

**LEGAL FRAMEWORK ON EUTHANASIA IN MENTAL DISORDER CASES: A
COMPARATIVE STUDY OF NIGERIA AND THE NETHERLANDS**

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**FACULTY OF LAW
UNIVERSITY OF BENIN**

DECEMBER, 2025

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

DECEMBER, 2025

CERTIFICATION

I, **Promise ORIAKHI**, with Matriculation Number **LAW2002938**, hereby certify that apart from references to other persons' works which have been duly acknowledged, the entire work is a product of my research, and this project has neither in whole nor in part been presented for another degree elsewhere.

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APPROVAL

We certify that this project was written and completed by **Promise ORIAKHI** with Matriculation Number **LAW2002938** in partial fulfilment of the requirements for the award of a Bachelor of Laws (LL. B) degree.

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DEDICATION

This project is dedicated to God Almighty, and my parents for their prayers, love and support.

ACKNOWLEDGEMENTS

I wish to express my immense gratitude to God Almighty, my source of unending strength, Wisdom and his banner of unconditional love, For the grace to start and complete this project and for His assistance throughout the duration of my study in this Institution of learning

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ABSTRACT

Euthanasia, particularly in mental disorders, represents one of the most ethically complex and legally contested issues in contemporary medical jurisprudence. While physical suffering has long been the focus of end-of-life discussions, the recognition of psychological suffering as a legitimate basis for euthanasia introduces new layers of legal, ethical, and human rights considerations. This research critically examines the legal framework governing euthanasia in mental disorder cases, using a comparative approach between Nigeria and the Netherlands two jurisdictions with significantly divergent legal, cultural, and ethical perspectives.

The study analyses the statutory and judicial positions on euthanasia in both countries, paying special attention to the criteria for mental competence, the evaluation of consent in psychiatric contexts, and the protections afforded to vulnerable individuals. In the Netherlands, euthanasia is legally permitted under strict conditions, even for individuals with psychiatric illnesses, provided that rigorous procedural safeguards are met. In contrast, Nigeria maintains a strict prohibition, with euthanasia treated as a criminal offence under both the Criminal Code and Penal Code, and without any provision for mental health-related exceptions.

This research employs doctrinal and comparative methodologies, drawing from legal texts, case law, academic commentaries, and international human rights instruments. It identifies the shortcomings of Nigeria's current legal stance and explores whether the Dutch model offers adaptable insights for humane and rights-based legal reform. The study ultimately argues for a more nuanced legal framework in Nigeria one that balances the sanctity of life with evolving standards of human dignity, mental health rights, and individual autonomy.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

Euthanasia, often referred to as “mercy killing,” is one of the most ethically contentious and legally complex issues facing modern societies. It involves the deliberate act of ending a person’s life, usually by a physician, at the individual’s request, to alleviate persistent and unbearable suffering. While the broader discourse on euthanasia often centers on terminal physical illnesses, a more controversial and less explored frontier is the application of euthanasia in mental disorder cases. These cases raise profound questions concerning autonomy, mental competence, and the extent to which the law should permit individuals with psychological suffering to make end-of-life decisions. Mental disorders present unique challenges to legal systems because of the fluctuating nature of mental capacity, the risk of coercion or impaired judgment, and the need to protect vulnerable persons. Unlike terminal somatic illnesses, mental illnesses may not be accompanied by a clear physical prognosis, making the determination of suffering and incurability more subjective. Consequently, permitting euthanasia in such cases requires not only careful ethical reflection but also robust legal safeguards.

Globally, legal responses to euthanasia have been diverse and deeply influenced by culture, religious, and politics. Some countries, such as Belgium, Canada, and the

Netherlands, have developed legal mechanisms that permit euthanasia under specified conditions, including in rare instances involving patients with severe psychiatric conditions. In contrast, many countries, including Nigeria, continue to criminalize all forms of euthanasia under existing criminal and medical laws. In the Netherlands, euthanasia is legally permissible under strict statutory conditions pursuant to the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* of 2002. This law recognizes unbearable psychological suffering as a legitimate ground for euthanasia, provided the patient is deemed mentally competent, and all due care criteria are met, including consultation with independent medical experts and psychiatric evaluation¹ On the other hand, Nigeria's legal framework makes no provision for euthanasia, treating it under the Criminal Code and Penal Code as murder or manslaughter, irrespective of the patient's mental or physical state². The divergent legal approaches in Nigeria and the Netherlands reflect broader philosophical tensions between the sanctity of life doctrine and the evolving emphasis on individual autonomy and dignity. This comparative study seeks to critically analyze the existing legal frameworks governing euthanasia in mental disorder cases in both jurisdictions. It aims to assess whether the Dutch model offers any lessons that could

¹ Heleen weyers “Euthanasia: The Netherlands,” in *European Journal of Health Law*, Vol. 8, No. 2 (2001), 183–200.

² O.A. Olatunji, “Euthanasia and the Law in Nigeria: A Comparative Perspective,” *Nigerian Journal of Public Law*, Vol. 12, No. 1 (2017), 44–60.

inform potential legal reforms in Nigeria, particularly in balancing the protection of mentally ill persons with the right to die with dignity.

As medical science continues to grapple with psychiatric illnesses that may be treatment-resistant, and as societies evolve toward more rights-based legal systems, the question of whether mentally disordered individuals should have access to euthanasia becomes increasingly relevant. This research is therefore not only timely but also necessary in contributing to the legal and ethical discourse on how the law can justly and humanely respond to cases of profound psychological suffering.

1.1 Background of Study

The evolution of medical technology and human rights jurisprudence has reshaped the conversation on life, death, and dignity. One of the most controversial manifestations of this shift is the increasing global debate surrounding euthanasia the intentional termination of a person's life by a medical practitioner at the patient's request. While euthanasia continues to stir legal and ethical controversy worldwide, its application in cases involving mental disorders has become a particularly complex and emotionally charged subject. Historically, the practice of euthanasia has been deeply influenced by cultural, religious, and societal values. In many African societies, including Nigeria, life is considered sacred and its termination whether voluntary or not is generally viewed as

morally unacceptable. Legal systems in such countries mirror these cultural norms, criminalizing all forms of euthanasia under homicide laws, irrespective of the patient's suffering or request³. However, in recent decades, some developed countries have moved toward a more progressive legal posture, recognizing the right of individuals to die with dignity. Notably, the Netherlands has institutionalized a legal regime that permits euthanasia not only for patients suffering from terminal physical illnesses but, in rare cases, also for those experiencing intractable psychological pain arising from mental disorders⁴.

The legal treatment of euthanasia in cases involving mental illness is particularly sensitive due to concerns about mental capacity, vulnerability, and the permanence of psychiatric suffering. While physical conditions such as advanced-stage cancer or organ failure may present a clear trajectory toward death, mental disorders are often non-terminal and fluctuate in severity. This raises legitimate concerns about whether patients suffering from mental illnesses can give informed and voluntary consent to end their lives. As such, any legal framework that considers the inclusion of mentally ill patients must be underpinned by robust safeguards to prevent abuse, coercion, or misdiagnosis⁵.

³ Augustine.I. Okeke, "Cultural Attitudes and the Criminalisation of Euthanasia in Nigeria," *African Journal of Legal Studies*, Vol. 9, No. 2 (2015), 101–120.

⁴ Heleen. Weyers, "Euthanasia: The Netherlands Experience," *European Journal of Health Law*, Vol. 8, No. 2 (2001), 183–200.

⁵ Abosede O. Olayemi, "End-of-Life Decisions and the Nigerian Legal System: An Unaddressed Crisis," *Nigerian Journal of Health Law and Policy*, Vol. 10, No. 1 (2018), 45–60.).

The Dutch approach to euthanasia demonstrates a calibrated balance between compassion and caution. Through the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, the Netherlands has laid down strict criteria for eligibility, requiring, among other things, that the patient's request be voluntary and well-considered, that their suffering be unbearable and without prospect of improvement, and that at least one independent physician confirms the diagnosis and prognosis⁶. This legal framework has sparked both praise and criticism. Supporters argue that it respects individual autonomy and human dignity, while critics warn that it may set a dangerous precedent in the treatment of vulnerable psychiatric patients. In stark contrast, Nigeria's legal system offers no such discretion. Euthanasia, whether passive or active, remains a criminal offense under the Criminal and Penal Codes. Medical practitioners are legally prohibited from assisting in the termination of a patient's life, even in cases of severe, treatment-resistant mental illness. The law provides no framework for assessing patient autonomy in end-of-life decisions, nor does it distinguish between physical and psychological suffering⁷.

This divergence in legal approaches underscores a significant gap in the global and national regulatory landscape regarding euthanasia in mental health cases. It also highlights

⁶ Robert Steinbrook, "Physician-Assisted Death in the Netherlands: New Developments and Concerns," *New England Journal of Medicine*, Vol. 354, No. 7 (2006), 660–663.

⁷ Abosede.O. Olayemi, "End-of-Life Decisions and the Nigerian Legal System: An Unaddressed Crisis," *Nigerian Journal of Health Law and Policy*, Vol. 10, No. 1 (2018), 45–60.

the need for a critical examination of whether legal reforms could enable a more nuanced and rights-based approach to end-of-life care in Nigeria. Given the rising burden of mental illness and the growing recognition of mental health as a serious medical and human rights issue, the question of whether the law should adapt to accommodate complex psychiatric euthanasia cases has become increasingly relevant. Accordingly, this study seeks to investigate the legal frameworks that govern euthanasia in mental disorder cases in both Nigeria and the Netherlands. It aims to offer a comparative analysis of the extent to which each jurisdiction recognizes, permits, or prohibits such practices, and to consider whether the Dutch model provides useful insights for potential legal reform in Nigeria.

1.2 Statement of the Problem

The growing discourse on the right to die, patient autonomy, and medical ethics has reignited global attention on the legality and moral permissibility of euthanasia. While the practice remains controversial in all forms, the legal and ethical challenges become even more pronounced when it involves individuals with mental disorders. The core of the problem lies in the legal uncertainty and conceptual difficulty in determining when, if ever, it is justifiable to allow a person suffering from psychiatric illness to voluntarily end their life through medical assistance. In Nigeria, the legal position on euthanasia is unequivocally prohibitive. The Criminal Code and Penal Code classify any act of assisted dying regardless of the patient's condition as murder or manslaughter, punishable by

imprisonment or death⁸. There is no statutory or judicial framework that allows for consideration of end-of-life choices, even in cases where a mentally ill person experiences unrelenting psychological suffering or loss of capacity to live with dignity. This legal vacuum exposes both patients and medical practitioners to criminal liability and leaves no room for compassion-based interventions or ethically guided medical discretion⁹. Moreover, Nigerian mental health legislation such as the National Mental Health Act of 2021 does not address the complexities surrounding end-of-life decisions for patients with severe psychiatric illnesses. While the Act provides general protections for the rights of persons with mental disorders, it offers no direction on how to approach requests for euthanasia, even in treatment-resistant cases. This omission reflects a broader societal reluctance to engage with the moral nuances of mental suffering and the possibility of dignified death for those living with incurable psychiatric pain¹⁰.

The Netherlands has adopted a highly structured and legally permissible framework that allows euthanasia under exceptional circumstances, including for mentally ill patients. The Dutch system recognizes psychological suffering as a legitimate ground for requesting

⁸ Criminal Code Act, Cap. C38, Laws of the Federation of Nigeria 2004, ss. 306–319; Penal Code Act, ss. 222–224.

⁹ Olusesan.Sola Ogunleye, “Criminal Liability and the Question of Euthanasia in Nigeria: A Legal Analysis,” *Journal of Contemporary Law and Policy*, Vol. 15, No. 1 (2019), 90–106.

¹⁰ Tochukwu. E. Okechukwu, “Legal Gaps in Nigeria’s Mental Health Framework: The Unspoken Dilemma of End-of-Life Decisions,” *University of Lagos Law Review*, Vol. 4, No. 2 (2022), 121–137.

euthanasia, provided that stringent criteria are met. These include evidence of unbearable suffering with no prospect of improvement, mental competence to make such a decision, and independent consultation with a psychiatrist and at least one other physician¹¹. However, this approach is not without criticism. There are ongoing debates about whether a person with a psychiatric disorder can ever be deemed capable of making such a grave and irreversible decision, especially given the possibility of fluctuating mental states and suicidal ideation being symptoms of the illness itself¹².

The comparative gap between the legal systems of Nigeria and the Netherlands reveals a profound tension between the values of life preservation, patient autonomy, and legal certainty. While Nigeria's legal system leans heavily on the sanctity of life doctrine, it fails to recognize situations where prolonging life may equate to prolonged suffering, particularly in cases of chronic and untreatable mental disorders. This rigidity leaves many individuals without legal or compassionate recourse and places medical professionals in ethically conflicting positions. Thus, the core problem this study addresses is the absence of a legal framework in Nigeria that adequately contemplates euthanasia in cases of mental illness, despite growing international recognition of the rights and autonomy of psychiatric

¹¹ Linda Boer & Peter de Jong, "Mental Suffering and the Limits of the Law: Euthanasia in the Netherlands," *International Journal of Law and Psychiatry*, Vol. 70 (2020), 101–118.

¹² Amir. Kim, "Ethical Complexities in Psychiatric Euthanasia: An Evaluation of the Dutch Experience," *Medical Law International*, Vol. 21, No. 3 (2021), 205–222.

patients. Furthermore, it interrogates whether the Dutch model, though imperfect, offers a pragmatic and ethically sensitive blueprint for legal reform in Nigeria. The study therefore seeks to evaluate whether Nigeria's current legal stance on euthanasia in mental disorder cases is tenable in light of evolving global human rights norms and to what extent a comparative legal analysis can inform meaningful reform.

1.3 Aims and Objectives of the Study

1.3.1 Aim of the Study

The principal aim of this study is to critically examine the legal framework regulating euthanasia in mental disorder cases, with a comparative analysis of Nigeria and the Netherlands, in order to assess whether Nigeria's current legal approach adequately addresses the ethical, medical, and human rights implications of euthanasia for individuals suffering from severe psychiatric conditions.

1.3.2 Objectives of the Study

To realize the above aim, the study is guided by the following specific objectives:

1. To examine the laws in Nigeria and the Netherlands that deal with euthanasia, especially for people with mental illness.
2. To examine the ethical and legal concerns about allowing mentally ill people to request euthanasia, including whether they can truly make such decisions.
3. To compare how both countries handle euthanasia for mental disorder cases.

4. Recommendations on how Nigeria's laws on mental health can be improved.

1.4 Research Questions

This study seeks to answer the following research questions:

1. Is there a nexus between Euthanasia and mental health?
2. What are the existing law on Euthanasia and mental health in Nigeria?
3. What are the ethical and legal tension that arises from euthanasia request in Nigeria and in another jurisdiction?
4. Does Nigeria's current legal system sufficiently protect the rights of persons with a mental health condition?
5. What legal reforms can be proposed for Nigeria, based on lessons drawn from other Jurisdictions?

1.5 Scope and Limitation of the Study

This study focuses on the legal framework governing euthanasia in cases involving individuals diagnosed with mental disorders. The research is limited to a comparative analysis between Nigeria and the Netherlands, two jurisdictions with distinctly different legal, cultural, and ethical positions on the subject. The scope of the study includes a critical

examination of the relevant statutes, case law, policy documents, and international human rights instruments applicable to euthanasia in both countries.

1.6 Significance of the Study

This study is significant for several reasons, particularly in the context of Nigeria's developing legal and mental health landscape. The increasing visibility of mental health challenges and the global movement toward recognizing the autonomy and dignity of individuals with psychiatric conditions demand a thorough examination of how the law responds to such sensitive issues as euthanasia. While euthanasia remains largely prohibited in Nigeria, the growing international recognition of the rights of mentally ill persons to participate in decisions about their lives including the choice to die raises important questions that the Nigerian legal system can no longer afford to ignore. This research contributes to the existing body of legal scholarship by providing a comparative analysis of two contrasting legal systems: Nigeria, where euthanasia is criminalized without exception, and the Netherlands, where a legal framework permits euthanasia under carefully regulated conditions, including for mental disorder cases. Through this comparison, the study sheds light on the strengths and weaknesses of both approaches, offering insight into how legal systems can either hinder or promote humane end-of-life decisions.

The study is relevant to policymakers and legal reform advocates in Nigeria. As mental health advocacy gains momentum and the country continues to reform its legal institutions, there is a need for informed legal discussions on the possibility of regulating complex bioethical issues such as psychiatric euthanasia. This research provides a foundation for considering whether Nigeria's laws should evolve to address these realities in a manner consistent with human rights standards, medical ethics, and judicial responsibility.

The study holds significance for legal practitioners, judges, and academics who grapple with the ethical and procedural challenges of end-of-life decision-making. It brings attention to the gap in Nigeria's current legal framework, where there is neither statutory guidance nor judicial precedent on euthanasia, thereby highlighting the need for legal clarity and judicial discretion in exceptional cases involving mental illness. Also, medical professionals, particularly psychiatrists and palliative care providers, stand to benefit from the findings of this research. By understanding the legal position on euthanasia in different jurisdictions, healthcare providers are better informed on how to balance professional responsibility with patient rights, especially in mentally ill patients seeking relief from unrelenting psychological suffering.

Finally, the study is of broader societal importance. It invites a critical national conversation on the intersection of law, mental health, and human dignity. In doing so, it

challenges existing legal norms, encourages legal reform, and advocates for a compassionate yet cautious approach to one of the most ethically complex issues of our time.

1.7 Research Methodology

This research would adopt the doctrinal research method, reference will be made to both primary and secondary sources such as relevant books, journals, statutes, case laws and internet sources. Reference will also be made to international conventions as well as the position of the law from foreign jurisdictions.

1.8 Structure of the Study

This research work is structured into five chapters, each logically organised to ensure clarity, coherence, and systematic progression of thought throughout the analysis.

Chapter One introduces the study by presenting the background, statement of the problem, research aims and objectives, research questions, scope and limitation, significance of the study, and the methodology adopted. It also outlines the structure of the work to guide the reader through the content of the research.

Chapter Two is dedicated to the literature review and theoretical framework. It engages with existing scholarly writings, legal texts, and conceptual clarifications on euthanasia, mental disorders, and patient autonomy. It further identifies the theoretical underpinnings

relevant to the subject matter and highlights gaps in the literature that this study seeks to address.

Chapter Three examines the legal and institutional frameworks governing euthanasia in both Nigeria and the Netherlands, with particular focus on how mentally disordered patients are treated under each jurisdiction's law. It analyses statutory provisions, case law, medical guidelines, and institutional practices that influence the regulation of euthanasia in both countries

Chapter Four presents a detailed comparative analysis of the legal positions of Nigeria and the Netherlands regarding euthanasia in mental disorder cases. It evaluates the strengths and weaknesses of both systems, draws lessons from the Dutch experience, and considers the cultural, legal, and institutional implications of applying such lessons to the Nigerian context.

Chapter Five concludes the study by summarizing the major findings, drawing relevant conclusions, explaining how the study contributes to knowledge and offering legal and policy recommendations aimed at reforming Nigeria's legal approach to euthanasia, particularly for individuals with severe and untreatable mental illnesses.

CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 Conceptual Clarifications

2.1.1 Concept of Euthanasia

The term *euthanasia* derives from the Greek words “*eu*” meaning “good” and “*thanatos*” meaning “death,” literally translating to “good death.” Historically, the idea of euthanasia was associated with the desire to relieve an individual from unbearable suffering, particularly in cases where medical intervention could no longer restore health or dignity. In contemporary discourse, euthanasia is generally understood as the intentional termination of a person’s life by another, usually a physician, at the explicit request of the patient, for the purpose of relieving intractable pain or suffering.¹

Legal scholars define euthanasia as “the deliberate act of hastening death in order to end suffering, carried out with the consent of the patient.”² The definition emphasizes both the element of *intentionality* and the necessity of *consent*, distinguishing it from ordinary medical negligence or homicide. Within the context of law, euthanasia is often framed in tension with the sanctity of life principle, which underpins criminal prohibitions on murder, and the autonomy principle, which emphasizes individual self-determination.

¹ John. Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalization* (Cambridge University Press 2002) 15.

² John Keown, “The Legal Definition of Euthanasia” (2010) 23 *Medical Law Review* 23.

From a jurisprudential perspective, euthanasia challenges the conventional understanding of the right to life. While most constitutions, including Nigeria's, guarantee the inviolability of human life, the question arises as to whether the "right to life" also encompasses a "right to die with dignity."³ International human rights discourse, particularly in Europe, has broadened this debate. For instance, the European Court of Human Rights (ECHR) in *Pretty v. United Kingdom*⁴ declined to recognize an absolute right to assisted dying but acknowledged the growing significance of autonomy and dignity in the context of end-of-life decisions. Euthanasia is not merely a medical or moral issue; it is a deeply contested legal concept that exists at the intersection of criminal law, constitutional law, medical ethics, and human rights. Its interpretation varies significantly across jurisdictions, reflecting divergent cultural, religious, and philosophical attitudes toward death and human dignity.

Classification of Euthanasia

The classification of euthanasia is central to understanding its legal and ethical dimensions. Scholars generally categorize euthanasia along two axes: (i) the consent of the patient, and (ii) the nature of the act performed.⁵

³ Constitution of the Federal Republic of Nigeria 1999 (as amended), s 33(1).

⁴ *Pretty v United Kingdom* (2002)34 E.H.R.R. 1

⁵ Lawrence. Gostin, "A Comparative Perspective on Euthanasia and Assisted Suicide: Law and Practice in the Netherlands" (1997) 2 *Legal Studies* 115.

(a) Voluntary Euthanasia

This occurs when a competent patient, in full possession of their mental faculties, makes an informed request for their life to be terminated in order to escape unbearable suffering.⁶ Voluntary euthanasia is the most legally and ethically defensible form, as it aligns with the principle of autonomy. The Netherlands provides the most notable example of a jurisdiction where voluntary euthanasia is legal under strict regulatory conditions through the Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2002.⁷

(b) Involuntary Euthanasia

Involuntary euthanasia arises when life is ended without the explicit request or against the expressed wishes of the patient.⁸ It is almost universally condemned as morally and legally impermissible, as it contravenes both the principle of autonomy and the right to life. In legal terms, involuntary euthanasia is indistinguishable from homicide and is criminalized in all jurisdictions, including those that otherwise permit voluntary euthanasia.

⁶ Emily. Jackson, *Medical Law: Text, Cases, and Materials* (3rd ed, Oxford University Press 2013) 678.

⁷ The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).

⁸ Ronald M. Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (Harper Collins 1993) 180.

(c) Passive Euthanasia

Passive euthanasia refers to the withdrawal or withholding of life-sustaining treatment, such as artificial ventilation, feeding tubes, or resuscitation measures, thereby allowing the patient to die naturally.⁹ Although controversial, passive euthanasia is often distinguished from active euthanasia on the ground that it involves “omission” rather than “commission.” Courts in many jurisdictions, including Nigeria, have tended to accept passive euthanasia as a form of respecting patient autonomy or acknowledging medical futility.¹⁰

(d) Active Euthanasia

Active euthanasia involves the deliberate administration of lethal substances or other direct interventions intended to cause death.¹¹ It is the most controversial category, as it directly implicates criminal prohibitions on intentional killing. While criminal law in Nigeria prohibits active euthanasia without exception, the Netherlands, Belgium, and a handful of other jurisdictions recognize it as lawful under strict procedural safeguards. The classification of euthanasia thus illustrates the complex interplay between legal principles of consent, criminal liability, and human dignity. It also reveals the challenges of balancing respect for autonomy against the state’s interest in preserving life.

⁹ John M. Finnis, “Euthanasia, Morality, and Law” (1998) 31 *Loyola LA Law Review* 112.

¹⁰ *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2001) 7 NWLR (Pt 711) 206 (Supreme Court of Nigeria).

¹¹ Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber 1957) 298.

Causes of Euthanasia

- **Illness-related Suffering:** This is the most frequent reason, often involving persistent and uncontrollable pain, fatigue, nausea, and other debilitating physical symptoms that have not responded to treatment.
- **Loss of Autonomy and Independence:** Patients frequently cite the desire to maintain control over their life and death and the distress associated with dependency on others for basic functions (e.g., feeding, excretion, mobility).
- **Loss of Ability to Engage in Enjoyable Activities:** A diminished quality of life resulting from the inability to participate in meaningful or pleasurable activities is a significant motivating factor.
- **Psychological Distress and Existential Suffering:** This includes a feeling of hopelessness, a sense of a "useless life," fear of an intolerable self-image, a feeling of being a burden on loved ones, and profound loneliness.
- **Fear of Future Suffering:** Many requests are driven by a fear of future pain or a worsening decline in physical and mental capabilities as an illness progresses.
- **Underlying Medical Conditions:** Requests are often linked to chronic or terminal physical conditions, with cancer (in a terminal phase) being the most common, followed by neurological diseases (like multiple sclerosis or ALS),

end-organ failure, and, in some legal jurisdictions, psychiatric disorders or dementia.

- Reaffirmation of Freedom: For some, requesting euthanasia is a way to reaffirm their personal freedom and the right to decide how and when they die, in the face of medical constraints and a prolonged dying process.

2.1.2 Mental health

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community.¹² It has intrinsic and instrumental value and is a basic human right. Mental health exists on a complex continuum, which is experienced differently from one person to the next. At any one time, a diverse set of individual, family, community and structural factors may combine to protect or undermine mental health. Although most people are resilient, people who are exposed to adverse circumstances are at higher risk of developing a mental health condition. Heavy strains on the psychological or mental health of people contributes to the request if for Euthanasia.

¹² World Health Organization (WHO).

2.1.3 Mental Health Conditions

Mental health conditions can be defined as impairments, activity limitations and individual and participatory restrictions arising from diagnosable mental disorders and include intellectual, psychosocial or cognitive disabilities".¹³ From a legal perspective, mental health conditions refer to a spectrum of psychological or psychiatric states that may affect decision-making capacity, legal responsibility, and rights enforcement. In law, the emphasis is on when a condition interferes with autonomy and legal competence. Under Nigerian law, mental health was primarily addressed through the outdated **Lunacy Act**¹⁴, which has been replaced by the mental health act of 2021, defining those with mental health conditions largely in custodial and medicalized terms.

2.1.4 Disability

“Disability” can be defined as a long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder the individual’s full and effective participation in society on an equal basis with others.¹⁵

¹³ S 57 Mental health act of 2021

¹⁴ Lunacy act of 1958

¹⁵ S 57 of the Nigerian Discrimination Against Persons With Disabilities (Prohibition) Act 2018.

In legal discourse, disability extends beyond mere medical impairment and includes the interaction between an individual’s physical, sensory, or mental condition and the barriers created by society. The United Nations Convention ratified by both Nigeria and the Netherlands, defines disability as “*long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others.*”¹⁶, In Nigeria, the Discrimination Against Persons with Disabilities (Prohibition) Act, 2018, adopts a rights-based definition, recognizing both physical and mental impairments. The Dutch legal framework, through its alignment with the CRPD and domestic equality laws, similarly adopts this broad interpretation, ensuring that disability encompasses mental health- related incapacities relevant to euthanasia debates.

2.1.5 Mental Illness

Legally, mental illness is understood as a diagnosable psychiatric disorder that substantially impairs reasoning, judgment, or behavior, thereby raising issues of legal capacity and responsibility. In Nigeria, although the Lunacy Act does not define “mental illness” in modern terms, courts have interpreted it in relation to criminal responsibility (insanity defense under Sections 27–28 of the Nigerian Criminal Code) and in matters of

¹⁶ The United Nations Convention on the Rights of Persons with Disabilities (CRPD), 2006

legal incapacity. Mental illness, therefore, has implications for determining whether a person can make legally valid decisions, including end-of-life choices.

2.1.5.1 Concept of Mental Disorders in Legal parlance

The concept of mental disorders goes beyond medical diagnosis and is primarily concerned with how such conditions affect legal capacity, rights, and responsibilities. Medically, mental disorders are defined as clinically significant disturbances in cognition, emotion, or behavior that impair an individual's functioning.¹⁷ Legally, however, the question is not simply whether a disorder exists, but whether it compromises a person's ability to make rational and informed decisions. The law often treats mental disorders within two principal contexts: criminal liability and civil capacity. In criminal law, mental illness is considered through the doctrines of insanity or diminished responsibility, which may absolve or mitigate liability if it can be shown that the defendant was incapable of understanding the nature or wrongfulness of their actions.¹⁸ In civil law, mental disorders affect the ability to contract, manage property, or consent to medical treatment.

The issue becomes especially contentious when examined in relation to euthanasia. Where a patient with a mental disorder requests euthanasia, the central legal dilemma lies

¹⁷ World Health Organization, *International Classification of Diseases (ICD-11)* (2019).

¹⁸ *R v. M'Naghten* (1843) 10 Cl & Fin 200.

in determining whether the individual has sufficient decisional competence to make such a grave choice. In the Netherlands, for instance, the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* permits euthanasia in cases of psychiatric suffering, provided doctors ascertain that the patient is competent and that the suffering is unbearable with no prospect of improvement.¹⁹ In contrast, Nigeria has no statutory or judicial framework that accommodates such considerations. Under the Nigerian Criminal Code, the intentional termination of life, regardless of consent, is treated as homicide.²⁰ This tension reflects the law's dual concern: on one hand, the need to protect vulnerable individuals from impaired judgment, and on the other, the recognition that mental suffering can be as profound as physical pain. The legal treatment of mental disorders therefore occupies a delicate balance between autonomy and protection, with different jurisdictions striking the balance in markedly different ways.

2.1.6. Concept of Patient Autonomy and Informed Consent

Patient autonomy is a central principle in medical jurisprudence, reflecting the idea that competent individuals have the right to make decisions concerning their own bodies and medical treatment. This principle has developed in response to the decline of medical

¹⁹ The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).

²⁰ S 306-308 Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004.

paternalism, where doctors historically assumed authority over treatment decisions.²¹ Autonomy is closely tied to the constitutional right to dignity and privacy, which form part of the legal framework for protecting individual choice. The doctrine of informed consent operationalizes autonomy in medical practice. It requires that patients be adequately informed of the nature, risks, and alternatives of a proposed treatment before making a voluntary decision. Consent must be given freely and by a person with the requisite mental capacity; otherwise, medical treatment may amount to trespass or negligence.²² Euthanasia debates are deeply rooted in this principle. Voluntary euthanasia rests on the assertion that individuals have the moral and legal right to determine the manner and timing of their death in cases of unbearable suffering.

The Nigerian Supreme Court in *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* underscored this by affirming the right of a competent adult to refuse medical treatment, even where such refusal may result in death.²³ While that case did not address euthanasia directly, it affirms autonomy as a core value in Nigerian medical law. Nonetheless, autonomy is not absolute. The law imposes restrictions in order to protect vulnerable groups such as minors and persons with impaired mental capacity. In

²¹ Hazel Biggs, *Euthanasia, Death with Dignity and the Law* (Hart Publishing 2001) 45.

²² Jonathan Herring, *Medical Law and Ethics* (8th ed), Oxford University Press 2022) 160.

²³ *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* (2001) 7 NWLR (Pt 711) 206 (SC).

euthanasia, this limitation is particularly relevant where requests are made by patients with psychiatric conditions, raising concerns about whether such decisions are truly autonomous. Thus, while autonomy and informed consent provide a foundation for voluntary euthanasia, the law continues to mediate this principle against broader societal interests in preserving life and preventing abuse.

2.2 Evolution and Legal Discourse on Euthanasia

The evolution of euthanasia reflects a long-standing tension between the sanctity of life and the relief of suffering. Legal and philosophical discourse on euthanasia has developed over centuries, shaped by religious traditions, moral philosophy, medical advancements, and changing societal attitudes towards death. Modern debates have increasingly drawn upon concepts of human rights and autonomy, which challenge older prohibitions grounded in natural law and religious doctrine.²⁴

2.2.1 Historical Development of Euthanasia Debate

The roots of the euthanasia debate can be traced to classical antiquity. In ancient Greece and Rome, attitudes toward assisted death were divided. The Hippocratic Oath, which forbade physicians from administering a deadly drug, reflected the medical

²⁴ Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber 1957) 298.

profession's early rejection of intentional killing. Conversely, philosophers such as Seneca argued that in cases of unbearable suffering, ending one's life could be considered rational and even honorable.²⁵ During the medieval and early modern periods, Christian theology came to dominate Western thought on the sanctity of life. The writings of St. Augustine and Thomas Aquinas emphasized that life was a divine gift and that taking life even one's own was a sin against God and society.²⁶ This theological perspective heavily influenced the development of common law, which criminalized both suicide and assisted suicide, treating them as felonies against the Crown.²⁷

By the nineteenth and twentieth centuries, however, the debate began to re-emerge under the influence of secular humanism, medical science, and liberal philosophy. Advances in medical technology prolonged life but also created new dilemmas about suffering and dignity. Intellectuals such as David Hume had earlier challenged the absolute prohibition on suicide, arguing that individuals possess the moral authority to choose death.²⁸ The twentieth century witnessed the establishment of movements advocating for voluntary euthanasia, particularly in Europe and North America, laying the groundwork for contemporary legislative reforms in places like the Netherlands. Thus, the historical

²⁵ Seneca, *Letters from a Stoic* (trans. R. Gummere, Loeb Classical Library 1917) Letter 70.

²⁶ Blackstone, *Commentaries on the Laws of England* (1769) Vol. IV, 189.

²⁷ David Hume, *Of Suicide* (1757).

²⁸ John. Finnis, *Natural Law and Natural Rights* (Clarendon Press 1980) 85.

development of euthanasia reveals a gradual shift from religious and absolute prohibitions towards a more nuanced debate balancing sanctity of life, individual autonomy, and medical realities.

2.2.2 Ethical and Moral Arguments on Euthanasia

The ethical debate on euthanasia is polarized between those who emphasize the sanctity of life and those who prioritize autonomy and the relief of suffering. Sanctity of Life Argument: Opponents of euthanasia argue that human life is inviolable and must not be intentionally ended under any circumstances. This position is rooted in natural law theory, which regards life as a fundamental good that forms the basis of all other rights.²⁹ Religious traditions, particularly Christianity and Islam, also affirm this principle, holding that life belongs to God and that human beings lack the moral authority to end it. From this perspective, legalizing euthanasia risks undermining respect for life and could lead to abuse or a “slippery slope” towards involuntary euthanasia.

Autonomy and Dignity Argument: Proponents of euthanasia emphasize individual self-determination, arguing that competent persons should be allowed to decide the timing

²⁹ Ronald M. Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (Harper Collins 1993) 190.

and manner of their death, especially in cases of unbearable suffering.³⁰ This view aligns with liberal theories of autonomy, which recognize personal choice as central to human dignity. Advocates contend that forcing individuals to endure prolonged suffering violates their rights to privacy and dignity, values increasingly recognized in international human rights law. Utilitarian Considerations: Utilitarian ethics add another layer by focusing on the consequences of actions. From this standpoint, euthanasia can be morally justified if it reduces overall suffering and maximizes welfare for both patients and their families.³¹ Critics of this view, however, argue that utilitarianism risks justifying the devaluation of vulnerable lives in the pursuit of greater social benefits.

2.2.3 Medical Perspectives on Euthanasia and Mental Disorders

From a medical standpoint, euthanasia has traditionally been associated with terminal physical illnesses such as cancer or neurodegenerative diseases. However, its extension to patients with severe and persistent mental disorders raises complex clinical, ethical, and legal dilemmas. Medical practitioners are guided by the principles of beneficence (acting in the best interests of patients) and non-maleficence (avoiding harm).³² In the context of mental disorders, these principles are complicated by questions

³⁰ John Stuart Mill, *Utilitarianism* (1863).

³¹ Hazel. Biggs, *Euthanasia, Death with Dignity and the Law* (Hart Publishing 2001) 62.

³² Tom. L. Beauchamp and James. F. Childress, *Principles of Biomedical Ethics* (7th edn, Oxford University Press 2013) 150.

of capacity and the fluctuating nature of psychiatric conditions. Unlike many physical illnesses, psychiatric disorders may impair judgment, distort perception of suffering, or diminish the patient's ability to make rational decisions. This creates uncertainty about whether consent to euthanasia is truly informed and voluntary. In countries such as the Netherlands and Belgium, where euthanasia laws extend to psychiatric conditions, physicians are required to adhere to strict safeguards. These include establishing that the patient's suffering is unbearable, that no reasonable alternative treatment exists, and that the request is voluntary and well-considered. Medical literature shows that while some patients with chronic depression, schizophrenia, or personality disorders experience long-term, treatment-resistant suffering, others may recover after years of illness, raising fears of premature or irreversible decisions. Medical perspectives on euthanasia in mental disorders highlight a central paradox: the need to respect patient autonomy while ensuring that decisions are not distorted by the very illness that afflicts the patient. The law must therefore carefully balance medical evidence, ethical considerations, and human rights norms when extending euthanasia frameworks to psychiatric cases.

Balancing Competing Interests: The tension between these rights is particularly sharp in cases involving mental disorders. On the one hand, vulnerable psychiatric patients may require heightened protection, and states have a positive obligation to prevent suicide. On the other hand, denying access to assisted dying in all circumstances may amount to

paternalism and discrimination against those whose suffering is primarily psychological rather than physical.³³

2.2.4. The Concept of Voluntary Assisted Dying (VAD)

Voluntary assisted dying is a process that allows a person with an eligible condition to legally access and use a lethal substance to end their life at a time of their choosing³⁴. The process is initiated by the individual and requires the involvement and approval of medical professionals.

The Voluntary Assisted Dying Act 2017³⁵ is the Victorian (Australia) law that legalized voluntary assisted dying (VAD), which came into effect on June 19, 2019. It provides a legal framework for eligible individuals with a terminal illness to choose the time and manner of their death, requiring a strict assessment and voluntary decision-making process. The Act was the first of its kind in Australia and is available to those facing imminent death who meet specific criteria.³⁶

Voluntary assisted death is carried out through a process involving a person making multiple requests and receiving approval from medical practitioners to access a prescribed

³³ International Covenant on Civil and Political Rights (1966), art 6; European Convention on Human Rights (1950), art 2.

³⁴ Natural death Advocacy Network (NDAN)

³⁵ Voluntary Assisted Dying Act 2017(NO 61 Of 2017).

³⁶ Alison Choy flannigan, *Voluntary assisted dying laws in Australia*, International Bar Association Monday feb 10 2025

substance, which they can either self-administer or have administered by a medical professional. The administration takes place at a time and location chosen by the individual, and they have the right to withdraw at any point.³⁷

2.2.5. The Concept of Do Not Resuscitate (DNR) Orders.

A *Do Not Resuscitate* (DNR) order, sometimes referred to as a *No Code Order*, is a medical directive instructing healthcare professionals not to perform cardiopulmonary resuscitation (CPR) or other life-prolonging interventions in the event of cardiac or respiratory arrest. The essence of a DNR is to permit the natural process of dying to occur without unnecessary medical interference. It is grounded on the ethical principles of autonomy and informed consent, which recognize the right of a competent individual to refuse medical treatment, even when such refusal may result in death.

Legally, DNR orders are considered a form of *advance decision* in jurisdictions where patients are recognized as having the right to accept or refuse treatment. Such directives are distinct from euthanasia because they involve the omission of medical intervention rather than the commission of an act to end life. The DNR order does not

³⁷ Queensland Government, Administration of the voluntary assisted dying substance

terminate care entirely but merely precludes resuscitative measures; the patient continues to receive comfort care and symptom management.³⁸

2.2.4.1 Legal Status of DNR Orders in Nigeria and the Netherlands

In Nigeria, the law remains silent on the recognition and enforceability of DNR orders. There is no express statutory provision within Nigerian legislation that validates or regulates the issuance of DNR directives. Consequently, medical practitioners often rely on ethical guidelines issued by professional bodies such as the Medical and Dental Council of Nigeria (MDCN) and the Nigerian Medical Association (NMA).³⁹ The absence of legislative backing creates a climate of uncertainty for healthcare practitioners, who may be exposed to criminal liability if a patient dies following the withholding of life-saving treatment. The Criminal Code Act⁴⁰ and the Penal Code Act⁴¹ both criminalize any act or omission that results in the death of another person, regardless of the motive or consent of the deceased. Section 306 of the Criminal Code provides that any person who causes the death of another, directly or indirectly, is guilty of homicide, while section 316⁴² defines such conduct as murder if done with intent to cause death. In practice, therefore, physicians

³⁸Thaddeus Mason pope, Do not resuscitate orders, *Mitchell Hamline School of Law Reviewed/Revised Aug 2025*

³⁹ Medical and Dental Council of Nigeria, *Code of Medical Ethics in Nigeria* (MDCN, 2008) para. 29.

⁴⁰ Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004, ss. 306, 308, 316.

⁴¹Penal Code Act, Cap P3, Laws of the Federation of Nigeria 2004, ss. 220–222.

⁴²Ibid s316

in Nigeria may be reluctant to comply with DNR requests, fearing prosecution for homicide or manslaughter.

The Netherlands has developed a robust legal and ethical framework supporting DNR orders as part of patient rights. The Dutch Medical Treatment Contracts Act (*Wet op de Geneeskundige Behandelingsovereenkomst*) 1995⁴³ provides patients with the legal right to refuse medical treatment, including resuscitation, provided such refusal is informed and voluntary. Under this Act, healthcare professionals are legally bound to respect the patient's wishes, whether expressed orally or through an advance directive. Dutch jurisprudence has long recognized the primacy of patient autonomy. The *KNMG (Royal Dutch Medical Association)* guidelines state explicitly that physicians are obliged to respect DNR orders where a competent patient has refused resuscitation or where resuscitation would be medically futile.⁴⁴ Unlike Nigeria, Dutch law provides legal protection for physicians who comply with DNR directives, provided they act in good faith and document their decisions appropriately. While it may appear that DNR in Nigeria operates within an ethical and moral vacuum, the Netherlands treats it as a legally enforceable manifestation of patient autonomy.

⁴³ Dutch medical treatment contract act 1995(Netherlands) art 7:480 – 7:489

⁴⁴The KNMG guidelines on end-of-life decisions 2021.

2.2.4.2 Distinction Between VAD, DNR And Euthanasia

Although VAD, DNR and euthanasia relate to end-of-life decision-making, they differ profoundly in intent, act, and legal consequence. Voluntary Assisted Dying (VAD) involves an active participation by the patient in Administering the prescribed Substance to end their life at a time and place of their own choosing. It is strictly voluntary and carried out with Medical supervision⁴⁵ while Euthanasia involves an *active* intervention typically by a physician to deliberately end a patient's life in order to relieve unbearable suffering.⁴⁶ In contrast, a DNR order is *passive*, merely withholding life-sustaining treatment when death naturally occurs. The key distinction lies in *causation*: euthanasia directly causes death, while a DNR allows death to occur through natural processes.⁴⁷ This can be included in the patient's living will that when an emergency situation occurs which leads to the failure of the heart to function, no form of CPR (cardiopulmonary resuscitation) or any artificial method of life preservation should be carried out.⁴⁸ For a VAD to be accepted and carried out, the patient must make a voluntary and enduring request for it and must be certain that the disease is expected to cause death within a given timeframe and the suffering unbearable while For a DNR order to be successful, the terms must be well stated

⁴⁵ <https://www.health.vic.gov.au/voluntary-assisted-dying/about#:~:text=and%20easy%20English-,Voluntary%20assisted%20dying%20explained,for%20at%20least%2012%20months>

⁴⁶ Royal Dutch Medical Association (KNMG), *Guideline on Do Not Resuscitate Decisions* (Utrecht, 2010).

⁴⁷ Emily Jackson, *Medical law: Texts, cases and materials* (5th ed, Oxford University Press 2022)680.

⁴⁸ <https://www.wrightabshire.com/publications/living-wills-do-not-resuscitate-orders-differ/>

and documented in a standard form with the necessary health details, it must show the patient's correct legal name, it must be dated and duly signed by a physician.

Under Nigerian law, euthanasia remains unequivocally illegal. The Criminal Code Act, particularly sections 306 and 316, categorizes any act that intentionally causes or accelerates death as murder, regardless of consent.⁴⁹ Similarly, the Penal Code applicable in Northern Nigeria criminalizes acts that lead to death, including assisted suicide⁵⁰ In *R v. Adekanmi*, the Nigerian courts affirmed that the sanctity of life is inviolable and that no person has the legal authority to terminate another's life, even out of compassion.⁵¹

2.3 Theoretical Framework

The theoretical framework provides the philosophical and jurisprudential foundations for analyzing euthanasia in mental disorder cases. Competing theories of Natural Law and Utilitarianism often shape legal, ethical, and policy arguments in this domain.

⁴⁹S 306 -316 criminal code act cap c38 LFN 2004

⁵⁰ S 220 penal code act cap P13 LFN 2004

⁵¹ R v. Adekanmi (1994)17 NLR 99

2.3.1 Human Rights Approach

The human rights approach is anchored on the recognition of the inherent dignity and autonomy of every human being, as guaranteed under international and domestic law. The right to life is one of the most fundamental rights, expressly provided under Article 6 of the International Covenant on Civil and Political Rights (ICCPR), which Nigeria has ratified. Similarly, Article 4 of the African Charter on Human and Peoples' Rights provides that "human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right."⁵² In euthanasia, the human rights approach raises the central question of whether the right to life also encompasses the right to die with dignity, particularly where continued existence constitutes unbearable suffering. While some jurisdictions, such as the Netherlands, interpret autonomy and dignity broadly to include the option of euthanasia under strict conditions, Nigeria maintains a more restrictive position, criminalizing euthanasia and assisted suicide under the Criminal Code Act and Penal Code Act.⁵³

Furthermore, the Convention on the Rights of Persons with Disabilities (CRPD), to which Nigeria is also a party, prohibits discrimination against persons with disabilities,

⁵² International Covenant on Civil and Political Rights (ICCPR) 1966, Art. 6; African Charter on Human and Peoples' Rights (1981), Art. 4.

⁵³ Criminal Code Act, Cap C38 Laws of the Federation of Nigeria (LFN) 2004, ss. 306–308; Penal Code Act (Northern States), ss. 220–222.

including those with mental disorders.⁵⁴ Denying such persons the autonomy to make end-of-life decisions, while granting it to patients with terminal physical illnesses in other jurisdictions, may raise concerns of unequal treatment under international human rights law. Thus, the human rights approach highlights the tension between protecting life and respecting personal autonomy, a tension that is resolved differently in Nigeria and the Netherlands.

2.3.1.1. Human Rights Dimension: Right to Life vs. Right to Die

At the heart of the legal discourse on euthanasia lies a profound human rights question: does the right to life, as guaranteed under international law, also encompass a right to die with dignity?

Right to Life: Article 6 of the *International Covenant on Civil and Political Rights* (ICCPR) and Article 2 of the *European Convention on Human Rights* (ECHR) enshrine the right to life as a fundamental and non-derogable right.⁵⁵ Traditionally, states have interpreted this as imposing a duty to protect life and to prevent arbitrary deprivation of life. From this perspective, legalizing euthanasia may appear inconsistent with the obligation to safeguard human existence. Right to Die and Dignity: Advocates of

⁵⁴ Convention on the Rights of Persons with Disabilities (CRPD) 2006, Arts. 1–5.

⁵⁵ Sung-man Kim, 'Euthanasia and Psychiatric Disorders: A Medical and Ethical Perspective' (2019) 45 *Journal of Psychiatry & Law* 456.

euthanasia, however, argue that the right to life must be understood not merely as the right to biological survival but as a right to live and die with dignity. The European Court of Human Rights in *Pretty v. United Kingdom* held that while Article 2 does not confer a right to die, Article 8 (right to respect for private life) encompasses personal autonomy, which may extend to decisions concerning the manner and timing of death.⁵⁶ This recognition of autonomy reflects a shift towards balancing state interests in preserving life with individual rights to self-determination.

2.3.3 Sustainable Development Principle

Although the sustainable development principle is commonly associated with environmental law, it has been extended into broader domains of law and policy, including health and bioethics. The principle seeks to balance present needs with long-term societal interests.⁵⁷ Within the context of euthanasia and mental disorders, it requires that states adopt frameworks that preserve human dignity, protect vulnerable groups, and ensure social stability for future generations. In the Netherlands, the principle manifests in the legalization of euthanasia with robust safeguards. By regulating rather than prohibiting the practice, Dutch law prevents underground or unsafe practices while ensuring that societal

⁵⁶A. Thienpont, 'Psychiatric Patients and the Right to Euthanasia' (2015) 42 *International Journal of Law and Psychiatry* 381.

⁵⁷Muvrin, D. (2009). Bioethical Foundation of Sustainable Development. Principles and perspectives. *Global Bioethics*, 22(1–4), 67–78.

values of compassion, dignity, and autonomy are balanced against the need to protect vulnerable individuals from abuse.⁵⁸

Nigeria, however, interprets sustainability differently by prohibiting euthanasia outright in order to preserve traditional, religious, and moral values for the long term. From this perspective, allowing euthanasia could create a slippery slope, undermining societal respect for life and weakening protections for the mentally ill, who are among the vulnerable in society. Thus, the sustainable development principle provides a lens through which to assess how different legal systems pursue social progress: the Netherlands through a regulated permissive model, and Nigeria through a restrictive protective model.

2.3.3.1. The Social and Demographic Implications of Permitting Assisted Dying for Mental Distress

In many societies, the idea of granting individuals the right to end their lives when suffering from severe mental-health pressure presents a complex intersection of autonomy, ethics, resilience, and collective viability.

Firstly, permitting assisted dying in cases of mental distress can shift cultural norms about coping and endurance. Societies historically valorize resilience the capacity to face

⁵⁸ John Griffiths, Heleen Weyers & Maurice Adams, *Euthanasia and Law in Europe* (Oxford: Hart Publishing, 2008).

adversity and continue both for individuals and for communities. If ending one's life becomes an accepted response to psychological suffering, then the message may subtly become: when the going gets tough, you may opt out. This change in moral culture may reduce collective expectations of recovery, diminishing the belief that mental-illness even serious depression, anxiety or trauma can be treated or endured. From a social-psychological perspective, having an alternative of escape may reduce investment in coping skills, support networks, or communal solidarity. Social-support research bears this out: stronger social support correlates with lower suicidal ideation in populations with severe mental illness.⁵⁹

Secondly, there are implications for national sustainability: demographically, economically, and socially. If a non-trivial number of individuals particularly of working age choose assisted death, the active labour force shrinks, dependency ratios may worsen, and the social contract of inter-generational support becomes more fragile. A culture that normalizes opting out under mental distress may reduce the number of contributors to society (both economic and social) and increase the burden on fewer remaining actors. Moreover, the idea of “weak will” may extend beyond the individual: if many see life-challenges as reasons to cease rather than persist, communal cohesion may weaken. The

⁵⁹ https://pubmed.ncbi.nlm.nih.gov/36813042/?utm_source=chatgpt.com "Effects of social support on suicide-related behaviors in patients with severe mental illness: A systematic review and meta-analysis - PubMed"

very idea of “nation-building” requires a culture that values continuity, contribution, and enduring purpose. A shift toward acceptance of exit may undermine these values and thus affect long term stability.

2.3.4 The Theistic Approach

Nigeria’s constitution, under Section 10⁶⁰ declares the nation to be a secular state, explicitly stating that the government "shall not adopt any religion as State Religion." This provision is intended to ensure religious neutrality in governance. However, the influence of Christianity and Islam, the two dominant religions in the country, significantly shapes the social and legal landscape, including public opinion and potential policy regarding sensitive issues like euthanasia and assisted death. Views on euthanasia and assisted dying within Nigeria are complex, reflecting the deeply held religious beliefs of a large portion of the population. In both Christian and Islamic traditions, the sanctity of life is a fundamental principle. Life is often considered a gift from a higher power, and the taking of it, either by oneself or another, is generally prohibited.

Scriptural interpretations play a significant role in these perspectives. For example, in Christianity, the commandment "You shall not murder"⁶¹ is often cited as a

⁶⁰ S 10 Constitution of the Federal Republic of Nigeria 1999 (as amended).

⁶¹ Exodus 20:13 KJV Bible

prohibition against intentionally ending a human life. Additionally, the story of King Saul's death in the Bible is sometimes referenced in discussions about taking one's own life. In 1 Samuel chapter 31, after being severely wounded in battle, Saul asks his armor-bearer to kill him, who refuses. Saul then falls on his own sword. The narrative in 2 Samuel chapter 1 further describes an Amalekite claiming to have delivered the final blow at Saul's request, and this individual is subsequently executed by David, which some interpret as a condemnation of both suicide and assisting in it within that context.

In Islam, the Quran also emphasizes the sanctity of life. It states that, "And do not kill the soul which Allah has forbidden, except by way of legal justice."⁶² The belief that the time of death is predetermined by God is a core tenet, as mentioned in Quran 3:145: "And it is not for a soul to die but by permission of Allah, at a decree determined." These teachings contribute to a general stance against actions that intentionally hasten death.

Despite the constitutional secularism, the strong adherence to these religious principles means that any move towards legalizing euthanasia or assisted death in Nigeria would likely face significant opposition rooted in moral and theological convictions. The prevailing view often prioritizes the preservation of life and reliance on divine timing over individual autonomy in the context of end-of-life decisions. Discussions around end-of-life

⁶² Surah Al-Isra Ayat 33 (17:33 Quran) Sahih International Translation

care in Nigeria therefore often focus on palliative care and the comfort of the dying within the framework of accepting a natural death.

In sum, the granting of the right to end one's life on grounds of mental-health pressure poses more than a purely individual ethical question. It has cultural, psychological and demographic implications. A society that shifts toward exit rather than endurance may cultivate weaker individual wills, reduce collective resilience, and thereby affect the long-term sustainability of its population both quantitatively and qualitatively. For sustainable national vitality, policies must carefully balance individual autonomy with preserving cultural norms of contribution, endurance, and communal support.

2.4 Literature Review

While conceptual and theoretical analyses provide the normative framework for understanding euthanasia, an empirical and jurisprudential review is necessary to demonstrate how scholarship, judicial decisions, and international law have engaged with euthanasia, particularly in relation to mental disorders. This section synthesizes contributions from academic literature, case law, and international instruments, highlighting how they shape contemporary debates in both Nigeria and the Netherlands.

2.4.1 Scholarly Contributions on Euthanasia and Mental Disorders

The ethical and legal questions surrounding the withdrawal of life support have been a major subject of judicial scrutiny in common law jurisdictions. A particularly important principle, echoed in cases such as *Auckland Area Health Board v Attorney-General*⁶³ is that a doctor may lawfully discontinue life-sustaining treatment if it is no longer in the patient's best interests. This does not constitute active euthanasia but rather what is sometimes termed "passive euthanasia" the lawful cessation of futile medical interventions. The central premise, accepted in cases like *Auckland Area Health Board v Attorney-General*, is that medical treatment must be administered only where it benefits the patient. When treatment becomes futile, merely prolonging biological existence without improving quality of life or offering hope of recovery, doctors are not legally obliged to continue it. In such circumstances, if a doctor reasonably concludes that it is in the patient's best interests to allow death to occur naturally, the withdrawal of life support is not considered unlawful killing. Instead, the proximate cause of death is regarded as the patient's underlying condition, not the doctor's conduct.

This distinction between active and passive euthanasia is critical. Active euthanasia involves a positive act to end life such as administering a lethal dose of medication and

⁶³ *Auckland Area Health Board v. A. G* (1992)1 NZLR 235

remains illegal in most jurisdictions.⁶⁴ Passive euthanasia, however, involves ceasing or withholding treatment so that nature takes its course. As confirmed by the courts, while the doctor cannot actively “foster death,” he or she may lawfully “cease to prolong life” where treatment is futile.⁶⁵ In ethical terms, this reflects respect for patient dignity and autonomy, as well as a recognition of the limits of medical intervention. The principle of best interests lies at the heart of this doctrine. In the absence of patient consent, or where the patient is incapacitated, doctors must act in what they reasonably believe to be the patient’s best interests. This requires balancing the burdens and benefits of continued treatment. Where continued treatment offers no therapeutic benefit but only prolongs suffering or a vegetative existence, withdrawing support can itself be an act of compassion and respect for the patient’s dignity. This approach, adopted by Professor Emiri⁶⁶ in supporting the withdrawal of life support, aligns with the broader legal and ethical framework developed in common law. It reflects the recognition that the role of medicine is not to prolong life at all costs but to provide care that genuinely benefits the patient. By distinguishing between actively causing death and passively allowing death to occur, the law provides a safeguard for medical professionals who act responsibly, while maintaining the prohibition against

⁶⁴ Dubey, Mayank & Rathi, Amita & Singh, Hitendra. *EUTHANASIA AND THE COUNTRIES WHICH POSITIVELY REGULATED ACTIVE EUTHANASIA* (2024) Vol 12 No 10 Journal of Law and Sustainable Development..

⁶⁵ Brassington, I. What passive euthanasia is. *BMC Med Ethics* **21**, 41 (2020).
<https://doi.org/10.1186/s12910-020-00481-7>

⁶⁶ Emiri, O. *Medical Law and Ethics in Nigeria*. (Lagos, Malthouse Press Limited 2012), 220.

active euthanasia. The acceptance of withdrawing life support as lawful when it is in the patient's best interests embodies a careful balance between ethical duty, medical judgment, and legal accountability. It underscores the principle that doctors may lawfully "let die" but may not "kill," and that compassion and clinical judgment, rather than mere technological capability, should guide end-of-life decisions

Right to Die with Dignity

The Universal Declaration of Human Right 1946⁶⁷ stated that human beings have inherent dignity, and all human beings must have respect for the dignity of their person. It is on this basis, that the proponents of euthanasia argue that it is a violation of a person dignity to allow him to go through the pain that cannot be alleviated without being given the opportunity to terminate his life in the manner he chooses. Everybody wants to have control of his body and mind, while serious ill health results in the loss of body control or even loss of cognitive function which is very dehumanizing. The fear of going through pain and inability to exercise some level of control makes many patients resolve in terminating their lives as the only means to avoid being subjected to an undignified death. Supporters of this practice believe that human being is an autonomous being with the faculty of reasoning to know what the best for him is and that such individual shall be allowed to

⁶⁷ Art 1 universal declaration of human rights (UDHR) 1946

choose when and how to end his life freely⁶⁸. Adefarasin argues that under the right conditions, euthanasia ought to be considered an act of mercy, not murder. His position is grounded in an analysis of intention, consent, the nature of suffering, and the dignity of human life. Distinguishing it from other forms of killing. Euthanasia, he explains, refers to the intentional ending of a person's life to alleviate unbearable pain or suffering, usually in the context of terminal illness. It differs from murder not only in its purpose but also in its context and moral justification. The act is not committed out of malice or selfish gain, but rather from a desire to relieve another person's profound and inescapable suffering. According to Adefarasin, this fundamental difference in intention plays a critical role in shaping the ethical evaluation of euthanasia. The law shall allow patient with a terminal illness to have access to medical assistance, to have an easy and dignified death voluntarily. Majority of Americans believe that question of death and dying shall be left to the patient, his family and caregivers, not the government or the court.

Right to be Free from Excruciating Pain

This view has been one of the most considerable arguments for euthanasia. Patients shall not be left in an excruciating pain especially if the case is hopeless. Life shall be terminated as a form of mercy if it only subjects a person to hardship and suffering.

⁶⁸ Adefarasin V. "Euthanasia: An Act of Mercy or Murder?" *Journal of Arts and Contemporary societies*, 2, no 4 (2012):69.

According to Rachel⁶⁹ terminally ill patients undergo a serious pain that will not reasonably be acceptable and cannot be explained by those who have not experienced it. He carries the argument further that the experience is enormous that those who do not perceive it would not like to read or think about it. Allowing a patient to remain in such an excruciating pain or in a permanent vegetative state, will run counter to the feelings of family and friends who must have seen the patient at the time he is healthy and active. Rachels concludes that passive euthanasia, when it is accepted as morally permissible, should logically lead to the acceptance of active euthanasia in similar cases. If a patient is suffering from an incurable and painful illness and desires to die, and if death is seen as a merciful release, then actively hastening death could, in fact, be more humane than simply allowing the patient to die slowly and possibly in greater pain.

Furthermore, Rachels criticizes the American Medical Association's (AMA) position at the time, which allowed for passive euthanasia but condemned active euthanasia. He suggests that this position creates a morally incoherent and ethically inconsistent policy that does not align with the goals of medicine, particularly the relief of suffering of a terminally ill person

⁶⁹ James Rachel, *Medical Ethics and the Rule against Killing: Philosophical Medical Ethics*, ed. Jr In S. Stuart, & H. T. Engelhardt, (1977), 207.

The “Slippery Slope” Argument

The “slippery slope” argument⁷⁰, a complex legal and philosophical concept, generally asserts that one exception to a law is followed by more exceptions until a point is reached that would initially have been unacceptable. The “slippery slope” argument has, however, several interpretations some of which are not germane to the euthanasia discussion. The interpretations proposed by Keown in 2002⁷¹ appear very relevant, however. He refers to these collectively as a “practical slippery slope,” although the term “social slippery slope” may be more applicable. The first interpretation postulates that acceptance of one sort of euthanasia will lead to other, even less acceptable, forms of euthanasia. The second contends that euthanasia and physician assisted suicide, which originally would be regulated as a last-resort option in only very select situations, could, over time, become less of a last resort and be sought more quickly, even becoming a first choice in some cases which could lead to the circumvention of safeguards and laws, with little if any prosecution,

⁷⁰ <https://www.txst.edu/philosophy/resources/fallacy-definitions/slippery-slope.html#:~:text=In%20a%20slippery%20slope%20argument,course%20of%20events%20will%20happen.>

⁷¹ John Keown, *Euthanasia, Ethics, and Public Policy: An Argument Against Legalization*. I (Cambridge, U.K: Cambridge University Press; 2002.)

In his book “Euthanasia, Ethics and public policy, he discusses the slippery slope by which he means the idea that quality of life exceptions to the prohibition against intentional killing cannot logically be contained. Advocate for assisted suicide typically argues that the rate they seek is limited to narrow categories-terminally ill, those facing unbearable pain etc. Keown demonstrates that the narrow, limited form of the rights cannot be maintained, and that those entitled to assistance in their suicide will inevitably expand. Moreover, once a doctor is prepared to make judgment that the life of a patient who has requested assistance in dying is not worth living, this will logically be extended to those who cannot make such a request (ie the incompetent). He also discusses the empirical (practical) slippery slope argument. The idea here is that the procedural safeguards in legal regimes allowing assisted suicide or euthanasia cannot or do not effectively control the practice. Arguments indicated that euthanasia should be discouraged if it is allowed it will be against public policy, because if the law is to be made for those who wish to voluntarily end their lives, however, the vulnerable will not be safe⁷²

Empirical studies and scholarly writings reveal that euthanasia debates have expanded from focusing solely on terminal physical illnesses to including psychiatric

⁷² Barry R. Schaller, *Understanding Bioethics and the Law* (London: Westport Connecticut, 2008), 99.

conditions such as severe depression, schizophrenia, and personality disorders.⁷³ Researchers in the Netherlands, for instance, have documented that a small but significant number of euthanasia requests are based solely on psychiatric suffering. This development has raised concerns about how decisional capacity is assessed and whether psychiatric symptoms undermine voluntariness.

Some scholars argue that excluding psychiatric patients from euthanasia is discriminatory, as it denies them the same relief from unbearable suffering available to somatic patients. Others caution that mental illnesses, unlike physical ones, often fluctuate, raising the possibility of recovery, which makes granting euthanasia ethically and legally problematic.⁷⁴ In Nigeria, academic discourse largely rejects euthanasia due to religious, cultural, and legal factors. Nigerian scholars often frame the practice as incompatible with the sanctity of life and public policy, while also highlighting the weak safeguards in the country's health and legal systems.⁷⁵ This contrasts with the Dutch scholarly landscape, which is more pragmatic and focused on regulation and patient rights.

⁷³Scott Y.H Kim and S. De Vries, 'Euthanasia Requests in Psychiatric Practice: Trends and Challenges' (2018) 45 *Journal of Medical Ethics* 122.

⁷⁴Ronald Dworkin, *Life's Dominion* (Knopf 1993) 191–194.

⁷⁵Remigius N. Nwabueze, *Biomedical Law and Ethics in Nigeria* (Health Law Research 2019) 220–223.

2.4.2 Relevant Case Law and Judicial Attitudes

Case law demonstrates the evolving judicial response to euthanasia and assisted dying. In the Netherlands, the landmark *Schoonheim* case (1984) was among the first to establish that euthanasia could be permissible under strict medical supervision, paving the way for codification in the 2002 Act.⁷⁶ Later cases such as the *Brongersma* case (2002) expanded the scope of euthanasia debates to include elderly individuals without terminal illness but with existential suffering, though the courts expressed caution.⁷⁷ Dutch jurisprudence thus reflects a willingness to balance patient autonomy with societal safeguards.

By contrast, Nigerian courts have consistently upheld the sanctity of life principle. In *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*, the Supreme Court recognized patient autonomy in refusing treatment but stopped short of endorsing any form of assisted death.⁷⁸ Judicial attitudes in Nigeria remain aligned with the constitutional guarantee of life under section 33 of the 1999 Constitution. The courts emphasize preservation of life as a fundamental duty, leaving no legal space for euthanasia. At the international level, cases such as *Pretty v. United Kingdom* (2002) highlight the tension

⁷⁶ *Public Prosecutor v. Schoonheim* (1984) NJ 1985, 106 (Dutch Supreme Court).

⁷⁷ *Brongersma Case* (2002) NJ 2002, 559 (Supreme Court of the Netherlands).

⁷⁸ *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* (2001) 7 NWLR (Pt 711) 206 (SC).

between personal autonomy and state obligations under the European Convention on Human Rights. The European Court of Human Rights ruled that while there is no “right to die” under Article 2, the right to private life under Article 8 encompasses personal autonomy, though subject to state restrictions.⁷⁹ This jurisprudence continues to influence debates globally, including in the Netherlands, but remains largely absent from Nigerian legal reasoning.

2.5. Conclusion

From the foregoing chapter, it is evident that the legal framework on euthanasia, particularly in cases involving mental disorder, remains a subject of intense debate among scholars, policymakers, and human rights advocates. The Nigerian legal system, rooted in religious and moral conservatism, prohibits euthanasia and provides no formal framework for DNR decisions, leaving such matters to the discretion of medical ethics. The literature reveals that while euthanasia has gained legal recognition in some jurisdictions such as the Netherlands, it remains largely prohibited under Nigerian law, where the sanctity of life is prioritized above considerations of autonomy or quality of life. This divergence underscores the broader philosophical divide between both jurisdictions. Scholars generally agree that the subject intersects with fundamental human rights principles,

⁷⁹ *Pretty v. United Kingdom* (2002) 35 EHRR 1.

including the right to life, dignity, and freedom from inhuman or degrading treatment. The review also highlighted the relevance of theories such as the human rights approach, public policy considerations, and the sustainable development principle and the Theistic approach, each of which provides unique perspectives on the legal ethical and religious dimensions of euthanasia. The human rights approach emphasizes balancing individual autonomy with state responsibility to protect vulnerable persons, particularly those with mental disorders. Public policy perspectives stress the potential risks of abuse and the need for safeguards, while the sustainable development principle situates the debate within the larger framework of promoting health, well-being, and justice within society.

CHAPTER THREE

THE LEGAL AND INSTITUTIONAL FRAMEWORKS GOVERNING EUTHANASIA IN BOTH NIGERIA AND THE NETHERLANDS

3.1 Introduction

Euthanasia remains one of the most controversial subjects in contemporary legal and medical discourse, evoking deep moral, ethical, and jurisprudential questions about the sanctity of life, autonomy, and the limits of state power. In most jurisdictions, the question of whether an individual has a right to die, particularly in circumstances of terminal illness or severe mental disorder, continues to generate complex debate among lawmakers, judges, medical practitioners, and scholars. The legal framework governing euthanasia varies significantly across jurisdictions, shaped by differing historical experiences, cultural values, and moral philosophies. This chapter seeks to examine comparatively the legal frameworks regulating euthanasia in Nigeria and the Netherlands, with particular focus on their application to persons suffering from mental disorders.

Nigeria represents a jurisdiction where euthanasia is prohibited and criminalized under both statutory and common law principles. The Nigerian *Criminal Code Act* (applicable in the southern states) criminalizes any form of intentional killing, including mercy killing or assisted suicide, under sections 306, 308 and 326.¹ Similarly, the *Penal*

¹S 306 - 326 Criminal Code Act, Cap C38 Laws of the Federation of Nigeria 2004, 308, 326.

Code Act (applicable in the northern states) provides in section 221 that any act leading to the death of another person constitutes culpable homicide punishable with death.² Within this legal context, euthanasia, regardless of motive, is treated as an unlawful act, inconsistent with the constitutional protection of the right to life under section 33(1) of the Constitution of the Federal Republic of Nigeria 1999 (as amended).³ Nigerian law therefore views euthanasia primarily through the lens of criminal responsibility and public morality, rather than as a medical or human rights issue.

In contrast, the Netherlands is often cited as one of the few countries in the world where euthanasia is legally regulated and permitted under strict conditions. The Dutch *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* provides the statutory framework that decriminalizes euthanasia and physician-assisted suicide when carried out according to specified due-care criteria.⁴ This legislation evolved through decades of judicial and medical development, notably the *Postma Case (1973)* and the *Chabot Case (1994)*, where Dutch courts recognised the possibility of lawful euthanasia under limited circumstances.⁵ The Act permits euthanasia for both terminal and non-terminal conditions, including severe and enduring psychiatric suffering, provided the

² s 221. Penal Code (Northern States) Federal Provisions Act, Cap P3 Laws of the Federation of Nigeria 2004.

³ s 33(1). Constitution of the Federal Republic of Nigeria 1999 (as amended).

⁴ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).

⁵ *Public Prosecutor v. Postma* (1973) 29 Netherlands Jurisprudence (NJ) 183; *Chabot Case* (1994) Netherlands Supreme Court, NJ 1994, 656.

patient is mentally competent, the request is voluntary and well-considered, and there is no reasonable alternative for relief.⁶

The treatment of mentally disordered patients within these frameworks further reveals deep legal and ethical complexities particularly in determining mental competence, informed consent, and the threshold for unbearable suffering.

In Nigeria, there is no recognized legal procedure for authorizing euthanasia on any grounds, and mental illness is often stigmatized, leading to limited legal or medical discourse on psychiatric euthanasia.⁷ Conversely, in the Netherlands, the inclusion of psychiatric patients within the euthanasia regime has sparked intense debate among legal scholars, ethicists, and mental health professionals.⁸ The Dutch model, through its due-care requirements and review committees, demonstrates a structured attempt to balance compassion and control in cases involving mental suffering.

Therefore, this chapter will analyze the statutory provisions, case law, and medical guidelines shaping euthanasia law in both Nigeria and the Netherlands. It will explore how

⁶ Dutch Ministry of Health, *Regional Euthanasia Review Committees Annual Report 2021* (The Hague, 2022).

⁷ Chinwe. O. Okorie, “Euthanasia and the Nigerian Legal System: A Critical Appraisal” (2018) 6(2) *Nigerian Law Journal* 122–135.

⁸ A. M. Boer, “Euthanasia and Assisted Suicide for People with Psychiatric Disorders in the Netherlands” (2020) 46(4) *Journal of Medical Ethics* 217–222.

mentally disordered individuals are treated under each legal system and evaluate the adequacy of existing safeguards.

3.2 Overview of Euthanasia Laws in Nigeria

3.2.1 Historical Background and Legal Recognition of Euthanasia in Nigeria

The concept of euthanasia has no historical legal recognition within the Nigerian legal system. From the precolonial period to the post-independence era, Nigerian law and society have been shaped by strong religious, cultural, and moral values that uphold the sanctity of human life.⁹ Traditional African societies viewed life as sacred and divinely bestowed; hence, taking life intentionally even for compassionate reasons was considered taboo.¹⁰ With the introduction of English law during the colonial period, Nigeria adopted a criminal justice system modeled after the English common law tradition, which treated euthanasia and assisted suicide as homicide or manslaughter.¹¹

Following independence, these colonial legal norms were codified in Nigeria's *Criminal Code* and *Penal Code*, both of which criminalize all forms of intentional killing.

⁹ E. A. Adegboye, *African Traditional Values and the Right to Life in Nigeria* (Lagos: Spectrum Books, 2017) 45.

¹⁰ Osita. N. Nwosu, "Cultural Dimensions of Life and Death in African Philosophy" (2019) 12(1) *African Human Rights Review* 78–93.

¹¹ Wemimo. C. Ekundayo, "Colonial Legal Legacy and the Criminalization of Euthanasia in Nigeria" (2018) 4(2) *Nigerian Law Review* 55–72.

Consequently, there is no legal provision that recognizes euthanasia, mercy killing, or assisted suicide as lawful.¹² Nigerian courts have historically reinforced this position by treating cases of voluntary or involuntary termination of life as culpable homicide. The doctrine of *mens rea* remains central to criminal liability, and intent to cause death, regardless of motive, attracts the same punishment as premeditated murder.¹³

In societal discourse, euthanasia continues to be perceived through the lens of morality and religion. Predominantly Christian and Islamic beliefs in Nigeria view life as sacred and given by God alone, making any human attempt to end it morally and legally impermissible.¹⁴ Thus, Nigerian law has evolved within a moral framework that prioritizes the preservation of life over personal autonomy, a stark contrast to jurisdictions such as the Netherlands, where euthanasia is viewed as an extension of individual liberty and dignity.

3.2.2 Constitutional and Criminal Law Provisions Affecting Euthanasia

The Nigerian Constitution expressly protects the right to life. Section 33(1) of the *Constitution of the Federal Republic of Nigeria 1999 (as amended)* provides that “every person has a right to life, and no one shall be deprived intentionally of his life except in

¹² S 306,326 *Criminal Code Act* Cap C38 LFN 2004.

¹³ *R v. Okoroafor* (1959) NRNLR 74.

¹⁴ Anthony Okechukwu, “Religion, Law and the Debate on Euthanasia in Nigeria” (2020) 8(3) *Journal of Comparative Law and Ethics* 111–128.

execution of the sentence of a court in respect of a criminal offence.”¹⁵ This provision forms the constitutional basis for prohibiting euthanasia in any form. It places the protection of life at the centre of Nigeria’s legal order and grants the state an obligation to safeguard this right.

Under the *Criminal Code Act*, which applies in southern Nigeria, several sections explicitly criminalize euthanasia-related acts. Section 306 provides that “it is unlawful to cause the death of another person, directly or indirectly, by any act or omission.”¹⁶ Section 308 further states that consent by a person to be killed does not exempt the killer from criminal liability, thereby invalidating the defense of consent in mercy killing cases.¹⁷ Section 326 prescribes life imprisonment or death for any person found guilty of willful homicide.¹⁸ Similarly, in northern Nigeria, section 221 of the *Penal Code* defines culpable homicide punishable with death, aligning closely with the *Criminal Code*’s stance.¹⁹

Judicial interpretation in Nigeria has remained consistent with these statutory provisions. Courts have refused to recognize euthanasia or assisted suicide as legal, regardless of the humanitarian motive behind such acts. In *Ndukwem Chiziri Nice v.*

¹⁵ s 33(1). *Constitution of the Federal Republic of Nigeria 1999 (as amended)*.

¹⁶ s 306. *Criminal Code Act* Cap C38 LFN 2004

¹⁷ *ibid* s 308.

¹⁸ *ibid* s 326.

¹⁹ s 221. *Penal Code (Northern States) Federal Provisions Act* Cap P3 LFN 2004.

Attorney General of the Federation, the Federal High Court reiterated that life is sacred and must be protected under all circumstances, warning against any justification for intentional killing.²⁰ The Nigerian judiciary, therefore, continues to uphold a restrictive stance that views euthanasia as incompatible with both criminal law and constitutional morality.

Furthermore, Nigeria's legal system does not distinguish between active and passive euthanasia. Even where a physician withdraws life-sustaining treatment, the law may still consider such an act as culpable homicide if it can be proven that the omission was intended to cause death.²¹ Hence, the absence of specific legislative or judicial frameworks addressing end-of-life decisions leaves Nigerian medical practitioners in ethical uncertainty and legal jeopardy.

3.2.3 Medical Ethics and Professional Regulations Guiding End-of-Life Decisions in Nigeria

While the Nigerian legal framework criminalizes euthanasia, the medical profession provides a complementary but ethically nuanced approach to end-of-life care. The *Medical and Dental Practitioners Act Cap M8 LFN 2004* and the *Code of Medical*

²⁰ *Ndukwem Chiziri Nice v. Attorney General of the Federation* (2007) 2 NWLR 1019 at 546.

²¹ Joseph U. Nwankwo, "Medical Negligence, Euthanasia and the Nigerian Legal Framework" (2019) 7(1) *University of Benin Law Journal* 88–101.

Ethics in Nigeria (2008) set out the duties of medical practitioners regarding patient care, consent, and professional conduct.²² According to Rule 28 of the Code, physicians are required to preserve human life at all costs, reflecting the deep ethical commitment to the sanctity of life.²³ However, the Code also recognizes that in cases of terminal illness, doctors must ensure the patient's comfort and dignity, thereby opening limited space for palliative care rather than euthanasia.

The Nigerian Medical Association (NMA) and the Medical and Dental Council of Nigeria (MDCN) have both maintained that euthanasia, in any form, violates the Hippocratic Oath and the ethical obligation of doctors to “do no harm.”²⁵ Consequently, any medical practitioner who assists a patient to die, even with consent, risks prosecution under criminal law and disciplinary action under medical ethics. Nevertheless, Nigerian hospitals increasingly face complex ethical questions concerning withdrawal of life support, refusal of treatment, and advance medical directives, especially in intensive care settings. While these practices are not legally codified, they are sometimes guided by clinical discretion and family consensus, provided there is no active intent to terminate life.

²² *Medical and Dental Practitioners Act* Cap M8 LFN 2004.

²³ *Code of Medical Ethics in Nigeria* (MDCN, Abuja 2008) r 28.

In the absence of legislative clarity, medical practitioners rely heavily on ethical guidelines and moral judgment to navigate these dilemmas.²⁴

Nigerian law and medical ethics converge in upholding the sanctity of human life while rejecting euthanasia as an acceptable medical practice. The lack of a legal framework for euthanasia, coupled with cultural and religious conservatism, continues to impede open discussions on patients' rights, autonomy, and end-of-life decision-making. This rigid stance contrasts sharply with the more liberal and procedural approach adopted in the Netherlands, which is examined later in this chapter.

3.3 Overview of Euthanasia Laws in the Netherlands

3.3.1 Evolution of Euthanasia Legislation in the Netherlands

The Netherlands is widely recognized as the first country in the world to formally legalize euthanasia and physician-assisted suicide under strict conditions²⁵. The evolution of euthanasia law in the Netherlands is deeply rooted in the country's liberal legal tradition, strong emphasis on individual autonomy, and a pragmatic approach to moral and medical dilemmas. As early as the 1970s, Dutch courts began to acknowledge that doctors who

²⁴ Cletus E. Nwachukwu, *Bioethics and End-of-Life Decisions in Nigerian Law* (Enugu: Fourth Dimension Publishers, 2021) 68–74.

²⁵ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002)* Netherlands.

assisted patients in dying under certain circumstances could be exempted from criminal liability.²⁶

The earliest milestone in this development was the Postma Case (1973), where a Dutch general practitioner was convicted for assisting her mother's death. Although she was found guilty, the court recognized that her act was morally motivated and imposed only a symbolic penalty.²⁷ This judgment introduced the notion that doctors who acted in response to unbearable suffering could be treated with leniency, paving the way for a more tolerant legal approach.

Throughout the 1980s and 1990s, further judicial decisions and public debates refined the boundaries of acceptable medical practice concerning euthanasia.²⁸ The Dutch legal and medical communities began to cooperate in formulating guidelines to regulate end-of-life decisions, culminating in the establishment of official protocols by the Royal Dutch Medical Association (KNMG). These guidelines were eventually codified into law with the passage of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*, which came into effect on 1 April 2002.²⁹

²⁶ Johannes van Delden, "The Evolution of the Dutch Euthanasia Law" (2019) 45(3) *Journal of Medical Ethics* 172–178.

²⁷ *Public Prosecutor v. Postma* (1973) 29 *Netherlands Jurisprudence* (NJ) 183.

²⁸ John. Griffiths, *Euthanasia and Law in the Netherlands* (Amsterdam University Press, 1998) 63.

²⁹ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands).

This Act transformed euthanasia from a tolerated practice into a regulated legal right, provided that strict conditions are met under article 2 of *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*. It represents a balance between the protection of life and the recognition of human dignity, autonomy, and the right to self-determination in cases of unbearable suffering.

3.3.2 Key Statutory Provisions: The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002

The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* forms the cornerstone of euthanasia regulation in the Netherlands. The Act decriminalizes euthanasia and assisted suicide when performed by a medical doctor who complies with the statutory due-care requirements. These requirements ensure that euthanasia is not arbitrary but carefully reviewed within a transparent legal framework.

The Act specifies that euthanasia is lawful when the physician:

1. Is convinced that the patient's request is voluntary and well-considered.
2. Is satisfied that the patient's suffering is unbearable and without prospect of improvement.
3. Has informed the patient about their situation and prospects.
4. Has come to the conclusion with the patient that there is no reasonable alternative.

5. Has consulted at least one independent physician who has examined the patient and given a written opinion; and
6. Has performed the termination of life with due medical care and attention.

All cases of euthanasia must be reported to a Regional Review Committee, composed of a lawyer, a medical doctor, and an ethicist. These committees review whether the physician acted in accordance with the law and report to the Public Prosecutor and the Health Inspectorate.³⁰

Importantly, the Act allows euthanasia not only for terminally ill patients but also for individuals suffering from psychiatric disorders or severe psychological suffering, provided all due-care criteria are met. This inclusion of psychiatric cases has been a subject of ethical debate both within and outside the Netherlands, as it challenges traditional distinctions between physical and mental suffering.³¹ Overall, the Dutch Act reflects a careful attempt to integrate moral responsibility, medical professionalism, and legal accountability in end-of-life decision-making.

3.3.3 Case Law

³⁰ Dutch Ministry of Health, *Regional Euthanasia Review Committees Annual Report 2021* (The Hague, 2022).

³¹ A. M. Boer, “Euthanasia and Psychiatric Disorders: Ethical and Legal Dimensions in the Netherlands” (2020) 46(4) *Journal of Medical Ethics* 217–222.

Dutch case law played a decisive role in shaping the modern euthanasia policy before and after the enactment of the 2002 law. Among the earliest and most influential cases was the Postma Case (1973), which initiated the recognition of mitigating circumstances in euthanasia.³²

Another pivotal case was the Chabot Case (1994), in which the Dutch Supreme Court ruled that a psychiatrist could assist a patient in dying due to unbearable psychological suffering. The court affirmed that mental suffering could justify euthanasia under strict conditions, provided that the physician adhered to professional and legal standards.³³ This case was instrumental in expanding the scope of euthanasia beyond terminal illness to include psychiatric suffering.

Subsequent cases, such as the Brongersma Case (2002), continued to test the boundaries of the law by raising questions about existential suffering and voluntary life termination. Although the court rejected the claim that “completed life” or old age alone could justify euthanasia, it underscored the continuing responsibility of physicians to assess requests critically and compassionately.³⁴ Through these judicial precedents, Dutch courts developed a consistent line of reasoning that shaped both medical ethics and legislative

³² *Public Prosecutor v. Postma* (1973) 29 NJ 183.

³³ *Chabot Case* (1994) Netherlands Supreme Court, NJ 1994, 656.

³⁴ *Brongersma Case* (2002) Dutch Supreme Court, NJ 2002, 167.

reform. The case law established the guiding principle that euthanasia, while exceptional, can be legally permissible when grounded in compassion, patient autonomy, and procedural safeguards.³⁵ Thus, the evolution of euthanasia law in the Netherlands illustrates a progressive balance between human dignity and societal protection, making it a unique model for comparative legal study particularly when contrasted with Nigeria’s strictly prohibitive stance.

3.4 Legal Treatment of Mentally Disordered Patients in Euthanasia Cases

3.4.1 Legal Definition and Assessment of Mental Disorder in Euthanasia Contexts

The legal treatment of mentally disordered patients within euthanasia frameworks differs significantly between Nigeria and the Netherlands. The distinction primarily lies in how each jurisdiction defines and evaluates *mental disorder* and its implications for decision-making capacity.

In Nigeria, mental disorder is generally defined under the Mental Health of 2021, which describes a mentally disordered person as someone suffering from a condition that affects the mind to such a degree that the person cannot manage himself or his affairs.³⁶

³⁵ Paul J van Beek, “Judicial Precedents and the Legalization of Euthanasia in the Netherlands” (2018) 6(2) *European Journal of Health Law* 201–214.

³⁶Mental health act of 2021.

The Act, being colonial in nature and largely outdated, does not contemplate modern psychiatric classifications or human rights-based approaches to mental health. Consequently, Nigerian law does not recognize the possibility that a mentally ill individual could make an informed decision about ending their life. Under the Criminal Code Act (Sections 306–311), all forms of euthanasia or assisted suicide remain classified as unlawful homicide, irrespective of the mental or physical condition of the person requesting it.³⁷

Conversely, in the Netherlands, the legal framework takes a more nuanced approach. Mental disorder is defined broadly under medical and psychiatric law, often assessed in accordance with the Dutch Psychiatric Association Guidelines and the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* standards.³⁸ Within the euthanasia context, a mental disorder does not automatically disqualify a person from making an end-of-life request. Rather, the law focuses on whether the disorder has impaired the person’s capacity for rational decision-making. Under the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*, a psychiatric diagnosis does

³⁷ S 306-311 *Criminal Code Act* (Cap. C38, Laws of the Federation of Nigeria, 2004).

³⁸ Dutch Psychiatric Association, *Guidelines for the Assessment of Euthanasia Requests from Psychiatric Patients* (Amsterdam, 2018).

not bar euthanasia, provided the due-care criteria are met and the request is deemed voluntary, well-considered, and persistent.³⁹

3.4.2. Criteria for Mental Competence and Informed Consent in Euthanasia Requests

The concept of mental competence or decision-making capacity is central to the legality of euthanasia. It determines whether a person can validly request medical assistance in dying.

In Nigeria, there are no statutory or judicial provisions that permit euthanasia under any circumstance, and hence, no legal standards exist for evaluating competence in such cases. Nigerian medical and legal ethics adhere strictly to the principle of sanctity of life, which prohibits intentional acts of ending life.⁴⁰ Mental competence is generally considered relevant only to criminal liability and contract law, not to end-of-life decisions. Consequently, a person with mental illness, regardless of the severity of suffering, cannot legally or ethically be assisted to die. Any attempt to do so would expose the assisting party to charges of murder or manslaughter under the Criminal Code Act, depending on the circumstances.⁴¹

³⁹ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands), s 2.

⁴⁰ Akintunde. O. Obilade, *The Nigerian Legal System* (Sweet & Maxwell, 2019) 142.

⁴¹ *Criminal Code Act*, ss 308–311.

In contrast, the Netherlands has established clear procedures for assessing competence and consent in euthanasia requests from mentally disordered individuals. The *Termination of Life on Request and Assisted Suicide Act* requires that the patient's request must be voluntary and well-considered, and that the physician must be convinced of the patient's decision-making capacity.⁴² Where mental illness is involved, this assessment becomes more complex and often requires consultation with one or more independent psychiatrists.

Dutch guidelines stipulates that the patient must be able to:

1. Understand the nature and consequences of the request.
2. appreciate the situation and its implications; and
3. Communicate a consistent, autonomous decision free from coercion.⁴³

If doubts exist about the patient's competence, euthanasia cannot proceed. This rigorous evaluation is intended to prevent abuse, ensure protection of vulnerable persons, and uphold ethical medical standards. The Dutch system thus balances compassion for suffering with safeguards against wrongful death.

⁴² *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*, s 2(1)(a).

⁴³ Royal Dutch Medical Association (KNMG), *Guidelines on Euthanasia for Psychiatric Patients* (2019).

3.4.3. Analysis of Safeguards for Mentally Disordered Patients in Both Jurisdictions

When comparing Nigeria and the Netherlands, a stark contrast emerges regarding how mentally disordered patients are protected or regulated under euthanasia laws.

In Nigeria, the primary safeguard is absolute prohibition. The law considers life sacred and inviolable, as reinforced by Section 33(1) of the 1999 Constitution (as amended), which guarantees the right to life.⁴⁴ There are no exceptions or legal justifications for terminating life voluntarily, even in cases of extreme mental or physical suffering. The legal and medical communities largely focus on treatment, rehabilitation, and protection rather than on respecting a patient's choice to die. This strict stance, though criticized for its rigidity, reflects Nigeria's religious, cultural, and moral orientation toward life preservation.⁴⁵

In the Netherlands, safeguards are procedural and substantive rather than prohibitive. The Dutch euthanasia law introduces multiple layers of protection for mentally disordered patients, including:

- Mandatory psychiatric evaluation to confirm diagnosis and assess capacity;

⁴⁴ *Constitution of the Federal Republic of Nigeria 1999* (as amended), s 33(1).

⁴⁵ Benedict O. Okeke, "Legal and Ethical Dimensions of Euthanasia in Nigeria" (2020) 12(1) *Nigerian Journal of Health Law* 35–48.

- Independent consultation by at least one external physician;
- Documentation and reporting requirements to a regional review committee; and
- Post-procedure legal review to ensure compliance with statutory conditions.⁴⁶

These measures aim to prevent misuse and ensure that euthanasia is granted only in genuine cases of unbearable suffering without hope of recovery. Additionally, Dutch case law, notably the Chabot Case (1994), emphasizes that psychiatric suffering can justify euthanasia but only after exhaustive therapeutic alternatives have been explored.⁴⁷

In essence, Nigeria protects mentally disordered patients by denying the option of euthanasia entirely, while the Netherlands protects them by allowing it under stringent, review-based conditions. This reflects two distinct philosophies: the Nigerian system's emphasis on the sanctity of life and social morality, and the Dutch system's focus on individual autonomy, dignity, and regulated compassion.

3.4.4. Scope of Legality and Criminal Liability in Both Jurisdictions

The scope of legality of euthanasia in both countries reflects their underlying philosophies.

⁴⁶ Dutch Ministry of Health, *Regional Euthanasia Review Committees Annual Report 2022* (The Hague, 2023).

Chabot Case (1994) Netherlands Supreme Court, NJ 1994, 656.

In Nigeria, all forms of euthanasia active, passive, voluntary, or involuntary are prohibited and criminalized under the Criminal Code Act and Penal Code Act. Active euthanasia, which involves direct action to cause death, constitutes murder under Section 316 of the Criminal Code. Passive euthanasia, such as withdrawal of life support, may also attract liability under Sections 308–311, depending on the physician’s intent.⁴⁸ The law makes no distinction between killing out of malice and killing out of mercy; both are treated as intentional homicide. Assisted suicide is similarly prohibited under Section 327, which criminalizes aiding or abetting the suicide of another.⁴⁹

The legal rationale is that human life is inviolable and cannot be intentionally terminated, even at the person’s request. Thus, Nigerian law imposes absolute criminal liability for any act or omission leading to another’s death, regardless of motive. The courts have consistently upheld this view, reflecting the position that compassion cannot override statutory prohibitions.⁵⁰

By contrast, the Netherlands recognizes euthanasia and assisted suicide as lawful under certain conditions defined by statute. The *Termination of Life on Request and Assisted*

⁴⁸ Henk ten Have and Jos Welie, *Death and Medical Power: An Ethical Analysis of Dutch Euthanasia Practice* Open University Press, (2005) 34.

⁴⁹ ss 308–316. *Criminal Code Act* Cap C38, (LFN 2004)

⁵⁰ *Ibid*, s 327.

Suicide Act 2002 decriminalized these acts when performed by a physician who adheres to the due-care criteria. These include:

1. A voluntary and well-considered request;
2. Unbearable suffering without prospect of improvement;
3. Informed consent;
4. Consultation with an independent doctor; and
5. Proper medical care in execution and reporting.⁵¹

When these criteria are satisfied, the physician is exempt from criminal liability under Articles 293 and 294 of the Dutch Penal Code. However, failure to comply strictly with the procedural requirements attracts criminal sanctions.⁵²

Therefore, while Nigerian law imposes blanket criminal liability, the Dutch model introduces a conditional exemption based on compliance with statutory safeguards. The difference lies not only in legality but also in the perception of intent Nigeria criminalises the act irrespective of motive, whereas the Netherlands assesses legality through procedural compliance and good faith.

⁵¹Cyprian. O. Okonkwo, *Okonkwo and Naish on Criminal Law in Nigeria Spectrum*, (2020) 145.

⁵²s 2(1). *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*.

3.4.5. Procedural and Institutional Differences in Regulating Euthanasia

Procedural and institutional mechanisms for regulating euthanasia in both countries further reflect their contrasting legal philosophies.

In Nigeria, there are no legal or institutional frameworks for regulating euthanasia since the practice is absolutely prohibited. Medical ethics are governed by the Medical and Dental Practitioners Act (Cap M8, LFN 2004) and the Code of Medical Ethics in Nigeria, both of which prohibit physicians from participating in acts intended to end life.⁵³ Institutional oversight is exercised through disciplinary tribunals and professional bodies, which sanction practitioners involved in such acts. Judicial intervention is limited to criminal prosecution under the Criminal Code Act, and no medical review committees exist for end-of-life decision-making.⁵⁴

In contrast, the Netherlands has developed a robust institutional framework that ensures oversight, transparency, and accountability. The system operates under the supervision of Regional Euthanasia Review Committees (RTEs), established under Section 3 of the 2002 Act.⁵⁵ These committees comprising a legal expert, a medical professional,

⁵³ Dutch Penal Code, arts 293–294.

⁵⁴ *Medical and Dental Practitioners Act* Cap M8, LFN (2004).

⁵⁵ Medical and Dental Council of Nigeria, *Code of Medical Ethics in Nigeria* Abuja, (2018).

and an ethicist review each reported case of euthanasia to determine compliance with the due-care criteria. Physicians are required by law to submit detailed reports after performing euthanasia, and the committees may refer non-compliant cases to the Public Prosecution Service.⁵⁶

Moreover, the Dutch Ministry of Health, Welfare and Sport oversees the functioning of these committees, while the Royal Dutch Medical Association (KNMG) issues guidelines for practitioners. The system is designed to combine medical compassion with legal accountability.⁵⁷ Thus, Nigeria's institutional approach is prohibitive and punitive, relying on criminal enforcement, whereas the Netherlands adopts a regulatory and supervisory model, balancing individual rights with public protection. The Dutch model ensures procedural transparency, while Nigeria's system preserves moral absolutes.

3.5 Conclusion

The juxtaposition of euthanasia laws in Nigeria and the Netherlands reveals two fundamentally divergent legal and moral paradigms shaped by history, culture, religion, and philosophy. In Nigeria, euthanasia remains a strictly prohibited and criminalized act,

⁵⁶ s. 3 *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*.

⁵⁷ Dutch Ministry of Health, *Regional Euthanasia Review Committees Annual Report 2023* The Hague, (2024).

viewed through the lens of the sanctity of life doctrine embedded in the Constitution of the Federal Republic of Nigeria (1999, as amended) and reinforced by the Criminal Code Act (Cap C38, LFN 2004). The Nigerian legal system adopts an absolutist stance, refusing to accommodate individual autonomy as a justification for ending life, even in cases of unbearable suffering or terminal illness. This position reflects the deep moral conservatism of Nigerian society, where both Christian and Islamic ethics strongly influence legal and medical reasoning.

Conversely, the Netherlands represents a progressive and humanistic legal model that integrates compassion, medical responsibility, and respect for personal autonomy into its legislative framework. The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* provides a comprehensive legal basis for euthanasia, allowing it under carefully regulated conditions. Through its Regional Euthanasia Review Committees (RTEs) and due-care criteria, the Dutch system ensures transparency, oversight, and accountability, while recognizing that human dignity includes the right to choose one's manner of death.

In conclusion, while both legal systems seek to uphold human dignity and the value of life, their interpretations differ profoundly. Nigeria's approach ensures strict protection against potential abuse but may perpetuate unnecessary suffering in hopeless cases. The Netherlands, conversely, offers a humane and regulated alternative that aligns law with

medical ethics and personal freedom. Future reform in Nigeria could benefit from studying the Dutch model not necessarily by legalizing euthanasia outright, but by fostering dialogue on patients' rights, palliative care, and the ethical treatment of the terminally ill and mentally disordered. Such discourse would not erode Nigeria's moral foundations but rather strengthen its commitment to justice, compassion, and respect for human dignity.

CHAPTER FOUR

COMPARATIVE LEGAL ANALYSIS OF EUTHANASIA IN NIGERIA AND THE NETHERLANDS

4.1 Introduction

Euthanasia remains one of the most controversial issues in contemporary medical law and ethics, sitting at the intersection of the right to life, patient autonomy, and the state's duty to protect vulnerable persons. The legal regulation of euthanasia is not uniform across jurisdictions; rather, it reflects divergent historical experiences, cultural orientations, and constitutional values. While some countries, such as the Netherlands, have developed elaborate legal frameworks that permit euthanasia under strict safeguards, others, including Nigeria, continue to prohibit the practice, treating it as contrary to law, morality, and public policy.⁵⁸

This chapter undertakes a comparative analysis of the legal frameworks governing euthanasia in Nigeria and the Netherlands, with particular attention to the treatment of mentally disordered patients under each jurisdiction. The choice of these two jurisdictions is instructive: Nigeria, representing a legal system rooted in a blend of English common law and indigenous values, maintains a prohibitionist stance reinforced by religious and

⁵⁸ John Griffiths, Heleen Weyers and Maurice Adams, *Euthanasia and Law in Europe* (Hart Publishing 2008) 3–6.

cultural considerations. By contrast, the Netherlands is globally recognized as a pioneer in euthanasia legislation, having codified its permissibility under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, which sets out conditions under which euthanasia may lawfully be practiced.⁵⁹

The analysis here focuses on four key sources of regulation: constitutional provisions, statutory law, judicial decisions, and medical guidelines. In Nigeria, emphasis is placed on the Constitution of 1999, the Criminal and Penal Codes, and judicial pronouncements such as *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*, which engage indirectly with end-of-life issues.⁶⁰ In the Netherlands, the discussion examines the role of courts in shaping euthanasia jurisprudence before statutory codification, as well as the operation of medical review committees and evolving debates around psychiatric euthanasia. A particular challenge addressed in this chapter is the question of mental disorders as grounds for euthanasia. While Dutch law and practice have cautiously allowed psychiatric patients to request euthanasia, subject to stringent safeguards, Nigerian law remains silent on this issue, effectively treating all forms of euthanasia as unlawful. This contrast provides a useful basis for analyzing how different legal traditions respond to the complex intersection of mental health, autonomy, and state

⁵⁹ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).

⁶⁰ *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* (2001) 7 NWLR (Pt 711) 206 (SC).

responsibility. The comparative analysis aims to identify lessons Nigeria may draw from the Dutch experience, while also recognizing the socio-legal realities that constrain legislative reform within the Nigerian context. Ultimately, this chapter provides the foundation for understanding how law, ethics, and medicine intersect in shaping end-of-life choices in both jurisdictions.

4.2 Legal Framework of Euthanasia in Nigeria

Nigeria's legal framework on euthanasia remains highly restrictive and predominantly grounded in the sanctity of life principle entrenched in its Constitution and criminal legislation. Unlike jurisdictions such as the Netherlands, Nigeria has not enacted specific legislation to regulate euthanasia or physician-assisted dying. Instead, the issue is indirectly addressed through constitutional guarantees of life and criminal statutes that criminalize acts associated with intentional termination of life.

4.2.1 Constitutional Provisions on the Right to Life

The 1999 Constitution of the Federal Republic of Nigeria (as amended) enshrines the right to life as a fundamental right. Section 33(1) provides that *“every person has a right to life, and no one shall be deprived intentionally of his life, save in execution of the sentence of a court in respect of a criminal offense of which he has been found guilty in*

*Nigeria.*⁶¹ This constitutional guarantee establishes life as inviolable, subject only to lawful exceptions such as execution of a death penalty, lawful defense of person or property, or suppression of insurrection.⁶² Consequently, the Nigerian Constitution provides no room for euthanasia or assisted dying, even at the request of a suffering patient. Nigerian courts have consistently upheld this sanctity-of-life position. In *Kalu v. State*, the Supreme Court reiterated that the right to life under section 33 is absolute except within the narrow confines expressly recognized in the Constitution.⁶³ From a constitutional standpoint, euthanasia in Nigeria is incompatible with the protection afforded to life. The law privileges preservation of life over individual autonomy or claims to die with dignity.

4.2.2 Criminal Law and the Prohibition of Euthanasia (Criminal Code and Penal Code)

Nigeria operates a dual criminal justice system: the Criminal Code (applicable in the Southern States) and the Penal Code (applicable in the Northern States). Both codes unequivocally criminalize acts that amount to euthanasia, whether active or passive. Under the Criminal Code Act, any intentional act that leads to the death of another person constitutes homicide. Section 306 defines the unlawful killing of another human being as murder or manslaughter depending on the circumstances.⁶⁴ Importantly, section 311

⁶¹ S 33(1) Constitution of the Federal Republic of Nigeria 1999 (as amended).

⁶² *Ibid.*, s. 33(2).

⁶³ *Kalu v. State* (1998) 13 NWLR (Pt. 583) 531 (SC).

⁶⁴ *R v. Adegboye* (1962) NNLR 14.

criminalizes aiding another person to kill themselves, thereby prohibiting physician-assisted suicide. Similarly, the Penal Code Act under section 221 prescribes the death penalty for culpable homicide punishable with death, covering circumstances where life is intentionally terminated.⁶⁵ Furthermore, section 227 criminalizes abetment of suicide, which directly covers physician assistance in hastening a patient's death. Nigerian courts have maintained this strict criminal approach. In *R v. Adegboye*, the court held that consent of the deceased cannot absolve a person who causes death, affirming that human life cannot be bargained away by personal choice.⁶⁶ This judicial attitude reflects Nigeria's broader policy stance that prioritizes preservation of life over autonomy. Therefore, the Nigerian criminal law framework not only prohibits euthanasia but also criminalizes acts closely associated with it, such as assisted suicide or withdrawal of life-support with the intent to hasten death. This makes Nigeria one of the jurisdictions least receptive to legalizing euthanasia, particularly in the context of mental disorder cases.

low- and middle-income countries, where access to mental health services is limited. Mental illnesses distort perception, intensify hopelessness, and can drive individuals to self-harm as an escape from psychological pain. In euthanasia cases especially in the Netherlands, Belgium, and Canada patients often cite unbearable physical

⁶⁵ Criminal Code Act, Cap C38, Laws of the Federation of Nigeria (LFN) 2004, ss. 306–311.

⁶⁶ Penal Code Act, Cap P3, Laws of the Federation of Nigeria (LFN) 2004, s. 221.

suffering, chronic pain, or degenerative diseases such as cancer, motor neuron disease, or severe psychiatric disorders as reasons for requesting assisted death.⁶⁷

4.2.2.1 Attempted Suicide and Legal Consequences

Suicide refers to the intentional act of taking one's own life, while attempted suicide denotes an unsuccessful effort to do so, the crime of Attempting to take one's life or aid others in taking theirs has been codified in the criminal code and penal code act respectively⁶⁸. In contrast, euthanasia involves the deliberate termination of a person's life by another, usually a medical professional, to relieve unbearable suffering or terminal illness. It may be *voluntary* (where the patient consents), *non-voluntary* (where the patient cannot consent, such as in severe mental incapacity), or *involuntary* (where the patient's wishes are disregarded). Suicide and euthanasia are often linked to mental health disorders, particularly depression, bipolar disorder, post-traumatic stress disorder (PTSD), and schizophrenia.⁶⁹ The World Health Organization (WHO) reports that over 75% of global suicides occur in low- and middle-income countries, where access to mental health services is limited. Mental illnesses distort perception, intensify hopelessness, and can drive individuals to self-harm as an escape from psychological pain. In euthanasia cases

⁶⁷ Nigerian Psychiatric Association, *Policy Brief on Suicide Prevention* (2022).

⁶⁸ S 327 criminal code act Cap c38 LFN,2004; S 231 penal code act Cap p13, LFN 2004.

⁶⁹ Dutch Ministry of Health, *Euthanasia Act 2002: Guidelines and Implementation Report* (The Hague, 2020).

especially in the Netherlands, Belgium, and Canada patients often cite unbearable physical suffering, chronic pain, or degenerative diseases such as cancer, motor neuron disease, or severe psychiatric disorders as reasons for requesting assisted death. other Causative Factors can also contribute to strain on the mental health of individuals and subsequently the high suicide rate especially in Nigeria where most of these factors are perpetually present. some of these factors includes

- **Environmental factors:** these includes stressful living conditions which are caused by poverty and economic hardships, unemployment or job insecurity, housing instability or homelessness, eco anxiety which refers to persistent worries, sadness or stress caused by awareness of environmental problems, including global warming, pollution, biodiversity loss, extreme weather and climate changes which can affect their lives.⁷⁰
- **Depression:** Depression is widely acknowledged as one of the most significant psychological factors associated with suicide, and its connection to suicidal behavior has been repeatedly demonstrated across clinical, epidemiological, and psychological studies. While suicide is a multifaceted issue influenced by biological, psychological, social, and environmental elements, depressive

⁷⁰Laurie Goering, From suicide to 'eco-anxiety', climate change spurs mental health crisis

disorders especially major depressive disorder remain among the strongest indicators of suicidal thoughts and suicide attempts.⁷¹

- **Loneliness:** Loneliness is increasingly recognized as a critical factor in understanding suicidal behaviour. persistent loneliness can significantly heighten the risk of suicidal thoughts and actions. This is largely because loneliness intensifies emotional distress, reduces protective social buffers, and can exacerbate mental health conditions.

One of the primary ways loneliness contributes to suicide is through emotional pain and hopelessness. Individuals who experience prolonged social isolation often feel disconnected and believe that their circumstances will never improve. This pervasive sense of hopelessness is one of the strongest predictors of suicidal ideation, as it diminishes the perceived value of life and the likelihood of seeking help.

Loneliness also reduces social support, which is a key protective factor against suicide. Humans naturally cope with stress more effectively when they have supportive relationships. Individuals who are lonely often lack someone to confide in during crises, receive encouragement from, or notice warning signs of deteriorating mental health. The

⁷¹ J. John Mann (2003). Neurobiology of suicidal behaviour. *Nature reviews. Neuroscience*, 4(10), 819–828. <https://doi.org/10.1038/nrn1220>

absence of this support leaves individuals vulnerable to the cumulative effects of stress and depression.⁷²

Under Nigerian law, attempted suicide remains a criminal offense punishable by imprisonment for one year under section 327 of the Criminal Code.⁷³ This provision criminalizes the mentally distressed individual instead of providing psychological rehabilitation. However, global best practices including the WHO Mental Health Action Plan (2013–2030) encourage decriminalization and integration of mental health services into primary care.⁷⁴

4.2.3 Suicide and the Criminalization of Suicide Bill in Nigeria

4.2.3.1 Legal Background

Nigeria inherited its anti-suicide laws from English common law. The Criminalization of Suicide (Repeal) Bill, introduced in 2023, seeks to decriminalize attempted suicide and substitute punitive sanctions with mandatory mental health assessment and therapy.⁷⁵ The bill aims to reform section 327 of the Criminal Code by acknowledging that suicide attempts are symptoms of distress, not moral failure.

⁷² Richard J. Shaw et al (2021). Living alone, loneliness and lack of emotional support as predictors of suicide and self-harm: A nine-year follow up of the UK Biobank cohort. *Journal of affective disorders*, 279, 316–323. <https://doi.org/10.1016/j.jad.2020.10.026>

⁷³ s 327 Criminal Code (1)

⁷⁴ WHO, *Comprehensive Mental Health Action Plan 2013–2030* (Geneva, 2021).

⁷⁵ House of Representatives, *Criminalization of Suicide (Repeal) Bill, 2023*.

4.2.3.2 Policy Implications

Decriminalization would harmonize Nigerian law with modern human rights norms, especially Articles 5 and 16 of the African Charter on Human and Peoples' Rights, which protect dignity and health.⁷⁶ It would also facilitate mental health interventions and reduce stigma associated with suicide. The National Mental Health Act (2021) already reflects a policy shift toward humane treatment of the mentally ill.

4.2.4 The African Charter on Human and Peoples' Rights and the Communal Approach

4.2.4.1 Human Dignity and the Mentally Unstable

Article 5 of the African Charter guarantees respect for human dignity, while Article 16 ensures the right to health. In *Purohit and Moore v The Gambia*⁷⁷, the African Commission held that the detention of mentally ill persons in inhuman conditions violated both provisions.⁷⁸ Nigeria, as a signatory, is bound to uphold these principles domestically.

⁷⁶ African Charter on Human and Peoples' Rights, art 5.

⁷⁷ *Purohit and Moore v The Gambia* (2003) AHRLR 96 (ACHPR 2003).

⁷⁸ UN Human Rights Council, *Resolution 41/13: Mental Health and Human Rights* (2019).

4.2.4.2 The Communal Dimension

African societies traditionally view individuals within the context of their community. While this communal ethos fosters social responsibility, it has also contributed to stigma against the mentally ill, often perceived as spiritually afflicted.⁷⁹ The Charter's emphasis on collective duties (Articles 27–29) should therefore be reinterpreted to promote inclusion and compassion. The communal ethic, properly applied, aligns with Ubuntu philosophy “I am because we are” which can support reintegration rather than exclusion.

The Netherlands has comprehensive social welfare systems⁸⁰ which provides extensive financial support and care for its citizens and legal residents but lacks communal. Support in the aspect of family as most families are too busy with work and other endeavors to take proper care of their elderly or terminally sick family members hence the rise in the rate of caregivers over there which in turn boosts the high request for euthanasia by those family members as they cannot cope with the loss of their autonomy and personal choice and don't wish to be burdens to their families as well .While In Nigeria, the lack of functional social welfare schemes a is a primary catalyst in the decline of traditional communal support systems for the elderly and terminally ill, which in turn fuels the youth

⁷⁹ S Ojo, ‘Cultural Attitudes to Mental Illness in Nigeria’ (2019) *Nigerian Journal of Psychiatry* 15(1) 34. African Charter (n 34) arts 27–29.

⁸⁰ Abi Carter, *Social security in the Netherlands*, published feb 28 2025

emigration trend known as the "japa syndrome". Historically, the extended family network served as the sole safety net, but modern economic realities have strained this structure to a breaking point. The resulting hardship and the absence of government support create powerful "push factors" that drive young, productive Nigerians to seek better opportunities abroad, leaving vulnerable family members behind with little or no care at all.

4.2.4.3 Nigeria's Implementation

The National Mental Health Act 2021 operationalizes Nigeria's commitment under the Charter by establishing a Mental Health Department, protection of patient rights, and non-discriminatory access to care.⁸¹ However, cultural and institutional barriers still hinder full compliance, especially in rural areas. Strengthening community sensitization and resource allocation is critical.⁸²

4.2.5 Judicial Attitudes toward End-of-Life Decisions (Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal and Related Cases)

Nigerian courts have generally taken a conservative stance on issues relating to end-of-life decisions, reflecting the sanctity-of-life principle entrenched in the Constitution. However, one case that offers a nuanced perspective is *Okonkwo v. Medical and Dental*

⁸¹ National Mental Health Act (36).

⁸² Federal Ministry of Health (23).

Practitioners Disciplinary Tribunal.⁸³ In that case, a medical doctor was accused of professional misconduct for respecting his patient's wish (a Jehovah's Witness) to refuse blood transfusion on religious grounds. The Supreme Court held that every competent adult has the right to determine what is done to his or her body, even if refusal of treatment might result in death. The court affirmed that patient autonomy is constitutionally protected under the right to dignity of the human person (s. 34, 1999 Constitution).⁸⁴

While the case did not directly involve euthanasia, it is significant because it recognized the principle of autonomy in medical decision-making. Nonetheless, the Court stopped short of endorsing euthanasia, and its reasoning maintained a distinction between *refusal of treatment* and *active termination of life*. Nigerian jurisprudence, therefore, remains cautious: it allows competent patients to decline life-sustaining interventions but does not permit physicians to take active steps to end life. Other cases reinforce this restrictive approach. In *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo*, the Tribunal initially sanctioned the doctor for failing to administer life-saving treatment, underscoring Nigeria's institutional resistance to practices resembling euthanasia.⁸⁵ The Supreme Court's reversal highlighted tension between medical

⁸³ *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999) 9 NWLR (Pt. 617) 1 (SC).

⁸⁴ Constitution of the Federal Republic of Nigeria 1999 (as amended), s. 34(1).

⁸⁵ *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* (1995) 4 NWLR (Pt. 392) 618.

paternalism and patient rights, but it did not extend autonomy to justify euthanasia or assisted suicide.

4.2.6 Medical Practice, Professional Ethics, and Euthanasia in Nigeria

Medical ethics in Nigeria are heavily influenced by professional codes and cultural values, both of which emphasize the preservation of life. The Code of Medical Ethics in Nigeria (2008), issued by the Medical and Dental Council of Nigeria (MDCN), provides that doctors must always act in the best interest of patients, guided by the Hippocratic Oath, which proscribes intentional killing.⁸⁶ Euthanasia is therefore considered a violation of professional ethics. Nigerian medical practitioners are bound to provide palliative care, pain relief, and supportive treatment, but not to hasten death. The Code stresses beneficence and non-maleficence, aligning with the constitutional protection of life. Physicians who engage in euthanasia could face disciplinary sanctions, including suspension or de registration. Furthermore, cultural and religious contexts reinforce medical conservatism. Nigerian society, influenced by Christian and Islamic values, generally views euthanasia as morally unacceptable. This socio-cultural orientation further discourages medical professionals from considering euthanasia as an ethically permissible option.

⁸⁶ Medical and Dental Council of Nigeria, *Code of Medical Ethics in Nigeria* (Abuja: MDCN, 2008).

4.2.7 Treatment of Mental Disorder Cases under Nigerian Law

The treatment of euthanasia in the context of mental disorders poses unique challenges under Nigerian law. Mental health law in Nigeria is still governed by the Mental health Act of 2021, it focuses largely on improving mental health services and protecting against discrimination, without addressing end-of-life decisions. From a legal standpoint, patients with mental disorders are considered vulnerable persons who may lack the requisite capacity to make decisions about ending their lives. Nigerian courts have not recognized any right of mentally disordered individuals to consent to euthanasia. Instead, the law prioritizes protection and treatment over autonomy in such cases. For instance, under the Criminal Code, killing a person with impaired mental capacity, even with their consent, still amounts to homicide.⁸⁷ In practice, mental health cases are approached with an emphasis on care, rehabilitation, and, in some cases, involuntary admission. There is no legal or ethical framework permitting physicians to consider euthanasia as an option for psychiatric patients, unlike in the Netherlands where euthanasia for unbearable mental suffering has been cautiously permitted. Nigeria's framework remains firmly prohibitive, rooted in concerns about vulnerability, abuse, and the lack of safeguards.

⁸⁷ Criminal Code Act, Cap C38, LFN 2004, s. 306.

4.3 Legal Framework of Euthanasia in the Netherlands

The Netherlands occupies a unique position in global euthanasia discourse, being the first country to formally legalize the practice under a comprehensive statutory framework. Dutch law on euthanasia developed incrementally, shaped by judicial tolerance, medical practice, and societal debates before culminating in statutory codification. The evolution of the legal regime reflects a balancing act between safeguarding the sanctity of life and recognizing individual autonomy, particularly in cases of unbearable suffering.

4.3.1 Historical Development of Dutch Euthanasia Law

The development of euthanasia law in the Netherlands is best understood as a gradual process of judicial liberalization, followed by legislative intervention. Before the enactment of specific statutes, Dutch criminal law, under Article 293 of the Dutch Penal Code, prohibited euthanasia and assisted suicide, prescribing imprisonment for those who intentionally ended another's life at their request.⁸⁸ However, from the 1970s onward, Dutch courts began to interpret the law with increasing leniency where physicians acted out of compassion and under strict conditions. One landmark case was the Postma case

⁸⁸ Dutch Penal Code, Art. 293.

(1973), in which a physician was convicted for performing euthanasia on her terminally ill mother but received only a suspended sentence. The court articulated that although euthanasia remained unlawful, punishment could be mitigated if carried out in response to unbearable suffering and under medical supervision.¹⁴ This case set the tone for subsequent judicial tolerance.

Through the 1980s and 1990s, the judiciary refined conditions under which physicians could rely on a “necessity” defense to avoid criminal liability. These included the patient’s voluntary and well-considered request, unbearable suffering with no prospect of improvement, and the requirement that the physician consult an independent colleague.⁸⁹ Over time, this body of case law created a quasi-legal framework, giving physicians practical guidance while still operating under the shadow of criminal prohibition. The cumulative effect of judicial decisions, coupled with growing public acceptance, created pressure for legislative reform. This culminated in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, which codified the conditions developed in case law and provided legal certainty for physicians

⁸⁹ *Postma Case* (1973) *Nederlandse Jurisprudentie* (NJ) 1973, 183.

4.3.2. Mental Disorder Cases and Psychiatric Euthanasia in Dutch Practice

Perhaps the most controversial aspect of Dutch euthanasia law is its cautious recognition of psychiatric conditions as legitimate grounds for euthanasia. Building on the *Chabot* case, the 2002 Act does not exclude mental disorders, provided the statutory criteria are met. However, psychiatric euthanasia cases are rare and subject to heightened scrutiny. In practice, psychiatric euthanasia requires an especially rigorous process. Physicians must ensure that the patient's request is consistent, voluntary, and well-considered, despite the presence of mental illness, which may impair decision-making capacity. Independent psychiatric evaluation is mandatory, often involving multiple specialists.⁹⁰

Dutch review committees have accepted psychiatric euthanasia in cases of chronic, treatment-resistant depression, severe personality disorders, and post-traumatic stress disorder. Nonetheless, such cases remain highly debated. Critics argue that mental suffering is more subjective and potentially reversible than physical suffering, raising concerns about premature decisions.⁹¹ Statistics indicate that psychiatric euthanasia accounts for a very small proportion of cases around 1% annually but its symbolic importance is immense, as it tests the boundaries of autonomy, vulnerability, and the state's

⁹⁰ A. K. P. van der Heide et al., "Euthanasia in Cases of Psychiatric Disorder: A Review of Dutch Practice" (2016) *Journal of Medical Ethics* 42(8), 486–492.

⁹¹ J. Griffiths, H. Weyers and M. Adams, *Euthanasia and Law in Europe* (Hart Publishing, 2008) 150–160.

duty of care.⁹² The Dutch experience thus represents one of the few global examples where mental disorders are recognized, albeit cautiously, as grounds for euthanasia.

4.3.3. Voluntary Assisted Dying in Australia

Voluntary Assisted Dying is legal in all Australian states and the Australian Capital Territory, with the Northern Territory being the only Jurisdiction where it remains Illegal as of November 2025. The laws and specific criteria vary slightly by state/territory and are highly regulated.⁹³

Overview of Australian VAD Laws

Each state and the ACT has passed and implemented its own VAD legislation. The laws are broadly similar, often referred to as the "Australian model," but include key differences in eligibility and process. The ACT legislation generally reflects what is now referred to as the 'Australian model' of VAD. Access is available for those who are terminally ill and meet strict eligibility criteria assessed by two independent and trained health practitioners. In order to access VAD in the ACT, individuals must be:

⁹² Regional Euthanasia Review Committees, *Annual Report 2022*.

⁹³ <https://www.eldac.com.au/Our-Toolkits/End-of-Life-Law/Voluntary-Assisted-Dying/Overview>

1. Aged 18 years and over
2. A resident in the ACT for the preceding 12 months or granted an exemption
3. Diagnosed with an advanced and progressive medical condition that will cause death and is causing intolerable suffering
4. Able to make and communicate decisions throughout the process.⁹⁴

4.4 Comparative Analysis of Nigeria and the Netherlands

The comparative assessment of Nigeria and the Netherlands illustrate two fundamentally divergent approaches to euthanasia regulation. While both jurisdictions acknowledge the importance of protecting life, their legal traditions, cultural orientations, and institutional practices lead them to opposite conclusions on whether euthanasia can be permitted, especially in cases involving mental disorders.

4.4.1 Divergent Legal Traditions and Approaches

The divergence between Nigeria and the Netherlands is rooted in their respective legal traditions and socio-cultural contexts. In Nigeria, euthanasia is unequivocally prohibited under both the Criminal Code (applicable in the South) and the Penal Code (applicable in the North). Both codes criminalize the intentional taking of life, even where

⁹⁴ <https://bnlaw.com.au/knowledge-hub/insights/voluntary-assisted-dying-in-australia-the-current-state-of-play/>

consent is given. Nigerian jurisprudence, such as in *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*, recognizes patient autonomy in the limited sense of refusing medical treatment, but not in actively requesting death.⁹⁵ The constitutional protection of the right to life under section 33 of the 1999 Constitution further reinforces this absolute prohibition. The Nigerian position is also shaped by religious and cultural values, which view euthanasia as morally impermissible.

By contrast, the Netherlands has developed a liberal and regulated framework that permits euthanasia under strict conditions. The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 reflects decades of judicial and social evolution, balancing patient autonomy with state oversight.⁹⁶ The Dutch approach reflects a pragmatic acceptance that some forms of unbearable suffering may justify ending life, provided procedural safeguards are observed. Review committees, medical guidelines, and statutory due care criteria all form part of a highly institutionalized system. Nigeria and the Netherlands represent opposite ends of the regulatory spectrum: Nigeria adopts a prohibitionist stance rooted in sanctity-of-life principles, while the Netherlands embraces a permissive but carefully controlled model that privileges autonomy and dignity.

⁹⁵ *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999) 9 NWLR (Pt. 617) 1 (SC).

⁹⁶ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Netherlands).

4.4.2 Cultural, Religious, and Ethical Considerations

Cultural and religious values play a decisive role in shaping each country's legal stance.

In Nigeria, both Christianity and Islam the dominant religions regard life as sacred and inviolable. The belief that life is given by God and cannot be taken except by Him reinforces resistance to euthanasia. Traditional African values, which emphasize communal belonging and respect for elders, also view deliberate termination of life as taboo.⁹⁷ Consequently, Nigerian law reflects a strong sanctity-of-life ethic, privileging protection of life over individual autonomy.

The Netherlands, in contrast, is characterized by a more secular and liberal culture, where autonomy and individual rights hold greater weight in public policy. Ethical debates in the Dutch context centre on dignity, compassion, and the right to self-determination in the face of unbearable suffering.⁹⁸ The cultural acceptance of euthanasia is reflected in consistently high levels of public support, which has legitimized and stabilized the legal framework. This divergence illustrates how law is not merely a product of legal doctrine

⁹⁷ John Griffiths, Heleen Weyers & Maurice Adams, *Euthanasia and Law in Europe* (Hart Publishing, 2008) 112–120.

⁹⁸ KNMG (Royal Dutch Medical Association), *Position Paper on Palliative Care* (2011).

but is also deeply shaped by societal values. What is perceived as compassionate autonomy in the Netherlands may be viewed as immoral and unlawful in Nigeria.

4.4.3. Lessons Nigeria Can Draw from the Dutch Model

Although Nigeria and the Netherlands are at opposite ends of the regulatory spectrum, certain lessons can be drawn from the Dutch model without necessarily endorsing euthanasia.

First, Nigeria could strengthen palliative care and pain management services. Dutch debates on euthanasia have consistently emphasized the importance of ensuring that patients have access to adequate palliative care before considering euthanasia. Nigeria's health system is underdeveloped in this regard, and prioritizing palliative care could alleviate suffering while avoiding the moral controversies of euthanasia.

Second, Nigeria can learn from Dutch emphasis on patient autonomy and informed consent. While euthanasia may remain prohibited, Nigerian law could be reformed to give greater weight to patient choices at the end of life, particularly in refusing invasive or futile treatment. The recognition of autonomy in *Okonkwo v. MDPDT* is a step in this direction but requires statutory reinforcement.⁹⁹

⁹⁹ Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo (2001) 7 NWLR (Pt 711) 206 (SC).

Finally, Nigeria can draw lessons from Dutch oversight mechanisms. Even if euthanasia remains unlawful, Nigeria could adopt independent review committees in mental health care to safeguard against abuse in psychiatric treatment, ensuring that patients' rights are protected while maintaining medical accountability. In essence, Nigeria need not adopt the Dutch model wholesale, but selective adaptation particularly in strengthening patient rights, medical ethics, and palliative care could enrich its legal and medical framework while remaining faithful to its cultural and moral values.

4.5 Challenges in Reconciling Both Jurisdictions

Reconciling the legal positions of Nigeria and the Netherlands on euthanasia, particularly in relation to mental disorders, presents profound challenges. These challenges stem not only from differences in legal traditions but also from divergent cultural, ethical, and institutional contexts.

4.5.1 Legal Barriers and Institutional Limitations in Nigeria

Nigeria's foremost barrier to adopting or adapting any elements of the Dutch approach is its rigid legal framework. The 1999 Constitution guarantees the right to life in absolute terms without any express exceptions permitting assisted dying.¹⁰⁰ The Criminal

¹⁰⁰ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, Art. 2.

Code and Penal Code criminalize euthanasia, categorizing it as murder or manslaughter regardless of consent.¹⁰¹ This statutory position creates a significant obstacle to reform, since any legislative attempt to introduce euthanasia would face constitutional hurdles and strong political resistance. Institutionally, Nigeria lacks the infrastructure necessary to implement Dutch-style safeguards. The Dutch framework relies on highly professionalized healthcare, independent review committees, and transparent reporting systems. Nigeria's health system, however, suffers from underfunding, poor regulation, and inadequate training in mental health law.¹⁰² The weak enforcement capacity of institutions such as the Medical and Dental Council of Nigeria further limits the possibility of monitoring sensitive practices like euthanasia. Thus, before Nigeria can even contemplate legal reform in this area, it must first strengthen its health sector, regulatory institutions, and capacity for independent oversight.

4.5.2 Ethical and Practical Concerns with Psychiatric Euthanasia

The recognition of psychiatric suffering as grounds for euthanasia in the Netherlands highlights one of the most controversial aspects of its system. While Dutch

¹⁰¹ Egun Ogunbanjo, "Ethical Issues in End-of-Life Decisions in Nigeria" (2018) 22 *African Journal of Bioethics*

¹⁰² *Brongersma Case* (Supreme Court of the Netherlands, 2002).

law requires that the suffering be “unbearable and without prospect of improvement,”¹⁰³ critics argue that assessing psychiatric suffering is inherently subjective. Unlike terminal cancer, where prognosis can be more objectively measured, mental illness involves fluctuating symptoms and potential for treatment breakthroughs.

In Nigeria, where access to mental health care is limited and stigma remains high, extending euthanasia to psychiatric patients would be fraught with ethical dangers. Concerns include misdiagnosis, inadequate treatment options, and coercion from family members or caregivers. The possibility of abuse is magnified in contexts where vulnerable individuals lack adequate legal and social protection.¹⁰⁴ Even in the Netherlands, psychiatric euthanasia cases remain controversial. The case of Brongersma (2002), where euthanasia was sought due to “life weariness” rather than medical illness, triggered debates about the limits of autonomy and whether psychological suffering should justify ending life.⁴⁵ For Nigeria, where cultural and religious worldviews overwhelmingly reject the deliberate termination of life, these ethical concerns reinforce resistance to adopting the Dutch model.

¹⁰³ International Convention on Civil and Political Rights, 999 U.N.T.S. 171 (entered into force 23 March 1976), Art. 6.

¹⁰⁴ *Pretty v. United Kingdom* (2002) 35 EHRR 1 (ECtHR).

4.5.3 Global Human Rights Standards and Their Applicability

International human rights law adds another layer of complexity. The International Covenant on Civil and Political Rights (ICCPR), to which both Nigeria and the Netherlands are parties, recognizes the right to life but frames it primarily as a right to protection against arbitrary deprivation.¹⁰⁵ This wording leaves space for interpretation but does not explicitly support euthanasia.

The European Court of Human Rights (ECtHR), in cases such as *Pretty v. United Kingdom* (2002), held that the right to life under Article 2 of the European Convention does not encompass a “right to die,” although states enjoy a margin of appreciation in regulating assisted dying.¹⁰⁵ This has given countries like the Netherlands room to legalize euthanasia, provided that safeguards are in place. Nigeria, however, interprets human rights standards through the lens of its constitutional and religious values. For Nigerian courts, the sanctity of life doctrine is non-negotiable, and international jurisprudence favoring assisted dying would likely be resisted.¹⁰⁶ Moreover, the weak domestic application of international treaties in Nigeria where treaties must be domesticated by legislation before having force of law further limits the direct applicability of global human rights debates to euthanasia. Thus, while the Netherlands integrates international human rights principles into its

¹⁰⁵ *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999) 9 NWLR (Pt. 617) 1 (SC).

¹⁰⁶ Constitution of the Federal Republic of Nigeria 1999 (as amended), s. 12(1).

euthanasia regime, Nigeria's approach underscores sovereignty, religious morality, and constitutional supremacy, making reconciliation between both jurisdictions especially difficult.

4.6 Summary of Comparative Findings

This chapter has explored the legal frameworks governing euthanasia in Nigeria and the Netherlands, with particular attention to how each jurisdiction addresses cases involving mental disorders. The comparative analysis reveals striking contrasts rooted in divergent legal traditions, cultural values, and institutional capacities.

In Nigeria, the legal system adopts a prohibitionist stance. The 1999 Constitution guarantees the right to life in absolute terms, while the Criminal Code and Penal Code criminalize any act amounting to euthanasia or assisted suicide. Judicial decisions, such as *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*, reinforce the sanctity of life principle and reject autonomy-based claims for assisted dying. Medical practice and professional ethics in Nigeria reflect similar restrictions, with euthanasia regarded as incompatible with both legal and cultural norms. Particularly in the context of mental disorders, Nigerian law provides no space for recognizing psychiatric suffering as grounds for ending life, emphasizing instead treatment and protection of vulnerable individuals.

By contrast, the Netherlands has developed one of the world's most liberal and highly regulated frameworks for euthanasia. The *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* permits physicians to lawfully assist in ending life under strict conditions, including voluntariness, unbearable suffering, and lack of reasonable alternatives. Dutch courts, in cases such as *Schoonheim* and *Brongersma*, have played a pivotal role in shaping euthanasia jurisprudence, particularly in extending the debate to psychiatric patients. The system is supported by independent review committees, medical guidelines, and transparent reporting obligations, which collectively aim to balance patient autonomy with safeguards against abuse.

The comparative discussion highlights three central findings. First, while the Netherlands conceptualizes the *right to die* as an extension of autonomy and human dignity, Nigeria interprets the *right to life* as inviolable and non-derogable. Second, the Dutch model rests on strong institutional oversight and a robust healthcare system, both of which are largely absent in Nigeria. Third, cultural, religious, and ethical values play a decisive role: the Netherlands emphasizes individual choice within a secular legal culture, whereas Nigeria, shaped by religious and communal worldviews, prioritizes the sanctity of life over personal autonomy. These differences make whole transplantation of the Dutch model into Nigeria impractical. However, certain lessons such as the importance of clear guidelines, ethical debates, and investment in mental health care may still be instructive.

Ultimately, the findings show that reconciling the two jurisdictions requires sensitivity to legal, cultural, and institutional contexts, as well as recognition of the unique challenges posed by mental disorder cases.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of findings

This study examined the legal framework governing euthanasia in cases involving mentally disordered patients, with a comparative focus on Nigeria and the Netherlands. It explored how both jurisdictions define and regulate euthanasia, particularly regarding individuals suffering from severe and untreatable mental illnesses.

In Nigeria, the study found that euthanasia is neither legally recognized nor ethically accepted. The Nigerian Constitution guarantees the right to life, and any intentional act of taking life, whether self-inflicted or assisted, is regarded as a violation of this right. The Criminal Code classifies euthanasia and assisted suicide as criminal offenses, punishable in the same way as homicide. This shows that Nigerian law makes no legal or moral distinction between mercy killing and criminal killing. Furthermore, Nigeria's medical and ethical frameworks strictly prohibit medical practitioners from participating in any act intended to end a patient's life. There are no institutional mechanisms or review committees to assess or regulate end-of-life decisions. Consequently, doctors and families facing such dilemmas rely solely on moral judgment and religious guidance. The result is a rigid and punitive legal system that upholds the

sanctity of life above all other considerations, even in circumstances of prolonged suffering.

In contrast, the Netherlands has established a liberal and structured legal framework that permits euthanasia and assisted suicide under defined conditions. The Termination of Life on Request and Assisted Suicide Act provides the legal foundation for euthanasia, outlining strict due-care criteria such as voluntariness, unbearable suffering, informed consent, and independent medical consultation. When these requirements are met, physicians are exempted from criminal liability.

The Dutch system also includes Regional Euthanasia Review Committees that ensure oversight and compliance with the law. Importantly, the law extends eligibility for euthanasia to mentally disordered patients, provided that they are mentally competent and experiencing unbearable psychological suffering. This demonstrates the Netherlands' recognition of psychological pain as equivalent in seriousness to physical pain. The comparative findings revealed that while Nigeria's legal framework is rooted in religious conservatism and moral absolutism, the Netherlands operates within a secular, rights-based, and humanitarian legal philosophy that values individual autonomy. The absence of legal reform or structured ethical dialogue in Nigeria contrasts sharply with the Dutch system of regulated compassion and procedural accountability.

5.2. Recommendations

Based on the findings of this study, the following recommendations are made to improve Nigeria's legal approach to euthanasia and end-of-life care, especially in cases involving mental disorders:

1. **Legal Reform and Clarification:** Nigeria should introduce clear legal provisions that address end-of-life decisions. While immediate legalization of euthanasia may not be feasible, the law should recognize passive euthanasia, advance directives, and palliative care rights. This would provide guidance for medical practitioners and families while reducing legal ambiguity.
2. **Establishment of Ethical Review Committees:** Hospitals and medical institutions should set up ethical review committees composed of legal experts, ethicists, psychologists, and medical professionals. These committees would assess complex end-of-life requests and provide balanced, transparent recommendations that prioritize patient welfare and professional integrity.
3. **Strengthening Palliative and Mental Health Care:** There is a need to expand access to palliative and mental health care services across Nigeria. Providing adequate medical, psychological, and social support would reduce the desperation that drives patients toward euthanasia. Improved mental health infrastructure would also ensure that patients receive compassionate and effective treatment.

4. Provide social welfare schemes and programs that are citizens centered:

Implementing citizen-centered social welfare schemes is critical for national development. These programs provide essential services like healthcare, education, and income support, directly improving citizens' quality of life. A key benefit of such initiatives is the potential to significantly reduce youth migration. By tackling the root causes of emigration economic insecurity, lack of opportunities, and failing social infrastructure governments can foster a stable environment. Ensuring domestic opportunities and a robust social safety net convinces young people that their future is secure at home.

5. Public and Religious Dialogue: Government, civil society, and religious institutions should encourage open discussions about euthanasia, moral ethics, and human dignity. Such dialogue would promote understanding, dispel misconceptions, and foster a more empathetic approach to terminal and mental health suffering.

6. Comparative Legal Study and Policy Exchange: Nigeria can learn from the Dutch experience by studying its procedural and ethical safeguards. A policy exchange program between Nigerian and Dutch legal and medical institutions could help Nigeria develop a model that suits its cultural and religious environment while respecting human rights principles.

7. **Judicial and Legislative Sensitization:** Training programs for judges, legislators, and medical practitioners are necessary to raise awareness about the ethical and legal complexities of euthanasia. Sensitizing these stakeholders would lead to fairer and more compassionate interpretations of cases involving end-of-life decisions.

5.3 Contribution To knowledge

This research makes several significant contributions to existing knowledge in the fields of medical law, human rights, mental-health policy, and comparative legal studies. Although euthanasia has received global scholarly attention, the subject remains largely under-explored in Nigeria, particularly in relation to persons suffering from mental disorders. By examining euthanasia through a comparative analysis of Nigeria and the Netherlands, this study fills a critical scholarly gap and expands current understanding of how different jurisdictions approach end-of-life decision-making.

Firstly , the research provides one of the few comprehensive legal analyses of euthanasia within the Nigerian context. Nigeria lacks statutory or judicial guidance on euthanasia, and its criminal law criminalises all forms of intentional killing regardless of consent. Existing literature often treats euthanasia as a purely moral or religious issue, leaving its legal dimensions insufficiently examined. This study therefore enriches Nigerian legal scholarship by clarifying how the absence of a regulatory framework affects

patients, medical practitioners, and the justice system. It also highlights the implications of this legal vacuum for individuals living with severe mental disorders, whose rights and autonomy are frequently overlooked in end-of-life debates.

Secondly, the study advances academic discourse by focusing on the intersection between euthanasia and mental illness an area that remains contentious even in developed jurisdictions. While most global discussions on euthanasia revolve around terminal physical illnesses, this study interrogates whether psychological suffering can be regarded as equally unbearable, and whether persons with mental disorders possess the capacity to make voluntary, well-considered decisions about ending their lives. By raising these questions, the study contributes to a deeper understanding of legal capacity, vulnerability, decisional competence, and patient autonomy in mental health contexts.

Another major contribution of this research is the comparative approach adopted. By juxtaposing Nigeria's entirely prohibitive stance with the Netherlands' highly regulated and permissive legal framework, the study illuminates the philosophical, cultural, and policy considerations that shape euthanasia laws across jurisdictions. This comparative analysis not only exposes the strengths and weaknesses of each model but also offers insight into how Nigeria could benefit from, or adapt, aspects of the Dutch due-care criteria, procedural safeguards, and institutional oversight mechanisms. In doing so, the study provides a valuable basis for evidence-driven policy reform in Nigeria.

Furthermore, the research contributes to knowledge by integrating multiple theoretical perspectives including the human rights approach, public policy theory, the sustainable development principle, and religious/theistic viewpoints to provide a holistic understanding of euthanasia. This interdisciplinary approach allows the study to address euthanasia not merely as a legal issue, but as a question that touches on ethics, human dignity, social responsibility, and cultural identity. By analysing euthanasia from these diverse perspectives, the research offers a more balanced and nuanced interpretation than is found in many existing works.

Finally, the study makes a forward-looking contribution by offering recommendations aimed at strengthening Nigeria's mental-health and legal systems. These recommendations are grounded in global best practices and informed by the Dutch experience, while remaining sensitive to Nigeria's cultural, religious, and socio-legal realities. In doing so, the research does not merely critique the status quo but provides a constructive framework for future legislative reform and policy development.

5.4. Conclusion

The comparative analysis between Nigeria and the Netherlands reveals that their legal positions on euthanasia are shaped by fundamentally different philosophical and moral foundations. Nigeria's legal system maintains an uncompromising stance that prohibits

euthanasia under any circumstance. The law is grounded in the belief that life is sacred and must be preserved at all costs. This reflects the country's strong religious, cultural, and traditional values, which view human life as divinely ordained and not subject to voluntary termination. However, this rigid approach overlooks the realities of human suffering and the importance of dignity at the end of life, particularly for mentally disordered patients who experience unbelievable pain and distress. Conversely, the Netherlands represents a more progressive model that balances the protection of life with the right to autonomy and dignity. By legalizing euthanasia under strict conditions, the Dutch legal system recognizes that compassion and regulation can coexist. It ensures that end-of-life decisions are transparent, accountable, and grounded in respect for human dignity.

The study concludes that Nigeria's total prohibition of euthanasia is outdated in light of modern medical ethics and global human rights discourse. While Nigeria may not be culturally ready to legalize euthanasia, it is imperative to begin a structured dialogue on end-of-life decisions, focusing on human dignity, compassion, and ethical medical care. Laws should not only protect life but also preserve the quality of that life. A humane legal system must therefore strive for a balance between moral protection and individual choice.

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