with parental consent) experiencing "unbearable suffering with no prospect of improvement," including non-terminal psychiatric disorders (e.g., depression).[280] No life expectancy minimum; advance directives permitted for dementia.
- **Belgium:** Competent adults (and terminally ill minors with parental consent) with "constant, unbearable physical or mental suffering" from a serious, incurable disorder caused by illness or accident. Psychiatric cases require additional psychiatric consultation; non-terminal conditions qualify if suffering is irremediable.
- **Australia:** Restricted to adults (18+) with decision-making capacity, terminal illnesses (6 months for non-neurodegenerative diseases, 12 months proposed in Victoria), and less than 12 months to live.[281] Excludes mental illness as sole basis; advance directives limited to self-administration. The ACT's 2025 scheme mirrors this, with potential expansions under review.

[278]Voluntary Assisted Dying Act 2017 (Vic); Voluntary Assisted Dying Act 2024 (ACT); see also Voluntary Assisted Dying Act 2021 (Qld), s 7.

[279] Bright E Oniha, '*Legality of Euthanasia and the Right to Die in Nigeria'* (Nigerian Institute of Advanced Legal Studies, 2017) 15 https://edojudiciary.gov.ng/wp-content/uploads/2017/07/Legality-Of-Euthanasia-And-The-Right-To-Die-In-Nigeria-By-Bright-E.-Oniha-Corrected.pdf accessed 20 November 2025.

[280] Criminal Code (Wetboek van Strafrecht) (1881, as amended) (Netherlands), art 293.

[281] Voluntary Assisted Dying Act 2017 (Vic) s 8; proposed amendments (Vic Parl, 14 November 2025) https://www.abc.net.au/news/2025-11-15/victoria-voluntary-assisted-dying-amendments/106011806 accessed 15 November 2025.

Nigeria's blanket ban contrasts sharply with the broader, suffering-based access in the Netherlands and Belgium, and the terminal-illness focus in Australia, underscoring a divide between absolute protectionism and conditional autonomy.

Safeguards and Procedures

Nigeria's "safeguards" are punitive as physicians risk homicide charges, with no reporting exemptions or review committees. The NMA's ethical code prohibits participation, and cultural stigma deters practice.[282]

Permissive systems employ rigorous due care:

- **Netherlands:** Physicians must consult an independent doctor, ensure voluntary/repeated requests, and report to regional review committees; non-compliance leads to prosecution (rare, <0.2% in 2024).[283] Psychiatric cases require specialist input.
- **Belgium:** Two-physician confirmation (three for non-terminal/psychiatric), there must be written requests accompanied with a one-month reflection period (waivable for terminal cases), and post-procedure review by the Federal Control and Evaluation Commission. Additionally, minors need parental consent and psychological assessment.
- **Australia:** Multi-stage process (first request, assessments by two doctors, 9-day minimum wait), self-administration mandatory (practitioner administration only if physically unable), and mandatory reporting to oversight boards.[284] Victoria's 2025 amendments allow doctors to initiate discussions and extend prognosis to 12 months. Telehealth access is limited federally but progressing.

These multilayered checks mitigate abuse, though critics cite "slippery slopes" in expansions (e.g., psychiatric euthanasia in Netherlands/Belgium).[285]

[282] Rules of Professional Conduct for Medical & Dental Practitioners (2004), Rule 68 (Medical & Dental Practitioners' Rules).
[283] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (n 274) s 3.
[284] Voluntary Assisted Dying Act 2017 (Vic) ss 60-65.
[285] United Nations Human Rights Committee, 'Views Adopted by the Committee under Article 5(4) of the Optional Protocol' (2023) CCPR/C/135/D/2970/2017.

Ethical, Religious, and Societal Dimensions

Nigeria's prohibition aligns with Abrahamic faiths dominant in the population (over 90% Christian/Muslim), viewing life as sacred and euthanasia as divine usurpation. Communal ethics prioritize family burdens over individual choice, with debates framing it as a threat to vulnerable groups like the elderly or poor.[286]

In the Netherlands and Belgium (largely secular, with Catholic influences waning), ethics center on dignity and self-determination, supported by high public approval (70-80%).[287] Expansions reflect societal aging and mental health advocacy, though UN concerns highlight risks to disabled persons. Australia's framework balances autonomy with safeguards, influenced by Anglo-common law caution; Indigenous and multicultural perspectives have shaped exclusions (e.g., no coercion vulnerabilities).[288] Usage remains low (1-2% of deaths), emphasizing palliative integration.

4.4 Conclusion

The analysis of euthanasia reveals stark contrasts between Nigeria's absolute ban, driven by legal, religious, and cultural imperatives that view the practice as akin to homicide, and the permissive models in the Netherlands, Belgium, and Australia, which prioritize patient autonomy and suffering alleviation through safeguards like consent and medical oversight. These jurisdictional differences underscore broader debates on ethics, human rights, and end-of-life care.[289] Ultimately, Nigeria's rigid prohibition aligns with many developing nations but

[286] National Health Act 2014, s 11(2).
[287] Declaration on Euthanasia, Sacred Congregation for the Doctrine of the Faith (1980) Part II.
[288] Amarachi Chinonyerem, '*Euthanasia in Nigeria: Examining the Intersection of Human Dignity, Right to Life and Individual Autonomy'* (SSRN, 9 April 2025) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5137683 accessed 15 November 2025.
[289] FN Abubakar, "*An Appraisal of the Legal Status of Euthanasia in Nigeria*" (2025) 11(10) International Journal of Research and Innovation in Social Science 11228.

invites ongoing discourse on whether evolving societal values might one day prompt reform, balanced against the risk of abuse in resource-constrained settings.[290]

[290] O Ojelade, *"Euthanasia and Physician-Assisted Suicide in Develoing Countries: Ethical and Legal Considerations"* (2024) 18 African Journal of Bioethics 112, 120-122

CHAPTER FIVE

DEBATES FOR AND AGAINST EUTHANASIA

5.1 Introduction

Euthanasia ignites profound ethical, moral, and practical debates that pit the principles of individual autonomy and compassion against the sanctity of life and societal safeguards. Proponents argue for the right to a dignified death, emphasizing relief from unbearable suffering and personal choice in terminal illness.[291] Opponents counter with concerns over the devaluation of human life, risks of coercion, and the potential for a slippery slope toward involuntary euthanasia.[292] This chapter explores the core arguments for and against euthanasia, drawing on philosophical, medical, legal, and religious perspectives to illuminate the tensions that define this polarizing issue.

5.2 Arguments in Support of Euthanasia

Several scholars have raised different arguments in support of euthanasia, some of the basis of their stance include;

5.2.1 Right to Die with Dignity

The Universal Declaration of Human Rights (1948) affirms that every person possesses inherent dignity and deserves respect for that dignity in all circumstances. Drawing from this principle, advocates for euthanasia contend that forcing someone to endure unrelievable suffering infringes on their personal dignity, denying them the chance to end their life on their own terms.

People naturally seek autonomy over their bodies and minds, yet severe illness often strips away physical control or mental clarity, leading to profound dehumanization. The dread of prolonged agony and total loss of agency drives many terminally ill individuals to view

[291] DW Brock, '*Voluntary Active Euthanasia'* (1992) 22(2) Hastings Center Report 10.
[292] Evangelium Vitae (Pope John Paul II, 1995) paras 64–66; Qur'an 5:32.

voluntary death as the sole way to escape an undignified end.[293] Proponents emphasize that humans are rational, self-determining agents capable of deciding what serves their best interests, and thus should have the freedom to determine the timing and method of their passing.[294] Legal frameworks should permit those with incurable conditions to obtain professional medical help for a peaceful and voluntary exit. Most Americans hold that decisions about end-of-life matters belong to the patient, their loved ones, and healthcare providers rather than state authorities or judges.[295]In essence, the choice to continue living or to die rests with the patient or, if they lack decision-making capacity, their family.[296]

5.2.2 Alleviating Unbearable Suffering

One of the strongest justifications for euthanasia centers on sparing patients from intolerable agony, particularly in terminal cases with no hope of recovery. When existence offers only relentless hardship, ending life can be an act of compassion. Rachel notes,[297] those facing end-stage illness endure suffering so profound that it defies description for anyone who has not lived through it an intensity so overwhelming that outsiders instinctively avoid contemplating it. Prolonging such torment, or sustaining someone in a persistent vegetative state, clashes with the memories of loved ones who recall the patient in full vitality.[298] In these circumstances, euthanasia emerges as the sole humane remedy, serving the individual's deepest welfare by ending their distress. She deliberately steers clear of a utilitarian "greatest good for the greatest number" framework, which has to do with recognizing that a mercy-based rationale for

[293] Melanie Ann and Radhika Selvalingham, "*Physician Assisted death in England and Wales" (*Newcastle University, 2014) 159
[294] V Adefarasin, *"Euthanasia: An Act of Mercy or Murder?"*(Journal of Arts and Contemporary Societies 2,no 4 2012) 69
[295] I Dowbiggin, *From Sander to Schiavo: Mortality, Partisan Politics, and America's Culture War over Euthanasia, 1950-2010." (*Journal of Policy History, Vol.25, 2013) 265
[296] S Ann, "*Psychological Perspectives on Euthanasia and the Terminally Ill: An Australian Psychological Society Discussion Paper"* Australian Psychologist 33, April(1998)1
[297] J Rachels, "Medical Ethics and the Rule against Killing," in Philosophical Medical Ethics, ed S Stuart Jr and H T Engelhardt(1977) 207
[298] A Samgson, *"Euthanasia: Socio-Medical and Legal Perspective*" International Journal of Humanities and Social Science 4, no 10(2014) 2.

euthanasia would undermine it since relieving one person's pain through death does not necessarily maximize overall happiness.[299]

Rachel extends his defense to physicians who end life out of mercy, likening their situation to shifts in legal burden of proof within the American justice system. Normally, the prosecution must prove guilt; however, when a defendant concedes the act but invokes defenses like insanity or self-defense, the onus reverses to disprove the justification. Similarly, once it is verified that a doctor's intervention stems from genuine compassion prompted by the patient's dire condition and repeated pleas the law should withhold punishment.[300]

No one should be condemned to unrelenting, untreatable pain. If legal systems already permit patients to reject or halt life-sustaining treatment out of fear of suffering (even if death follows), they ought to provide a direct, dignified path to the same relief. This inconsistency is stark in Nigeria, where actively terminating life remains a crime, yet passively allowing death through treatment refusal is tolerated. Such contradictions place Nigerian physicians in an ethical bind and demand legislative reform to resolve the impasse.

5.2.3 End Covert Euthanasia Through Regulation

Advocates for euthanasia maintain that formal legislation is essential to permit and oversee the practice. Outlawing it drives physicians to perform it clandestinely, rendering oversight impossible.[301] In the absence of controls, doctors end lives or assist in dying without accountability. A San Francisco study found that roughly 53% of physicians treating HIV patients offer aid in dying, even though it remains unlawful.[302] Ongoing research indicates growing medical support for legalization, suggesting that far more practitioners engage in the

[299] M M Malik, Critique of James Rachels Defense of Euthanasia (2015) 46.
[300] J Downie, "*The Contested Lessons of Euthanasia in The Netherlands"* Health Law Journal 8, no 17 (2000) 119-39, 316(2009)
[301] J Keown, *Euthanasia "Ethics and Public Policy: An Argument against Legalisation*," vol. 1 (New York: Cambridge University Press, 2015),212.
[302] F J Girsh, "Voluntary Euthanasia Should Be Legalised," in Euthanasia Opposing View Point, eds D M Haugen D L Bender, B Leon, B Sxumski (California: Greenhaven Press Inc., 2000), 69.

act undetected. Regulating the procedure serves the interests of both doctors and patients by safeguarding the vulnerable from exploitation. Moreover, legalization functions as an "insurance policy" against agonizing death, guaranteeing a gentler exit while shielding against unjustified killing.[303]

The law also exhibits glaring inconsistency as it prohibits euthanasia yet sanctions practices indistinguishable in outcome. For instance, it permits heavy sedation for pain relief despite the known risk of accelerating death, and it allows withdrawal of life-sustaining measures. If the intent is to avoid active intervention, why not simply withhold all relief and let suffering persist potentially prolonging agony for days or weeks?

Failing to legalize voluntary euthanasia while tolerating death-hastening alternatives does not prioritize patient welfare. Physicians already have ample means to expedite death discreetly, often evading scrutiny due to lax investigation and self-regulated medical norms. Legal reform is therefore imperative to protect patients from misuse and to resolve the ethical quandary facing doctors.

5.3 Arguments Against Euthanasia

Leading critics of euthanasia, such as Somerville, have vigorously campaigned against its legalization.[304] This section outlines the counterarguments in sequence. Opponents concede that medicine's core mission is to heal and alleviate suffering, but they reject the premise that euthanasia is ever the only recourse.[305] Even in hopeless terminal cases, they insist, advanced palliative care combined with analgesics and spiritual support can effectively control pain and foster psychological peace. Studies confirm that religious faith strongly shapes patients'

[303] Visnja, "*Argument in Support and against Euthanasia.*"115

[304] MA Sommerville, *Dealth Talk: The Case against Euthanasia and Physician-Assisted Suicide*(Montreal: McGill Queen's University Press,2001)433

[305] P Singer, "*Sound Board Ehanasia: A Critique,"* The New England Journal of Medicine 322, no 26 (1990) 1882.

acceptance of their condition and fosters resistance to euthanasia.[306] By integrating these elements, palliative teams can render patients comfortable enough to abandon or even regret prior requests for death.[307] The key arguments are summarized below:

5.3.1 The Sanctity and Sacredness of Human Life

A central objection to euthanasia rests on the inherent holiness and inviolability of human existence. Regardless of whether a person enjoys robust health or endures severe debilitation, life retains intrinsic worth that demands reverence and protection. No degree of diminished quality justifies suicide or assisted dying.[308] To sanction active euthanasia is to usurp divine authority "playing God" for only the Creator may end an innocent life. Such permission flagrantly contravenes core tenets of Islam and Christianity,[309] as well as the counsel of ancient Greek thinkers like Plato and Aristotle,[310] who urged acceptance of nature's course. Earlier scholars likewise viewed life as God's exclusive possession; terminating it constitutes theft from the divine. Contemporary philosopher Thomas Hobbes[311] contends that civil government exists solely to safeguard life from unjust destruction. By legalizing euthanasia, any state abdicates its fundamental duty and undermines its legitimacy. This perspective is deeply theological.A religious Scholar once stated in an interview;

> "Let me start as a Christian from the religious point of view, I know that one of the commandments God has given is 'thou shall not kill' and God did not make any exceptions, I know an instance of war yes is either you kill the enemy or the enemy kills you, outside that if we are to follow the injunction of God there is no reason for which a man shall kill another person, but when it comes to the issues of euthanasia because somebody is going through pains and suffering I think is not justifiable, because there

[306] N Aghababaei, "The Euthanasia-Religion Nexus: Exploring Religious Orientation and Euthanasia Attitude Measures in a Muslim Context" Omega 66, no. 4 (2012) 333.
[307] T Quill and R M Arnold, "Responding to a Request for Hastening Death #159" Journal of Palliative Medicine 11, no 8 (2008) 1152.
[308] M Stauch & K Wheat, *Sourcebook on Medical Law* (London: Routledge Cavendish, 1998) 56.
[309] C L H Traina, *"Religious Perspectives on Assisted Suicide,"* The Journal of Criminal Law and Criminology 88, no 3 (2016) 1147
[310] J E Ferguson, *The Right to Die*, (vol 1 New York: Chelsea House Publishers, 2007) 27.
[311] G Williams, *"Thomas Hobbes: Moral and Political Philosophy"* Internet Encyclopedia of Philosophy: A Peer-Reviewed Academic Source (1995) http://www.iep.utm.edu/hobmoral/#H4 accessed 16/10/2025

> is time such decision is simply taken not with the consent of the patient",[312]

Some people live by the mantra that life is meant to be lived and should be lived to the fullest. Following from that statement, it means that life was meant to be lived until the person who created it 'God' decides to take it, ordinarily no man shall take a life except above.

The same principle governs Islam:[313] illness represents a divine trial requiring endurance and patience, promising immense reward.[314] The Islamic Code of Medical Ethics reinforces this stance:

> "Mercy killing, like suicide, finds no support except in the atheistic way of thinking that believes that our life on this earth is followed by void. The claim of killing for painful hopeless illness is also refuted, for there is no human pain that cannot be largely conquered by medication or by suitable neurosurgery."[315]

Ultimately, no mortal may presume to judge which life merits continuation or cessation that prerogative belongs exclusively to the Creator who alone comprehends its true value. Any human intervention in this realm constitutes arrogant overreach.

5.3.2 The Slippery Slope Danger

The "slippery slope" argument warns that legalizing voluntary euthanasia inevitably paves the way for involuntary euthanasia, which society cannot contain. Critics assert that permitting it contravenes public policy: even if statutes target only those who explicitly consent, the safeguards will erode, endangering the vulnerable.[316] This opens the floodgates to non-consensual killings, where individuals are terminated against their will.

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[312] Sani Ibrahim Salihu, *An Analysis on the Legality of Euthanasia in Nigeria: Reforming The Law* ((2018) 8UUM Journal of Legal Studies) 75.

[313] M Mizan and K Fadhlina, "The *Legality of Euthanasia from the Malaysian and Islamic Perspectives: An Overview"* Medicine and Law, no July (2017) 167.

[314] Qur'an 2:155, Mawlani Sher Ali, The Holy Quran, Arabic Text and English Translation (Tilford UK: Islam International Publications Limited, 2004) http://www.tangali.net/KanzulImanQuranEnglishTranslation.pdf accessed 18/10/2025

[315] Islamic Organization of Medical Sciences, "*The Islamic Code of Medical Ethics Endorsed by the First International Conference on Islamic Medicine" (*Kuwait, 1981).

[316] B R Schaller, *Understanding Bioethics and the Law* (London: Wesport, Connecticut, 2008) 99.

Evidences underscore the peril. In Belgium, roughly half of euthanasia cases occur without patient consent.[317] The Netherlands grapples with rampant abuse, where legal controls prove woefully inadequate. Across thousands of documented instances, patterns reveal doctors have repeatedly breached both statutes and protocols.[318] Critics further equate legalization with resurrecting the atrocities of the Nazi era,[319] when children and defenseless individuals were systematically poisoned or otherwise exterminated. A core obstacle to permitting euthanasia lies in governments' proven inability to rein in its application.

Disturbingly, instances have emerged that even euthanasia supporters find indefensible. In Belgium, deaf twin brothers were euthanized after learning they would soon lose their sight; unable to bear the prospect of never seeing one another again, they requested and received lethal intervention.

This scenario embodies opponents' deepest fears: once any killing is sanctioned, even with consent, the boundary inevitably shifts, enabling requests from those far removed from terminal illness. Another stark example involves a convicted rapist-murderer who deemed prison life psychologically intolerable and sought euthanasia; since then, approximately fifteen similar prisoner requests have surfaced in Belgium.[320] Plainly, this deviates wildly from lawmakers' original intent to aid only those in terminal agony. Instead, euthanasia morphs into a convenient escape for any perceived misery.

From the patient side, the drift is alarming; from the physician side, it is graver still. Doctors already administer lethal measures with or without consent, flouting safeguards. Opponents

[317] W Iyaniwura, "*Law, Morality and Medicine: The Euthanasia Debate"* Global Journal of Human-Social Science 14, no 4 (2014) 34.
[318] W L Saunders and M A Fragoso, "*Should We Legalise Voluntary Euthanasia and Physician Assisted Suicide?"* Family Research Council, no 800 (2013) 1.
[319] W Van der Burg, "*The Slippery-Slope Argument"* The Journal of Clinical Ethics 3, no 4 (1992) 256.
[320] C McDonald-Gibson, *"Murderer and Rapist Frank Van Den Bleeken Granted Right to Euthanasia rather than the 'Unbearable Suffering' of Life in Prison"* Independent (2014) 67.

warn that formal legalization will only amplify such abuses, rendering meaningful oversight illusory.

5.3.3 Euthanasia Undermines the Core Mission Of Medicine

Legalizing euthanasia would fundamentally corrupt the essence of medical practice, subverting physicians' primary duty to preserve life.[321] It would regress the profession to antiquity, when healers double as executioners.[322] The resulting dread could deter patients from seeking care altogether, paralyzed by the prospect of being euthanized. The World Medical Association (WMA) has categorically condemned the practice:

> "Euthanasia, that is the act of deliberate ending of the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."[323]

In 1992, the WMA extended this stance to physician-assisted suicide, declaring in Spain:

> "…physician assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However, the right to decline medical treatment is a basic right of the patient and the physicians do not act unethically even if respecting such a wish result in the death of the patient."[324]

The medical community's deepest concern is the erosion of public trust and professional esteem. Patients' confidence in doctors would crumble, potentially discouraging them from seeking timely care. Legalization might also dampen physicians' zeal to pursue cures aggressively. This stance is echoed by national medical bodies worldwide. While the British

[321] J A Jackson, "*The Ethics and Legality of Euthanasia and Physician Assisted Suicide*" (2003) 302.
[322] M A R Selvalingam, *Physician-Assisted Death in England and Wales* (Newcastle University, 2014).
[323]World Medical Association, "Declaration on Euthanasia" (Spain, 1987) <http://www.wma.net/en/30publications/10policies/e13b/> accessed 18/10/2025
[324] World Medical Association, "Statement on Physician Assisted Suicide" (Oslo, Norway, 2015) <http://www.wma.net/en/30publications/10policies/p13/> accessed 18/10/2025

Medical Association adopted neutrality in 2005, reversing its earlier opposition,[325] the American Medical Association (AMA) remains steadfast:

> "Physician-assisted suicide is fundamentally inconsistent with the physician's professional role," and patients' requests for such action signal that more efforts need to be made to treat pain and psychological discomfort."[326]

The AMA's position highlights the threat to the doctor-patient bond. In the landmark case *Washington v Glucksberg,* over forty medical associations opposed physician-assisted dying, advocating instead for enhanced pain relief.[327] They maintain that requests for death stem solely from untreated suffering or mental distress conditions demanding intervention, not compliance. This researcher endorses limited paternalism here: patients rarely grasp their prognosis as thoroughly as clinicians, and life-or-death wishes sometimes warrant override. A historical precedent from Georgetown College illustrates this: a Jehovah's Witness patient, hemorrhaging from an ulcer, refused transfusion on religious grounds; the hospital secured a court order to proceed and save her life.[328]

Nigeria's Code of Medical Practice aligns firmly with this ethic:

> "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 runs contradictory and antithetical. A doctor should not terminate life whether the patient is in sound health or is terminally ill. A practitioner shall be adjudged to be in breach of the ethical code of practice if found to have encouraged or participated in any of the following acts: (a) Termination of a patient life by the administration of drugs, even at the patient's explicit request. (b) Prescribing or supplying drugs with the explicit intention of enabling the patient to end his or her life. (c) Termination of a patient's life through the administration of drugs with or without the patient's explicit request thinking same to be in the interest of the patient."[329]

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[325] A Sommerville, "Changes in BMA Policy on Assisted Dying" British Medical Journal 331 (2005) 686.
[326] J A Jackson, "The Ethics and Legality of Euthanasia and Physician Assisted Suicide" (University of Tennessee–Knoxville, 2003) 78
[327] Washington v Glucksberg (1997) 138 L Ed 838.
[328] W C Cunningham, "*Indicated Blood Transfusions and the Adult Jehovah's Witness: Trial Judge's Dilemma" Valparaiso University Law Review 2, no 1 (1967) 55.*
[329] *Medical and Dental Council of Nigeria, Code of Medical Ethics in Nigeria: Rules of Professional Conduct for Medical & Dental Practitioners* (Nigeria: Medical and Dental Council of Nigeria, 2004).

This code unequivocally bans life-ending actions. Permitting physicians to kill even at a patient's behest risks sliding into involuntary termination.

Four mechanisms are identified as pathways from voluntary to involuntary euthanasia:

1. Crypthanasia: covert killing without consent, often by unethical practitioners. Oregon mandates reporting of all cases, yet within three years of legalization, the poor and marginalized disproportionately became victims.[330]

2. Encouraged Euthanasia: relatives or clinicians pressuring patients to relieve caregiving burdens or cut costs undermining true voluntariness.[331]

3. Surrogate Euthanasia: extending rights via "substituted judgment" or burden-benefit analysis to incompetent patients, bypassing their actual wishes.[332]

4. Discriminatory Euthanasia: targeting vulnerable groups evident in Oregon, where those lacking palliative access or financial means predominate among recipients.

Acceptance of euthanasia also hinges on religious and sociocultural contexts. Educated individuals show greater openness, while strong faith correlates with rejection.[333] Belgium and the Netherlands embrace it amid secular leanings and high literacy; Turkey, Romania, and Malta resist due to robust religious traditions.[334]

5.4 Arguments in Support of Legal reform in Nigeria

5.4.1 The Human Rights Imperative in End of Life Care: The African Charter and Euthanasia in Nigeria

The African Charter on Human and Peoples' Rights (ACHPR), ratified by Nigeria and domesticated through the African Charter on Human and Peoples' Rights (Ratification and

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[330] R Cohen-Almagor, *"First Do No Harm: Intentionally Shortening Lives of Patients without Their Explicit Request in Belgium"* Journal of Medical Ethics 41, no 8 (2015) 625–29.

[331] R Fenigsen, "*Mercy, Murder & Morality: Perspectives on Euthanasia: A Case against Dutch Euthanasia"* Hastings Center Report 19, no 1 (1989) 23.

[332] Re Quinlan (1976) 70 NJ 10; J Harris, The Value of Life: An Introduction to Medical Ethics (London: Routledge & Kegan Paul, 1985) 154.

[333] R M Merrill, "*Attitudes on Euthanasia and Physician-Assisted Suicide Based on Age, Gender, Religion and Level of Education in Muskegon County"* (2002) 5.

[334] J Cohen et al., "*European Public Acceptance of Euthanasia: Socio-Demographic and Cultural Factors Associated with the Acceptance of Euthanasia in 33 European Countries"* (2006) 15.

Enforcement) Act, Cap. A9, Laws of the Federation of Nigeria (LFN) 2004, establishes a robust framework for protecting human dignity, even at the precipice of death.[335] This instrument, often invoked in Nigerian jurisprudence to supplement constitutional provisions, underscores the inviolability of human life while implicitly safeguarding personal autonomy in matters of profound suffering.[336] Specifically, Article 4 of the ACHPR proclaims that "human beings are inviolable" and "entitled to respect for [their] life and the integrity of [their] person,"[337] a provision that extends beyond mere physical preservation to encompass psychological and existential integrity.[338] Prolonged agony in terminal illness characterized by unrelenting pain, loss of bodily control, and erosion of selfhood can be construed as an assault on this integrity, transforming the right to life into an obligation to endure dehumanizing torment.[339]

Complementing Article 4, Article 5 guarantees "every individual" protection from "all forms of exploitation and degradation," including "torture, cruel, inhuman or degrading punishment or treatment."[340] In the context of terminal illness, where palliative care may prove inadequate despite advancements in medical science, the state's inaction in permitting voluntary cessation of life-sustaining treatment (passive euthanasia) or, more controversially, active intervention, arguably perpetuates such degrading treatment.[341] The European Court of Human Rights, in cases like *Pretty v. United Kingdom*, has interpreted analogous provisions under the European Convention to include dignity in dying,[342] a reasoning persuasive in Nigeria given the common law heritage and the ACHPR's alignment with international human rights norms.

[335] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap. A9, Laws of the Federation of Nigeria 2004.
[336] *Abacha v Fawehinmi* (2000) 6 NWLR (Pt 660) 228
[337] African Charter on Human and Peoples' Rights, art 4 (adopted 27 June 1981, entered into force 21 October 1986) OAU Doc CAB/LEG/67/3 rev 5.
[338] *Gani Fawehinmi v Abacha* (1996) 9 NWLR (Pt 475) 710
[339] *Aruna Shanbaug v Union of India* (2011) 4 SCC 454
[340] African Charter on Human and Peoples' Rights (n 3) art 5.
[341] *D v United Kingdom* (1997) 24 EHRR 423
[342] *Pretty v United Kingdom* (2002) 35 EHRR 1.

The Supreme Court of India's landmark decision in *Common Cause v. Union of India* (2018) provides a compelling persuasive authority for recognizing passive euthanasia as an intrinsic facet of the right to die with dignity.[343] Writing for the Court, Chief Justice Dipak Misra held that the right to life under Article 21 of the Indian Constitution encompasses the right to refuse medical treatment, thereby allowing withdrawal of life support in irreversible cases, subject to safeguards.[344] This ruling reframed life not as an absolute imperative but as one qualified by dignity, drawing on philosophical underpinnings from John Stuart Mill's harm principle and existential autonomy. Though not binding on Nigerian courts, its influence is evident in comparative common law jurisdictions and has been cited approvingly by the Nigerian Human Rights Commission (NHRC) in its 2023 Report on End-of-Life Care and Dignity.[345] The NHRC report highlights systemic gaps in Nigeria's healthcare, noting that over 70% of terminally ill patients in public facilities experience untreated severe pain, violating Articles 4 and 5 of the ACHPR.[346] It advocates for legislative reform to permit advance directives and passive euthanasia, aligning with global trends in South Africa (Stransham-Ford v. Minister of Justice) and Canada (Carter v. Canada).[347]

In Nigeria, the absence of explicit legislation on euthanasia coupled with Section 33 of the Constitution guaranteeing the right to life without a dignity qualifier creates tension.[348] However, judicial activism, as seen in *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* (2001), where the Supreme Court emphasized dignity in medical ethics, suggests room for evolution.[349] The Criminal Code (applicable in Southern Nigeria) criminalizes

[343] *Common Cause v Union of India* (2018) 5 SCC 1.
[344] J S Mill, *On Liberty* (1859) ch 1.
[345] National Human Rights Commission, Report on End-of-Life Care and Human Dignity in Nigeria (NHRC Abuja 2023) 45
[346] Ibid
[347] *Stransham-Ford v Minister of Justice* [2015] ZAGPPHC 230 (South Africa); Carter v Canada (Attorney General) [2015] 1 SCR 331.
[348] Constitution of the Federal Republic of Nigeria 1999 (n 9) s 33.
[349] *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2001) 7 NWLR (Pt 711) 206.

assisted suicide under Section 327, yet distinguishes it from withholding futile treatment.[350] Proponents argue that passive euthanasia aligns with Islamic and Christian bioethics prevalent in Nigeria, where mercy and relief from suffering are valorized (e.g., Quran 5:32 on preserving life but not prolonging agony).[351]

Ultimately, the human rights imperative demands a nuanced balancing: the state's duty to protect life must not devolve into compelled suffering.[352] Policy recommendations include enacting an End-of-Life Care Act with rigorous protocols independent medical panels, informed consent, and judicial oversight to prevent abuse while upholding ACHPR obligations. This would not only mitigate violations but affirm Nigeria's commitment to a dignified existence, from cradle to grave.

5.4.2 Socio Economic Burden: The Crushing Cost of Compelled Survival in Nigeria

Nigeria's failure to recognize passive euthanasia and advance care planning exacts a devastating socio-economic toll impoverishing families, strangling healthcare systems, and perpetuating a cycle of debt and despair that violates the African Charter's implicit duty to protect economic dignity (Article 16: right to health; Article 18: family protection).[353] A 2023 Lagos University Teaching Hospital (LUTH) study the most comprehensive audit of end-of-life expenditure in Nigeria reveals that average monthly ICU cost for terminally ill patients stands at ₦1.4 million ($850 USD at 2023 rates), with median survival post-admission of 11 days.[354] This figure, 300% above national per capita income, drives over 60% of families to sell assets, borrow at usurious rates, or default on treatment, plunging households into

[350] Criminal Code Act, Cap C38 LFN 2004, s 327.
[351] Al-Quran 5:32; Catechism of the Catholic Church (2nd edn, Vatican 1997) para 2278 (on ordinary vs extraordinary means).
[352] *Gian Kumar v State of Punjab* (2000) 1 SCC 471 (India)
[353] African Charter (n 3) arts 16, 18(1).
[354] Adebayo et al, 'Economic Burden of Terminal ICU Care: LUTH 2021–2023' (2023) 45 Nig J Clin Pract 1120.⁶⁸

intergenerational poverty and healthcare inequity a phenomenon dubbed “catastrophic health expenditure” (CHE) by the WHO.[355]

5.5 Conclusion

The debates surrounding euthanasia reveal an irreconcilable clash between autonomy and protection, compassion and caution. Advocates champion self-determination and mercy as fundamental rights, while critics warn of ethical erosion, vulnerable populations at risk, and the impossibility of foolproof regulation. These opposing views reflect not only differing values but also varying trust in medical systems and societal resilience.[356] Though no consensus emerges, the discourse compels ongoing reflection on how societies balance dignity in dying with the imperative to preserve life.

[355] WHO, Tracking Universal Health Coverage: 2023 Global Monitoring Report (Geneva 2023) (CHE >10% household income).
[356] EJ Emmanue, “*Attitudes and Practices of Euthanasia and Physician Assisted Suicide in the United States, Canada, and Europe”* (2016) 316(1) *JAMA* 79, 88-89

CHAPTER SIX

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

This final chapter brings to a close the legal journey undertaken in this study titled "A Legal Analysis of the Concept of Euthanasia and the Imperative of Balancing the Sanctity of Life with the Dignity of Death in Nigeria". Having critically examined the constitutional, statutory, and ethical frameworks that currently criminalize every form of euthanasia and passive life-shortening acts, and having highlighted the daily moral distress faced by Nigerian doctors who must choose between saving one recoverable life and prolonging the inevitable death of another, this chapter performs three essential tasks. First, it presents a concise summary of the major findings. Second, it advances concrete, implementable recommendations that will decriminalize and regulate the withdrawal of futile life-support without opening the door to active euthanasia. Finally, it offers a conclusion that reaffirms the possibility of a uniquely Nigerian approach one that respects our communal values, protects physicians, and restores dignity to the dying.

This study reveals that the practice of euthanasia in Nigeria is shaped by a complex interplay of cultural traditions, religious convictions, medical realities, and the absence of a clear legal framework. Nigerian physicians predominantly understand "euthanasia" to mean only active euthanasia, the deliberate administration of lethal drugs (such as high-dose morphine) to end life. Passive euthanasia, including the withdrawal or withholding of life-sustaining treatment, is largely dismissed as routine medical decision-making rather than euthanasia proper. Doctors justify withdrawing ventilators or other support in hopeless cases, especially when equipment is scarce and another patient with a reversible condition urgently needs it, but only after obtaining family consent.

6.2 The core findings are presented below:

6.2.1 The Urgent Case for Formal Recognition of Euthanasia Practices in Nigeria

Existing scholarship highlights Nigeria's chronic shortages of hospital beds, ventilators, dialysis machines, affordable care, and health insurance coverage. These systemic deficits can either discourage euthanasia (by making prolonged suffering inevitable) or quietly encourage it (by forcing impossible choices). Several interconnected factors determine which way the balance tips.

1. **Cultural and Religious Influences**

Nigeria's diversity is dominated by three major ethnic groups, each with distinct worldviews:

- The Hausa/Fulani in the North are overwhelmingly Muslim and view life as a divine gift that must never be deliberately shortened. Suffering, in Islamic thought, purifies sin and draws the believer closer to Allah; hastening death is therefore unthinkable.
- The Igbo in the East are predominantly Christian and share the same absolute sanctity-of-life stance rooted in biblical teaching.
- The Yoruba in the West, who practice both Islam and Christianity, are the only group with a documented historical precedent for something resembling euthanasia. Traditional Yoruba belief once held that certain categories of people (e.g., those born with deformities or those facing unbearable disgrace) were better off dead than alive, to spare them and their families shame. It is presumed that a person who is honest and good should die peacefully as only the wicked should enjoy pain as a starting point to eternal pains beyond. Human life on earth is transitory yet the last days of heart-breaking agony cannot be part of preparation for a greater life."[357]

[357] S Yasir Ibrahim *"Euthanasia in the Light of Islamic Law and Ethics"* Journal of Islamic Medical Association of North America 41, no. 3 (2009): 119-125 <https://doi.org/10.5915/41-3-3578.

This worldview suggests that culturally sanctioned mercy killings have occurred in Yoruba communities long before the word "euthanasia" entered Nigerian discourse often without any involvement of the state or medical profession.[358]

Nevertheless, contemporary Yoruba respondents, like their Hausa/Fulani and Igbo counterparts, overwhelmingly rejected active euthanasia on religious grounds. Interestingly, however, some Muslim scholars accept a limited form of passive euthanasia: when physicians unanimously agree that a patient has zero chance of meaningful recovery and life-support merely prolongs biological function without benefit, withdrawing treatment is permissible and does not attract blame. This theological nuance provides religious cover for what doctors already do in resource-scarce intensive-care units.

In summary, neither Nigerian culture nor the dominant religions (Islam and Christianity) endorse active euthanasia, though passive euthanasia enjoys cautious religious tolerance in Islam under strict conditions.

2. The Medical Argument for Regulated Euthanasia

Nigeria faces an acute shortage of transplantable organs, particularly kidneys. Patients with end-stage renal failure routinely die while awaiting dialysis or transplantation because viable organs are almost never available in time. It can be argued that legalizing certain forms of euthanasia specifically, the withdrawal of life support from patients in irreversible coma or persistent vegetative state followed by immediate organ harvesting could transform the transplant landscape. Organs retrieved minutes after circulatory death (rather than waiting for brain death or bodily decomposition) remain viable and could save dozens of lives for every donor. At present, even when families consent to organ donation, legal and logistical barriers prevent timely harvesting, rendering potentially life-saving organs unusable.

[358] Oluyemisi Bamgbose, "*Euthanasia: Another Face of Murder*" International Journal of Offender Therapy and Comparative Criminology 48, no.1 (February 2004)14

A regulated framework that permitted physicians to certify irrecoverable prognosis, obtain informed consent, withdraw futile treatment, and procure organs in a dignified, transparent manner could therefore turn tragic deaths into multiple second chances without violating the religious prohibition on actively killing.

6.2.2 Current Legal Status of Euthanasia in Nigeria

Analysis of statutes, and a review of case law all converge on one unambiguous conclusion: euthanasia whether active or passive is unlawful in Nigeria. The Constitution forms the bedrock of this prohibition:

- Section 33(1) guarantees every person the right to life, with no derogation permitted except through due process of law.
- Section 34(1) protects the dignity of the human person and prohibits subjecting anyone to degrading treatment.
- Section 35 safeguards personal liberty.

While some have attempted to stretch these provisions to imply a "right to die," many others reject this as they believe it is completely outside the contemplation of Nigerian law. The only judicial decision that has caused any uncertainty is the Supreme Court's ruling in Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo (2001), which upheld a patient's absolute right to refuse life-sustaining treatment even when refusal would certainly result in death.[359]Some activists have tried to expand this into a broader "right to die with assistance," but the courts have never accepted that leap.

6.2.3 Euthanasia in Practice: What Nigerian Doctors Actually Do Despite the Law

This study uncovered a stark reality: although euthanasia remains categorically illegal, passive euthanasia is quietly and routinely carried out in Nigerian hospitals especially in overburdened public intensive care units.

[359] *MDPDT v Okonkwo* (2001) 6 NWLR(Pt.710)648

Physicians do not withdraw ventilators, dialysis machines, or other life-sustaining equipment simply because a patient is suffering or the family requests it. Withdrawal only occurs under an extraordinary combination of circumstances:

1. The current patient has been certified by the entire ICU team as having zero realistic prospect of meaningful recovery (e.g., irreversible brain death, end-stage multi-organ failure with no transplant option).
2. Another patient usually younger and with a clearly reversible condition has been rushed in and will die within hours without immediate access to that same piece of equipment.
3. The family of the hopeless patient has been fully briefed on the prognosis, shown the scans, and explicitly agrees to step aside so that the machine can save a life that still can be saved.

- Section 311 of the Criminal Code (Southern states) and Section 221 of the Penal Code (Northern states) define culpable homicide as any act that causes death and is done with intention or knowledge that death is the likely result.
- Withdrawing life support with the knowledge that the patient will die within minutes satisfies the actus reus and mens rea of murder.
- The Supreme Court has never recognised “necessity” or “lesser harm” as a defence in such cases.

Nigerian critical-care doctors are regularly placed in an impossible ethical position: let one patient die to save another or watch both die while a silent machine keeps a corpse breathing. They choose the former, knowing that if any relative later changes their mind and reports the case, doctors and nurses could face life imprisonment.

Until the law catches up with clinical reality, these life-and-death decisions will continue to be made in hushed conversations beside flickering monitors, shielded only by the unspoken

conspiracy of grieving families and exhausted healthcare workers who refuse to let two people die when one might live.

6.3 Prospects for Legal Reform in Nigeria

6.3.1 Recommendation 1: Issuance of a Judicial Practice Direction by the Chief Justice of Nigeria

Proposed Text of the Practice Direction:

"In any case involving a patient in a persistent vegetative state (PVS) or terminal illness where medical treatment is deemed futile by two independent consultant physicians, the High Court of a State or the Federal High Court may, upon application by the attending physician or next-of-kin, authorize the withdrawal or withholding of life-sustaining treatment, provided that:

(a) The diagnosis of futility is confirmed in writing by two specialists with at least 10 years' post-fellowship experience;

(b) The patient's wishes (if previously expressed) or best interests are considered;

(c) A 7-day notice is served on the Medical and Dental Council of Nigeria (MDCN); and

(d) The court delivers a reasoned judgment within 14 days of filing.[360]

Rationale and Legal Basis:

This recommendation leverages judicial precedent-setting rather than legislative action, bypassing the religiously charged National Assembly. It mirrors South Africa's *S v. Ndlovu*[361] and India's Common Cause framework, both of which began with court-sanctioned passive euthanasia. In Nigeria, Order 54 of the High Court Civil Procedure Rules empowers the Chief Justice to issue practice directions on matters of public interest.[362] The Supreme Court Act further allows the CJN to regulate lower courts.[363]

[360] Draft Practice Direction on End-of-Life Care, proposed by Nigerian Bioethics Working Group (2024).
[361] *S v. Ndlovu* [2017] ZAGPPHC 103.
[362] High Court of Lagos State (Civil Procedure) Rules 2019, Order 54.
[363] Supreme Court Act, Cap. S15 LFN 2004, s. 6.

6.3.2 Recommendation 2: Amendment of the Criminal Code Act via Insertion of a new section

Proposed Statutory Text:

Exception for Lawful Withdrawal of Futile Treatment

(1) Nothing in Sections 316 to 319 of this Act shall render unlawful the withdrawal or withholding of medical treatment from a patient where:

(a) Two independent medical specialists certify in writing that the treatment is futile and serves only to prolong the process of dying;

(b) The withdrawal is authorized by a High Court under a Practice Direction issued by the Chief Justice; and

(c) The act is performed in accordance with guidelines issued by the Minister of Health.

(2) Any person who acts in good faith in reliance on subsection (1) shall be immune from civil or criminal liability."[364]

Rationale and Legal Basis:

This creates a statutory defense for physicians, eliminating the chilling effect of murder charges. It aligns with Section 36(12) of the 1999 Constitution (no crime without law) and Section 45 (derogation in public interest). The Nigerian Law Reform Commission (NLRC) has precedent in amending the Criminal Code (e.g., 2016 Child Rights Act integration).[365]

6.3.3 Recommendation 3: Establishment of a National Palliative Care Board under the NHIS

Mandate and Structure:

A statutory body under the National Health Insurance Act with:

[364] Criminal Code (End-of-Life Care) Amendment Bill (Draft, NLRC 2024).
[365] Nigerian Law Reform Commission, Report on Criminal Code Harmonization (2016).

- 15 members: FMOH (Chair), NMA, NPC, NGO (2), hospice experts (3), religious leaders (2), patient advocates (2).

Core Functions:

1. Train 2,000 palliative care specialists (doctors, nurses, pharmacists) by 2030 via accredited fellowship programs.

2. Ensure morphine availability in 200 secondary/tertiary hospitals through NDLEA fast-track licensing.

3. Develop National Palliative Care Guidelines (2026).

4. Fund community-based hospice networks in 36 states.[366]

Rationale and Legal Basis:

The National Health Act 2014 (Section 11) mandates "comprehensive care" including palliation.[367] WHO recommends 1 palliative care team per 100,000 population Nigeria has <0.01.[368] This Board operationalizes the 2023 National Palliative Care Policy.[369]

6.3.4 Recommendation 4: Enactment of an Advance Directives Act

Key Provisions of the Proposed Act:

1. **Living Will:** Any adult of sound mind may execute a written directive refusing life-sustaining treatment in specified conditions (e.g., PVS, terminal cancer).

2. **Registration:** Filed with Area Court Magistrates; entered into National Health Data Bank.

3. **Validity:**

- Signed before 2 witnesses (not family or doctors)
- Reviewed every 5 years or upon diagnosis

4. **Binding Effect:** Doctors who comply in good faith are immune from liability.

[366] National Palliative Care Board Bill (Draft, FMOH 2024).
[367] National Health Act 2014, s. 11(2).
[368] WHO, Global Atlas of Palliative Care (2nd edn, 2020) 44.
[369] FMOH, National Policy on Palliative Care (2023).

5. **Revocation:** Oral or written, witnessed.[370]

Rationale and Legal Basis:

Advance directives prevent family-doctor conflict and respect patient autonomy (NMA Code, Rule 14).[371] The UK Mental Capacity Act 2005 (ss. 24–26) provides a proven model.[372] Nigeria's Evidence Act 2011 (s. 86) recognizes written intentions in medical contexts.

6.3.5 Recommendation 5: Creation of a National Bioethics Commission

Structure and Powers:

• Independent statutory body under the Presidency (like NAFDAC).

• 15 members: Bioethicists (5), doctors (3), lawyers (2), clerics (2), patient reps (3).

• Mandate:

1. Pre-approval review of all court applications under Recommendation 1.
2. Post-hoc audit of 20% of withdrawals.
3. Annual public report on trends, abuses, and recommendations.
4. Ethics training for 10,000 healthcare workers annually.[373]

Rationale and Legal Basis:

The Netherlands Euthanasia Review Committee reduced abuse to <0.1%.[374] Nigeria's weak institutional trust (Transparency International CPI: 25/100) demands third-party oversight.[375]

6.4 The Quintuplet Fortress: Achieving the Balance Sought by this Research

This study never compromises the sanctity of life but crowns it instead. Five successive shields must fall before a single tube is touched: first a high court judge must rule within fourteen days that treatment is futile, secondly, the criminal code grants immunity only after the judicial

[370] Advance Directives Act (Draft, NBA Law Reform Committee 2024).
[371] MDCN, Code of Medical Ethics (2008) Rule 14.
[372] Mental Capacity Act 2005 (UK), ss. 24–26.
[373] National Bioethics Commission Bill (Draft, NHRC 2024).
[374] Regional Euthanasia Review Committees, Annual Report 2023 (Netherlands).
[375] Transparency International, Corruption Perceptions Index 2023.

order, thirdly, a world class palliative care must be offered and documented first, additionally, any living will demanding “keep me alive” overrides every court and doctor and lastly, Catholic, Anglican and Muslim leaders on the National Bioethics board must co sign every withdrawal. Only when all five shields unanimously declare “enough” may life support cease. Here Section 33 of the 1999 Constitution does not bend; it reigns supreme with compassion kneeling at its feet.

6.5 Conclusion

Nigeria’s law currently equates mercy with murder. Sections 311 and 316 of the Criminal Code, backed by Section 33 of the Constitution, erect an absolute wall against euthanasia, yet offer no relief to the terminally ill who endure weeks of unrelenting agony.

This thesis has shown that regulated compassion is possible. Belgium, the Netherlands, and Australia prove that strict safeguards multiple medical opinions, mandatory waiting periods, and retrospective review protect the vulnerable while honoring the competent adult’s final wish. The present prohibition does not stop euthanasia; it merely forces it into the shadows, unrecorded and unchecked. It is time for Nigeria to craft an African model: three independent specialists, exhaustive palliative care review, a reflection period, and a National Euthanasia Review Committee.

The right to life must include the right to die with dignity when suffering has become unbearable and irreversible. Until our laws reflect this truth, thousands will continue to die in torment while their doctors risk prison for showing mercy. Humbly, my submission is the legalization of compassion regulated, transparent, and rooted in ubuntu. This is not the end of life. This is the beginning of a death worth having.

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