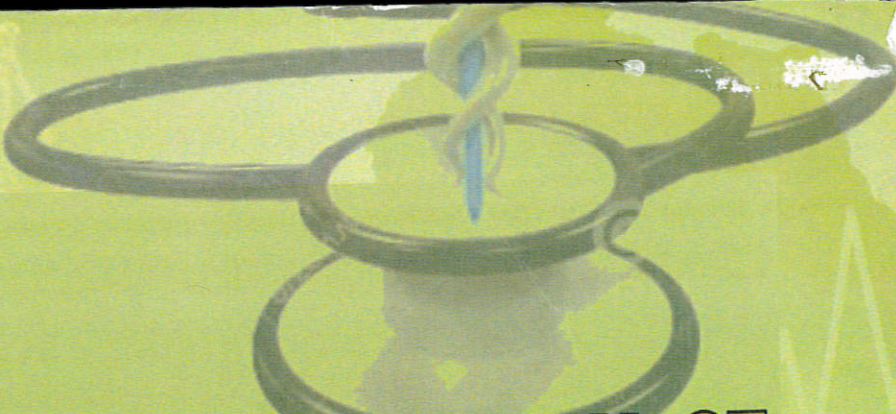
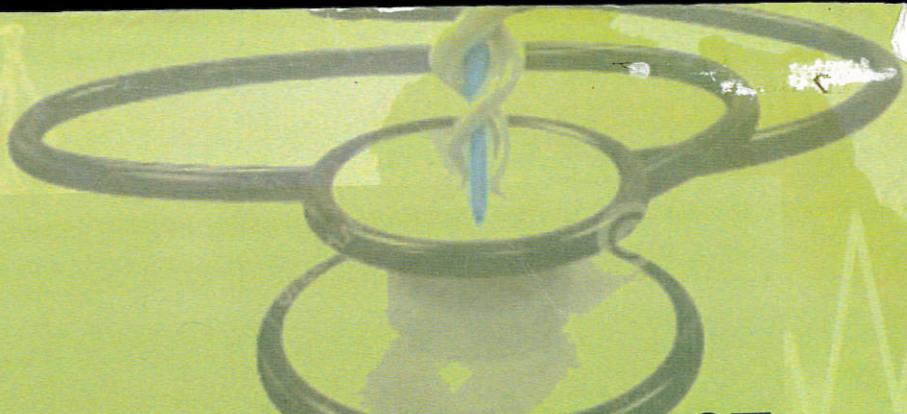




INTERNATIONAL JOURNAL OF MEDICAL AND HEALTH LAW PRACTICE





INTERNATIONAL JOURNAL OF MEDICAL AND HEALTH LAW PRACTICE



A Publication of Association of Medical and Health Law Practitioners in Africa

Published June, 2026

© Copyright June, 2026 Association of Medical and Health Law Practitioners in Africa

All Rights reserved. No part of this journal may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior permission of the editors and/or publishers.

ISSN : 3115 - 4238

Printed in Nigeria by
MONO EXPRESSIONS LTD
No. 8 Rwang Pam Street
By St. Theresa's Catholic Church
Jos- Nigeria

08037200637

EDITORIAL BOARD

Editor-in-Chief and Chairman Editorial Board

ENOCH IBU OTOR, PhD, BL, JP, Notary Public

Reader/Associate Professor

President, Association of Medical and Health Law Practitioners

Dr Friday O. Agbo, PhD, BL, Notary Public

Editorial Advisory Board

Prof Michael Adikwu

Prof John A.M. Agbonika

Prof Kabweru W. Musoga Uganda

Prof Salome K. Kigbu

Prof Josephine A. Agbonika, SAN

Prof Jadesola Lokulo-Sodipo

Prof Richard A. Adegbola

Prof Ibrahim A. Oreagba

Prof Khadijat T. Musah

Prof Komolafe A. Olawole

Prof Roy Beran Australia

Prof Johannes Marisa Zimbabwe

Prof Francis A Rubabinda Uganda

Prof Alphonsus O. Alubo, SAN

Dr Friday O. Agbo President, AMHLPA

Dr Freddie J.G. Coker Sierra Leone

Dr Neneh J. Tamedou Gambia

Isaac K. Ssemakadde, SCM Uganda

Dr Simon Kigonde Kenya

Dr Zainab K.M. Idris

Dr Olapo Olutoya

Dr Khadijat A. Usman

Publication Policy

Opinions expressed in the Journal are those of the authors and do not reflect the views of the publisher essentially.

Please accept our warmest regards.

Shalom.

Table of Contents

Preservation of Life: Stakeholders' Perceptions on Euthanasia and Assisted Suicide in Africa <i>Prof Josephine A.A. Agbonika, SAN, Prof. John A.M. Agbonika & Folorunso Bamidele</i>	1
Responding to Climate-Induced Health Risks in Nigeria: A Medico-Legal Analysis of Healthcare System Preparedness <i>Ibiere Dateme Hope Asiki</i>	29
Rights Of Patients to Confidentiality in the Health Care System in Nigeria <i>Enoch Ibu Otor & Morgan G. Piwuna</i>	52
Navigating the Legal Framework of Informed Consent in Medical Practice: Challenges and Best Practices <i>Imiefoh, Andrew Ikhayere & Victor James Ekanem</i>	83
Regulating Assisted Reproductive Technologies in Nigeria: A Comparative Analysis with European Jurisdictions <i>N. C. Nwachukwu</i>	107
Platelet and white blood cell Indices as Diagnostic and Management Markers in sickle cell anaemia patients: Insights from a Tertiary Hospital Clinic in South-South Nigeria <i>Opara Chukwuka O, Okpokam Dorathy C., Akaba, Kingsley O., Okafor, I. M. Iji, Moses O</i>	127
The Imperative for Surrogacy Legislation in Nigeria: Legal Justifications from Constitutional, International, and Statutory Frameworks <i>Akatiki Grace Dominic</i>	148

Legal Framework on Surrogacy in Nigeria and South Africa <i>Ugonna Sharon Ihekoronye, Dorcas A. Odunaike & Ugochi Best-Man Umezuruike</i>	175
Artificial Intelligence Diagnosis, Medical Negligence and the Crisis of Liability in African Healthcare Systems: Rethinking Doctoral Responsibility in the Age of Machine Medicine <i>Abbas O. Ochogwu</i>	198
Imperatives of Artificial Intelligence on Healthcare Delivery in Africa: Analysis of the Regulatory Frameworks <i>Godfree Matthew</i>	225
The Catheter Case and the Liability of a Doctor: An Examination <i>Asiawu Belgore-Abdulhamid & Ogboi Anthony U. Enahoro</i>	247
The Defence of Insanity: Streamlining Non-Culpability of Crime to Medical Responsibility <i>Lilian Ifeoma Nwabueze</i>	263
Pre-Employment Medical Examinations: A Critical Analysis of Merits, Demerits and Medicolegal Implications <i>Akinwumi Oluwole Komolafe, John Akintunde Oladotun Okeniyi, Josephine Adetinuola Eniola Eziyi, Felix Ayodeji Bobade, Olalekan Olasehinde & Hezekiah Morakinyo Akinyemi</i>	281
Reproductive Autonomy as a Fundamental Human Right and Implications for Access to In Vitro Fertilisation Services in Nigeria <i>Jaleelah Fehintola Idris</i>	305
Retained Foreign Objects/Items as Medical Negligence: A Legal Imperative for Surgical Safety in Nigeria <i>Agbo Friday Ojonugwa</i>	336

Reviewing and Reassessing the Traditional Bolam Test as the Basis for Evaluating Medical Malpractice and Clinical Negligence <i>Akinwumi Oluwole Komolafe</i>	364
The Doctrine of Vicarious Liability in Negligence in Medical Practice <i>Akinwumi Oluwole Komolafe, Abiola Olubusola Komolafe, David Toluwalase Komolafe & Deborah Jesutofunmi Komolafe</i>	391
Artificial Intelligence, Medical Misdiagnosis and the Redistribution of Liability: A Comparative Analysis of the United Kingdom, European Union and Nigeria <i>Onome Lisa Ejenavi</i>	422
Euthanasia and the Nigerian Legal Order: Between the Right to Life and Right to Human Dignity <i>Mohammed Amali, Samuel Oguche & Shalom Andemi</i>	441
Health Information Systems in Disaster Response and Recovery in Nigeria: A Review <i>Buhari Abdulhafeez Oladimeji & Khadijat Toyin Musah</i>	470
Biometric Collection in Medical Practice: Is Nigerian Law Doing Enough? <i>Ndubuisi Okonta</i>	488
An Overview of the Legal Framework for Health Workers under the Various Legislations in Nigeria <i>Khadijat Ahmed</i>	511
Medico-Legal Risks of Telehealth <i>Titi Adegbile</i>	542
Death Without Diagnosis: Autopsy Refusal and Avoidance, Medico-Legal Uncertainty, and the Erosion of Forensic Evidence in Uninvestigated Hospital Deaths <i>Olubukola Ogunlade & Dorcas Thanni</i>	565

Beyond Borders: Constitutional Constraints, Pandemic Preparedness,
and Regional Health Governance in Africa

*Abba Elguja, Umar Alkali, Maimunatu Yerima Iyawa & Kelechi
Onyegbule* 598

Law Without Compliance: The Collapse of Cooperative Federalism in
Nigeria's Primary Health Care System

Simileoluwa Eritomiwa Ogunsanwo & Dolapo O. Olutayo 624

Should the Death Penalty be Abolished in Nigeria?

Victor O. Ayeni 654

Comparative Evaluation of Haemostatic and Inflammatory Biomarkers
in Prostate Cancer Patients and Apparently Healthy Controls in Calabar,
Nigeria

*Emmanuel E. Abam, Dorathy C. Okpokam, Blessing Essiet,
Oluwadarasimi N. Emmanuel & Godwin A. Ebughe* 688

Informed Choice and Consent for Blood Transfusion in Nigeria: Patient's
Rights and Remedies in Focus

Erimma Gloria Orié & Ebere Iwuagwu Akwuebu 705

Gender-Responsive Engineering Governance, Health Sector
Development, and Inclusive Professional Participation in Africa: A Legal
and Policy Analysis of Regulatory Frameworks and Institutional Reform

Grace Perpetual Dafiel 732

Healthcare Governance and Medical Negligence in Nigeria: A Critical
Legal and Policy Analysis *Douglas Ighodaro Ekhaesomhi* 767

Notes on Contributors

Prof Josephine A.A. Agbonika, SAN, Dean, Faculty Of Law, Veritas University, Abuja, Professor Of Law Of Taxation, Senior Advocate Of Nigeria, SAN, LL.B (ABU), BL, LL.M, (University Of London), Ph.D (Uni-Abuja), FCTI, FIPMD, AClarb, FCAI, FIMC, Notary Public, LSM, JP; Commissioner, Tax Appeal Tribunal (2010-2016), Email, Phinagbonika@Yahoo.Com.

Prof. John A.M. Agbonika, Professor Of Law, Kogi State University (KSU), Anyigba, L.L.B (ABU), L.L.M. (ABU), Ph.D (University Of London) BL, FCTI, FIPMD, AClarb, FIMC, KSM, JP, Former Commissioner For Justice And Attorney General, Kogi State, Former Special Adviser Legal And Chieftaincy Affairs, Kogi State, Adjunct Professor 2016-2021, Salem University, Lokoja And Sabbatical 2021-2022, Salem University, Lokoja.

Folorunso Bamidele, Faculty of Law, Veritas University, Abuja

Ibiere Dateme Hope Asiki

Enoch Ibu Otor, PhD, Enoch Ibu Otor, PhD, LL.M, BL, LLB, Notary Public, Reader in the Department of Commercial Law, Faculty of Law, University of Jos-Nigeria. otore@unijos.edu.ng; otorenochibu@gmail.com +2347036150805, +2348027382869. ORCID 0009-0007-2597-1611.

Morgan G. Piwuna, PhD, LL.M, BL, LLB, Professor of Law and Head of Department of Commercial Law, University Of Jos. piwunam@unijos.edu.ng; +234 7039255004.

Imiefoh, Andrew Ikhayere Faculty of Law, University of Benin, Benin City, Nigeria, Email: Andrew.Imiefoh@uniben.edu, Phone: +2348188899353, ORCID: 0009-0005-6738-4672

Victor James Ekanem, Dept. of Anatomic Pathology, School of Basic Clinical Sciences, College of Medical Sciences

guidance that emphasises accountability, transparency and equity as core principles for AI in health.⁵⁷

Conclusion

AI-assisted medical misdiagnosis exposes the limits of traditional medical negligence law. In the UK and Nigeria, the predominance of clinician-facing fault and orthodox causation rules risks creating a liability gap in the face of probabilistic outputs and black-box opacity.⁵⁸ The EU's evolving framework, anchored in the Artificial Intelligence Act and a modernised Product Liability Directive, more accurately reflects socio-technical reality by imposing lifecycle duties and empowering claimants through disclosure and presumptions.⁵⁹ This article's contribution subsumes a value-chain model of liability distribution, supported by layered reforms: procedural presumptions, shared liability across deployers and providers, mandatory auditability, strengthened consent practices, and regulatory capacity-building in Nigeria. The core normative claim is that patient safety and innovation are best reconciled when law treats AI-assisted misdiagnosis as system-generated harm and allocates ultimate responsibility to those who actually design, deploy and govern the systems that create the risk.

⁵⁷ World Health Organization, Ethics and governance of artificial intelligence for health: WHO guidance (Geneva, 2021) <https://iris.who.int/server/api/core/bitstreams/f780d926-4ae3-42ce-a6d6-e898a5562621/content> accessed 29 May 2026

⁵⁸ See, *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428. Also, *Wilsher v Essex Area Health Authority* [1988] AC 1074

⁵⁹ See, Directive (EU) 2024/2853 of the European Parliament and of the Council of 23 October 2024 on liability for defective products OJ L 2024/2853 <https://eur-lex.europa.eu/eli/dir/2024/2853/oj/eng> accessed 27 May 2026. Proposal for a Directive of the European Parliament and of the Council on adapting non-contractual civil liability rules to artificial intelligence (AI Liability Directive) COM (2022) 496 final <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52022PC0496> accessed 29 May 2026



N i n e t e e n

Euthanasia and the Nigerian Legal Order: Between the Right to Life and Right to Human Dignity

Mohammed Amali*

Samuel Oguiche**

Shalom Andemi***

Abstract

Euthanasia remains one of the most contested issues in contemporary legal and bioethical discourse, raising fundamental questions about the sanctity of life, human dignity, and individual autonomy. This paper examined euthanasia within the Nigerian legal order, particularly the interplay between the constitutional protection of the right to life and emerging arguments grounded in dignity and self-determination in end-of-life decision-making. It interrogates the existing legal framework, particularly the provisions of the Constitution of the Federal Republic of Nigeria, 1999, the Criminal Code Act and the Penal Code, which collectively render euthanasia unlawful regardless of consent or compassionate motives. The paper explored the ethical and professional dimensions of end-of-life care, highlighting the role of the Medical and Dental Council of Nigeria in

*LL.B (Maiduguri), BL, LLM (Huddersfield), Ph.D (Huddersfield), Senior Research Fellow, National Institute for Legislative and Democratic Studies (National Assembly) amalimoh@yahoo.com; +2348036091751; Orcid <https://orcid.org/0000-0001-5967-6273>

** LLB (Jos), BL, LLM (Jos) Associate Professor/Deputy Director National Institute for Legislative and Democratic Studies (National Assembly) oguchesamlaw@yahoo.com

*** LLB (Jos) BL, LLM (in view). Managing Partner S. D Andemi and Associates (Andonai Chambers); andemidashalom@gmail.com

regulating medical practice and reinforcing the duty of healthcare practitioners to preserve life. It also examined the conceptual distinction between active and passive euthanasia, particularly in relation to withdrawal of treatment and patient refusal of medical intervention, areas which remain insufficiently regulated within Nigerian law. Through a doctrinal and comparative approach, the paper analyses selected jurisdictions where euthanasia or physician-assisted dying are legalised under strict safeguards, drawing lessons relevant to Nigeria. It argued that while active euthanasia remains incompatible with Nigeria's current legal, moral, and socio-cultural framework, significant gaps exist in the regulation of end-of-life medical decisions. The paper recommended that Nigeria must enact clear legislative and policy frameworks on palliative care, patient autonomy, and end-of-life decision-making to address the ethical, legal, and practical challenges arising from contemporary medical practice.

Keywords: Assisted Dying, Euthanasia, Human Dignity, Right to Life, Medical Ethics, Patient Autonomy

Introduction

Euthanasia, generally understood as the intentional termination of a person's life in order to relieve suffering,¹ continues to attract divergent legal and philosophical opinions across jurisdictions. It remains one of the most controversial and emotionally charged issues in contemporary legal, medical, and ethical discourse. Advances in medical technology have significantly prolonged human life and enhanced the capacity of healthcare systems to sustain critically ill patients through artificial means, but they have also generated difficult legal and moral questions concerning end-of-life decisions, particularly in situations involving terminal illness, unbearable pain, irreversible

¹ Sheila A M McLean, *Autonomy, Consent and the Law* (Routledge-Cavendish 2010) 198.

medical conditions, and loss of personal dignity.² Consequently, the debate surrounding euthanasia has increasingly shifted from a purely moral controversy to a broader discourse involving constitutional rights, patient autonomy, medical ethics, and human dignity.³ The legal regulation of euthanasia has therefore become a critical issue for policymakers, courts, and healthcare professionals seeking to balance the sanctity of life with respect for individual choice and dignity.

The legal status of euthanasia varies considerably across jurisdictions, reflecting differing conceptions of life, autonomy, morality, and the role of the state in end-of-life decision-making. Despite euthanasia and physician-assisted dying being legalised under carefully regulated conditions in recognition of individual autonomy and the right to die with dignity in some countries,⁴ many other jurisdictions, particularly those with strong religious and communitarian traditions, maintain strict legal prohibitions against any form of intentional termination of life.⁵ This divergence in global approaches reflect the persistent conflict between the sanctity of life doctrine and the growing emphasis on personal autonomy and human dignity in modern human rights discourse. In Nigeria, euthanasia remains unlawful under existing criminal law provisions regulating homicide and related offences, because the Nigerian legal system places a premium on the protection and preservation of human life, a position reinforced by the constitutional guarantee of the right to life under the Constitution of the Federal Republic of Nigeria, 1999.⁶ This legal position continues to generate debate as advances in medical science and evolving notions

² Andreas Fontalis Eftymia Prousalis, and Kunal Kulkarni, 'Euthanasia and Assisted Dying: What is the Current Position and what are the Key Arguments Informing the Debate?' (2018) 111(11) *Journal of the Royal Society of Medicine*.

³ Samuel Oguiche, 'Enthronement or Retreat into Obfuscation: The Euthanasia Debate in Focus' (2011) *Kogi State University Law Journal*

⁴ Belgium, Netherlands, Switzerland and Spain all have different forms of euthanasia regulations.

⁵ Nigeria and the UK are some of the countries with this strict approach.

⁶ s 33.

of patient rights increasingly challenge traditional understandings of the state's obligation to preserve life at all costs.

Notwithstanding the prevailing legal prohibition, the practical realities of modern healthcare have exposed significant gaps in Nigeria's legal response to end-of-life care and decision-making. The absence of a comprehensive legal and regulatory framework specifically addressing euthanasia and related end-of-life raises concerns within the Nigerian healthcare system. Significantly, the Nigerian debate on euthanasia is deeply influenced by religious beliefs, and cultural values, all of which generally regard human life as sacred and inviolable. Consequently, discussions surrounding euthanasia are often approached with moral caution and political sensitivity. However, the increasing global recognition of human dignity and individual choice in healthcare decisions has continued to stimulate scholarly debates regarding whether the rigid criminalisation of euthanasia sufficiently accommodates the realities of terminal suffering and personal autonomy.

Against this backdrop, this paper critically examines the concept of euthanasia within the context of the Nigerian legal system, with particular emphasis on the tension between the constitutional protection of the right to life and the evolving discourse on human dignity, patient autonomy, and end-of-life decision-making. It explores the legal, ethical, medical, and socio-cultural issues surrounding euthanasia in Nigeria and analyses how other jurisdictions have responded to similar challenges through legislative and judicial interventions. The paper further assesses whether Nigeria's existing legal framework adequately addresses the complex realities presented by terminal illness, prolonged suffering, and advances in modern healthcare. It contends that while the legalisation of active euthanasia may not be compatible with Nigeria's current constitutional, cultural, and religious environment, there is an urgent need for a clearer and more comprehensive legal framework governing end-of-life care,

patient autonomy, advance medical directives, and palliative care in order to provide greater certainty for patients, healthcare professionals, and policymakers.

Conceptual Analysis and Theoretical Framework

Conceptualising Euthanasia

Etymologically, the term 'euthanasia' is derived from the Greek words, 'eu' meaning 'good', and 'thanatos', meaning 'death', collectively denoting 'good death'.⁷ In contemporary legal and medical discourse, euthanasia generally refers to the intentional termination of the life of a person suffering from a terminal or incurable condition for the purpose of relieving pain, suffering, or indignity.⁸ The defining element in euthanasia is the deliberate act or omission intended to bring about death in order to alleviate unbearable suffering. Euthanasia manifests in several forms depending on the nature of consent and the method employed in ending life. Voluntary euthanasia occurs where a competent patient consciously and willingly consents to the termination of his or her life.⁹ Involuntary euthanasia arises in situations where the patient is incapable of giving consent due to unconsciousness, coma, infancy, or severe mental incapacity, thereby leaving the decision to relatives, guardians, or medical practitioners.¹⁰

A further distinction exists between active and passive euthanasia. Active euthanasia involves a direct and deliberate act undertaken to end life, such as administering a lethal injection or overdose of medication.¹¹ Passive euthanasia, however, involves the withholding or withdrawal of life-sustaining treatment, including artificial ventilation,

⁷ Warren T. Reich (ed), *Encyclopedia of Bioethics* (Simon & Schuster Macmillan 1995).

⁸ Stephen Garrard Post (ed), *Encyclopedia of Bioethics* (4th edn, Macmillan Reference USA 2014).

⁹ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (8th edn, OUP 2019); Jonathan Herring, *Medical Law and Ethics* (9th edn, OUP 2023).

¹⁰ Mason and McCall Smith's *Law and Medical Ethics*, Jonathan Herring, *Mason and McCall Smith's Law and Medical Ethics* (12th edn, Oxford University Press 2023).

¹¹ Tom L. Beauchamp and James F. Childress (n 9); Jonathan Herring (n 9).

feeding mechanisms, or resuscitative procedures, thereby allowing the patient to die naturally from the underlying medical condition.¹² While active euthanasia is widely criminalized in many jurisdictions, passive euthanasia often occupies a legally uncertain terrain due to its close relationship with patient autonomy, refusal of treatment, and end-of-life medical decisions.¹³ Closely related to euthanasia is physician-assisted suicide, which occurs where a medical practitioner provides a patient with the means or information necessary to end his or her own life, while the final act leading to death is performed by the patient. Although euthanasia and physician-assisted suicide are sometimes used interchangeably in public discourse, they remain legally and conceptually distinct.¹⁴ In euthanasia, the medical practitioner directly causes death, whereas in physician-assisted suicide, the patient performs the final act.¹⁵ Within the Nigerian context, euthanasia remains both legally prohibited, and socially controversial due to the combined influence of criminal law, religious doctrines, and cultural perceptions regarding the sanctity of life. Nevertheless, advancements in healthcare technology and increasing debates surrounding patient autonomy and human dignity have continued to provoke questions regarding the adequacy of existing legal responses to end-of-life decisions.

Theoretical Framework

This paper is anchored on an integrated set of moral, ethical, and jurisprudential frameworks which collectively structure the legal analysis of euthanasia within the Nigerian legal order. It proceeds from the premise that euthanasia cannot be adequately understood through a purely doctrinal lens of criminal law alone, but rather as a normative contest between competing conceptions of the value of life, personal

¹² Ibid.

¹³ Jonathan Herring (n 9).

¹⁴ Peter A. Singer and A.M V Viens (eds), *The Cambridge Textbook of Bioethics* (Cambridge University Press 2008).

¹⁵ Ibid.

autonomy, and the role of the state in regulating end-of-life decisions. Central to this framework is the sanctity of life doctrine, which constitutes the dominant moral foundation of the Nigerian legal prohibition of euthanasia.

The sanctity of life doctrine is founded on the principle that human life is sacred, inviolable, and deserving of absolute protection irrespective of circumstances.¹⁶ The theory posits that life possesses intrinsic value which cannot be diminished by pain, illness, disability, or perceived loss of dignity. Consequently, no individual, institution, or government possesses the moral or legal authority to intentionally terminate innocent human life. This perspective has historically shaped criminal law systems across the world, including Nigeria, where homicide laws strictly prohibit intentional killing regardless of motive or consent. The doctrine is strongly reinforced in Nigeria by religious beliefs and African socio-cultural values. Both Christianity and Islam, which constitute the dominant religious traditions in Nigeria, generally regard life as a divine gift over which humans possess no absolute authority. Similarly, African communitarian philosophy emphasizes the collective value of life and communal responsibility toward preserving human existence.¹⁷ These moral and cultural influences substantially explain the resistance towards euthanasia within the Nigerian society and its continued criminalization under existing legal frameworks.

The constitutional protection of the right to life under the Constitution of the Federal Republic of Nigeria 1999 further reflects the influence of the sanctity of life principle within Nigerian jurisprudence.¹⁸ Under this framework, the state assumes a fundamental obligation to protect life and prevent its unlawful deprivation. In legal terms therefore, this

¹⁶ *Mojekwu v Iwuchukwu* (1997) 7 NWLR (Pt 512) 283 (CA); Constitution of the Federal Republic of Nigeria 1999 (as amended), s 33(1).

¹⁷ Kwame Gyekye, *African Philosophy: An Introduction* (Revised edn, Temple University Press 2004); Paulin J Hountondji, *African Philosophy and the Future of Africa* (Indiana University Press 2002).

¹⁸ s 33.

principle underpins the criminalisation of homicide, murder, and related offences under Nigerian criminal law,¹⁹ and it provides the justification for the absolute or near-absolute prohibition of intentional killing, even where consent is present. Within this paper, the doctrine is treated as the baseline normative position against which all pro-euthanasia arguments are assessed.

Opposing this is the principle of autonomy, which has gained increasing prominence in contemporary bioethics and human rights jurisprudence. Autonomy is premised on the recognition of individuals as rational agents entitled to self-determination, particularly in relation to decisions affecting their own bodies and existence.²⁰ In the context of euthanasia, autonomy supports the argument that competent persons facing incurable illness, severe suffering, or irreversible decline should have the right to determine the timing and manner of their death.²¹ This principle therefore challenges the paternalistic assumptions embedded in sanctity of life reasoning, and reframes end-of-life decision-making as an issue of personal liberty and dignity rather than state-imposed moral protection.

Closely related to autonomy is the utilitarian ethical theory, which evaluates the morality and permissibility of actions based on their consequences, particularly the maximisation of overall well-being and minimisation of suffering.²² From a utilitarian perspective therefore, the ethical justification for euthanasia arises where continued existence produces disproportionate pain with no realistic prospect of recovery or improvement. In such circumstances, permitting assisted dying may be viewed as producing a greater overall balance of benefit by alleviating suffering for the individual and reducing emotional and

¹⁹ Criminal Code, s 316 (murder) and s 306 (unlawful killing) and Penal Code, ss 220–221 (culpable homicide).

²⁰ H. Tristram Engelhardt Jr., *The Foundations of Bioethics* (2nd edn, OUP 1996).

²¹ *Ibid.*

²² John Stuart Mill, *Utilitarianism* (OUP 1998); Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (OUP 2000).

economic burdens on families and healthcare systems. Utilitarianism thus introduces a consequentialist dimension into the euthanasia debate, shifting the focus from the sanctity of life as an absolute value, to the quality and outcomes of continued existence.²³ Accordingly, proponents of euthanasia contend that, in exceptional cases involving irreversible suffering and the absence of meaningful therapeutic options, compassion and the promotion of human welfare may justify permitting a medically assisted death.

From a jurisprudential standpoint, the analysis is further situated within the relationship between natural law theory and legal positivism. Natural law theory reinforces the sanctity of life doctrine by asserting that law is inherently connected to morality, and that certain actions, such as intentional killing, are intrinsically wrong regardless of legal enactment.²⁴ On this view, the prohibition of euthanasia is not merely a matter of statutory command but a reflection of an objective moral order that law is bound to uphold. Legal positivism, by contrast, detaches law from morality and emphasises the validity of law based on its formal enactment by legitimate authority.²⁵ Within the Nigerian context, positivism explains the binding force of statutory provisions criminalising acts that may be construed as euthanasia regardless of ethical arguments in favour of reform. This conflict between moral legality and enacted legality is central to understanding the rigidity of the current legal framework.

Cumulatively, these frameworks reveal euthanasia as a deeply contested legal and ethical issue characterised by a structural conflict between the sanctity of life doctrine and emerging autonomy-based and consequentialist perspectives. While the Nigerian legal order is

²³ *Ibid.*

²⁴ John Finnis, *Natural Law and Natural Rights* (2nd edn, OUP 2011); Thomas Aquinas, *Summa Theologiae* (Benziger Bros. ed, 1947).

²⁵ H. L. A. Hart, *The Concept of Law*, (2nd edn, OUP 1994); Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (OUP 2000).

predominantly shaped by sanctity of life reasoning reinforced through a positivist statutory regime, contemporary bioethical and human rights discourses increasingly challenge the adequacy of this position. This theoretical interplay provides the analytical foundation for examining relevant provisions of the Constitution of the Federal Republic of Nigeria, Criminal Code, Penal Code, judicial interpretations, and the broader question of whether Nigerian law should maintain an absolute prohibition of euthanasia or move towards a more nuanced regulatory approach.

Existing Legal Order

Constitutional Framework

The legal framework regulating euthanasia in Nigeria is fundamentally rooted in the constitutional protection of the right to life. Section 33(1) of the Constitution of the Federal Republic of Nigeria, 1999 provides that every person has a right to life and that no person shall be intentionally deprived of his life except in execution of a court sentence in respect of a criminal offence for which the person has been found guilty in Nigeria. This constitutional guarantee underscores the importance attached to the preservation and sanctity of human life within the Nigerian legal order, and serves as the foundation upon which criminal prohibitions against unlawful killing are established. The right to life has traditionally been interpreted in Nigeria as imposing a duty on the state to protect and preserve life rather than recognizing a corresponding right to terminate life.²⁶ Consequently, Nigerian constitutional jurisprudence does not presently recognize a "right to die", or a legally enforceable entitlement to euthanasia or physician-assisted suicide. Unlike certain jurisdictions where courts have expanded constitutional rights to encompass personal autonomy in end-of-life decisions, Nigerian courts have generally adopted a conservative approach toward issues involving intentional deprivation

of life.²⁷ Nevertheless, the constitutional discourse surrounding euthanasia inevitably raises difficult questions concerning the relationship between the right to life and other constitutionally recognized rights such as human dignity, privacy, and personal liberty. It may be argued that the right to life should not simply imply the biological continuation of existence, but also encompass the quality and dignity of human existence. This argument becomes particularly relevant in cases involving terminal illness, irreversible suffering, or prolonged dependence on artificial life-support mechanisms. However, in the absence of judicial pronouncements or legislative reforms recognizing such an interpretation, the prevailing legal position in Nigeria remains firmly opposed to euthanasia.

Criminal Law Framework

The prohibition of euthanasia in Nigeria is principally enforced through the criminal law provisions governing homicide and related offences. Under the Criminal Code Act, unlawful killing accompanied by intention to cause death or grievous harm constitutes murder and attracts severe criminal penalties, including life imprisonment or capital punishment depending on the circumstances prescribed by law.²⁸ Similarly, the Penal Code criminalizes culpable homicide and imposes liability for acts intentionally causing death.²⁹ Consequently, active euthanasia, involving deliberate medical intervention to terminate life, would amount to unlawful homicide under Nigerian law regardless of the compassionate motives underlying the act. An important feature of Nigerian criminal law is that consent of the victim generally does not operate as a defence to homicide.³⁰ Accordingly, even where a terminally ill patient voluntarily requests euthanasia, the medical practitioner or individual involved may likely incur criminal liability for

predominantly shaped by sanctity of life reasoning reinforced through a positivist statutory regime, contemporary bioethical and human rights discourses increasingly challenge the adequacy of this position. This theoretical interplay provides the analytical foundation for examining relevant provisions of the Constitution of the Federal Republic of Nigeria, Criminal Code, Penal Code, judicial interpretations, and the broader question of whether Nigerian law should maintain an absolute prohibition of euthanasia or move towards a more nuanced regulatory approach.

Existing Legal Order

Constitutional Framework

The legal framework regulating euthanasia in Nigeria is fundamentally rooted in the constitutional protection of the right to life. Section 33(1) of the Constitution of the Federal Republic of Nigeria, 1999 provides that every person has a right to life and that no person shall be intentionally deprived of his life except in execution of a court sentence in respect of a criminal offence for which the person has been found guilty in Nigeria. This constitutional guarantee underscores the importance attached to the preservation and sanctity of human life within the Nigerian legal order, and serves as the foundation upon which criminal prohibitions against unlawful killing are established. The right to life has traditionally been interpreted in Nigeria as imposing a duty on the state to protect and preserve life rather than recognizing a corresponding right to terminate life.²⁶ Consequently, Nigerian constitutional jurisprudence does not presently recognize a "right to die", or a legally enforceable entitlement to euthanasia or physician-assisted suicide. Unlike certain jurisdictions where courts have expanded constitutional rights to encompass personal autonomy in end-of-life decisions, Nigerian courts have generally adopted a conservative approach toward issues involving intentional deprivation

²⁶ *Mojekwu v Iwuchukwu* (1997) 7 NWLR (Pt 512) 283 (CA); Constitution of the Federal Republic of Nigeria 1999 (as amended), s 33(1).

of life.²⁷ Nevertheless, the constitutional discourse surrounding euthanasia inevitably raises difficult questions concerning the relationship between the right to life and other constitutionally recognized rights such as human dignity, privacy, and personal liberty. It may be argued that the right to life should not simply imply the biological continuation of existence, but also encompass the quality and dignity of human existence. This argument becomes particularly relevant in cases involving terminal illness, irreversible suffering, or prolonged dependence on artificial life-support mechanisms. However, in the absence of judicial pronouncements or legislative reforms recognizing such an interpretation, the prevailing legal position in Nigeria remains firmly opposed to euthanasia.

Criminal Law Framework

The prohibition of euthanasia in Nigeria is principally enforced through the criminal law provisions governing homicide and related offences. Under the Criminal Code Act, unlawful killing accompanied by intention to cause death or grievous harm constitutes murder and attracts severe criminal penalties, including life imprisonment or capital punishment depending on the circumstances prescribed by law.²⁸ Similarly, the Penal Code criminalizes culpable homicide and imposes liability for acts intentionally causing death.²⁹ Consequently, active euthanasia, involving deliberate medical intervention to terminate life, would amount to unlawful homicide under Nigerian law regardless of the compassionate motives underlying the act. An important feature of Nigerian criminal law is that consent of the victim generally does not operate as a defence to homicide.³⁰ Accordingly, even where a terminally ill patient voluntarily requests euthanasia, the medical practitioner or individual involved may likely incur criminal liability for

²⁷ *Uzoukwu v Ezeonu II* (1991) 6 NWLR (Pt 200) 708 (CA).

²⁸ ss 315-324.

²⁹ Penal Code (Northern States) Federal Provisions Act, ss 220-221.

³⁰ *Nwali v State* (1991) 3 NWLR (Pt 182) 663 (CA).

causing death. This position reflects the strong influence of the sanctity of life doctrine within Nigerian criminal jurisprudence.

The legal framework governing euthanasia in Nigeria is derived principally from the general law on homicide, which prioritises the protection and preservation of human life and leaves little room for intentional acts designed to bring life to an end. Although Nigerian statutes do not expressly mention euthanasia or physician-assisted suicide, existing homicide provisions such as the ones discussed in the preceding paragraph are sufficiently broad to encompass such conduct. Furthermore, any person who aids, counsels, or procures another to commit suicide may potentially incur criminal responsibility under principles relating to aiding and abetting unlawful acts.³¹ Thus, Nigerian criminal law maintains an unequivocal prohibition against intentional termination of life whether directly or indirectly facilitated. The legal position concerning passive euthanasia and withdrawal of treatment, however, remains less certain. Situations involving refusal of treatment, discontinuation of life support, or "Do Not Resuscitate" decisions create complex legal and ethical dilemmas that Nigerian law has not comprehensively addressed. In practice, medical practitioners may occasionally withdraw futile treatment where recovery is medically impossible, particularly in cases involving brain death or irreversible terminal conditions. Nevertheless, the absence of statutory guidelines regulating such decisions creates uncertainty regarding the scope of lawful medical discretion and patient autonomy in end-of-life care. This legal uncertainty underscores the need for legislative and policy interventions that clearly define the rights and responsibilities of patients, families, and healthcare providers in making end-of-life decisions while maintaining appropriate safeguards against abuse.

³¹ Criminal Code Act, s 326; Penal Code, s 228.

Medical and Ethical Regulations

Apart from constitutional and criminal law provisions, medical practice in Nigeria is regulated through professional ethical standards designed to preserve life, maintain professional integrity, and protect patient welfare. The Medical and Dental Council of Nigeria (MDCN) serves as the principal regulatory body governing medical and dental practice in Nigeria and is responsible for enforcing standards of professional conduct among healthcare practitioners. It was established by the Medical and Dental Practitioners Act ³² and provides for the registration, licensing, discipline, and regulation of medical and dental practitioners. Medical ethics in Nigeria is largely influenced by the traditional Hippocratic Principle/Oath of 'I will abstain from all intentional wrongdoing and harm.'³³ It refers to the core medical idea that guides medical practice.³⁴ The principle holds that physicians should 'do no harm, and act in the best interest of the patient.'³⁵ Impliedly, physicians are required to preserve life and refrain from acts intentionally causing death. Consequently, active participation in euthanasia or physician-assisted suicide would likely constitute professional misconduct capable of attracting disciplinary sanctions, including suspension or revocation of medical licences. Nigerian medical practice generally prioritizes treatment, pain management, and palliative care rather than intentional termination of life. The doctrine of informed consent and the right of competent patients to make decisions regarding medical treatment has however been judicially recognized in Nigeria.³⁶ Consequently, patients possess the right to refuse treatment, decline surgical procedures, or reject extraordinary medical interventions. In the case of *Medical and Dental*

³² Cap M8, LFN 2004, s 1.

³³ Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* (Johns Hopkins Press 1964).

³⁴ *Ibid.*

³⁵ *Ibid.*

³⁶ *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2001) 7 NWLR (Pt 711) 206 (CA).

Practitioners Disciplinary Tribunal v Okonkwo,³⁷ the case involved a Jehovah's Witness who refused blood transfusion on religious grounds. The court held that a competent adult person has a constitutional right to refuse medical treatment, even where such refusal may lead to death.³⁸ The court also affirmed that the right to privacy implies a right to protect one's thought, conscience or religious belief and practice from coercive and unjustified intrusion.

This presents a profound dilemma for medical practitioners in Nigeria. On one hand, physicians are bound by professional ethics (the Hippocratic principle), and statutory duties requiring them to provide medical care in the best interest of patients. On the other hand, the court has affirmed the autonomy of competent adults to refuse medical treatment, even where such refusal may result in death. This places physicians in a precarious position where the duty to save life may conflict with the legal obligation to respect patient autonomy and informed consent. In emergency or end-of-life situations, doctors may therefore struggle to reconcile their moral conscience and professional commitment to preserving life with the constitutional rights of patients to dignity, privacy, and freedom of choice. The dilemma becomes even more acute in a legal system such as Nigeria's, where euthanasia and assisted dying remain criminalised, yet patient refusal of life-sustaining treatment is judicially recognised. Despite these realities, Nigeria presently lacks a comprehensive statutory or institutional framework specifically regulating end-of-life care, palliative treatment, advance directives, or passive euthanasia. Instructively, the Nigerian legal and institutional framework reflects a predominantly prohibitionist approach toward euthanasia grounded in constitutional protection of life, criminal law sanctions, and conservative medical ethics. However, contemporary medical realities and evolving human rights discourse continue to expose significant legal gaps concerning patient autonomy,

³⁷ Ibid.

³⁸ Per Aloysius Iyorgyer Katsina-Alu JCA (as he then was).

withdrawal of treatment, and end-of-life decision-making within the Nigerian healthcare system.³⁹

Human Dignity, Autonomy, and End-of-Life Decision-Making

The debate on euthanasia cannot be fully understood within the Nigerian legal order without confronting the broader question of human dignity and patient autonomy, particularly in the context of end-of-life medical care. While Nigerian law strongly emphasises the sanctity and protection of life, modern medical ethics and human rights discourse increasingly highlights the idea that the value of life is about biological existence, and the quality, dignity, and autonomy with which that life is lived.⁴⁰ This conflict becomes most visible in situations involving terminal illness, irreversible pain, and prolonged dependence on life-support systems. Human dignity, as a legal and moral principle, is central to contemporary constitutional and human rights theory. It suggests that every human being possesses inherent worth that must be respected and protected by law and institutions. In the medical context, dignity is often invoked to argue that individuals should not be compelled to endure prolonged suffering that strips them of bodily integrity, independence, and self-respect. From this perspective, euthanasia is sometimes framed not as the negation of life, but as an attempt to preserve dignity in the face of unavoidable and extreme suffering.

Closely related to dignity is the principle of patient autonomy. Autonomy in medical law refers to the right of a competent individual to make informed decisions about their own body and medical treatment.⁴¹ This includes the well-established right to refuse medical intervention, even where such refusal may result in death.⁴² In practice,

³⁹ Christiana Nneka Onuigbo, EOC Obidinma and Cornelius Onyeka, 'An Appraisal of the Right to Health versus the Right to Die: Medico-Legal Analysis' (2023) 10(1) *Nnamdi Azikiwe University Journal of Commercial and Property Law*.

⁴⁰ Ibid.

⁴¹ Tom L. Beauchamp and James F. Childress (n 9); Jonathan Herring (n 9).

⁴² n 36.

Nigerian medical ethics recognises informed consent as a fundamental requirement for lawful treatment, thereby acknowledging a limited sphere of self-determination in healthcare decisions.⁴³ However, whether this autonomy extends to a right to actively request assistance in dying remains highly contested within Nigerian law and ethics. Although not exactly a request for assisted killing, the court in *Medical and Dental Council Disciplinary Tribunal v Okonkwo*⁴⁴ grounded its reasoning in the broader constitutional protection of dignity and personal autonomy, thereby acknowledging that respect for individual choice forms part of the constitutional conception of human dignity. This decision has been widely regarded as introducing a limited autonomy-based exception within Nigerian medical jurisprudence. Despite this recognition of autonomy however, Nigerian law maintains a clear doctrinal distinction between passive and active forms of euthanasia. While the refusal or withdrawal of medical treatment may be defensible under the dignity framework articulated in *Okonkwo*, the intentional administration of life-ending measures remains incompatible with the constitutional protection of life. This distinction reflects a judicial preference for interpreting dignity as regulating the *quality of life* rather than authorising control over its termination.

The reconciliation of these two rights is therefore achieved through a hierarchical and purposive interpretive approach. The right to life is treated as the more structurally dominant norm, reflecting its foundational role in the constitutional order. The state is thereby placed under a positive obligation to protect life, and any limitation must be narrowly construed. The right to dignity, while equally fundamental, operates primarily as a constraint on the manner in which life is preserved, ensuring that individuals are not subjected to inhuman or degrading treatment, and that bodily autonomy is respected within the bounds of lawful medical practice. Accordingly,

⁴³ Ibid.

⁴⁴ Kwame Gyekye (n 17); Paulin J Hountondji (n 17).

dignity does not function as a legal justification for the termination of life under Nigerian law, but rather serves to guarantee that life, once protected, is lived in conditions consistent with respect for human worth. The two rights are thus not strictly antagonistic but operate at different normative levels, with the right to life defining the threshold of legal protection against unlawful death, and the right to dignity regulating the conditions of humane existence within that threshold.

This begs the question- is the constitutional right to life an obligation to live? It is trite that Nigerian constitutional law firmly privileges the sanctity of life over autonomy-driven conceptions of dignity, thereby precluding any legal recognition of euthanasia while preserving limited space for passive refusal of treatment grounded in dignity and personal autonomy. It is argued therefore, that the right to life is therefore best understood as a state obligation to protect life, not a personal duty to continue living. However, because the legal system also prohibits assisted death and suicide-related conduct, it can functionally resemble a strong presumption in favour of continued life even in the face of medical hopelessness and dignity-degrading conditions.

Another seeming contradiction within the Nigerian legal conception of the sanctity of life lies in the simultaneous criminalisation of any euthanasia-related practice, and the constitutional retention of the death penalty.⁴⁵ While the constitution guarantees the right to life, it expressly permits deprivation of life in execution of a court sentence,⁴⁶ thereby recognising state-authorised termination of life within defined legal limits. In contrast, any form of private or consensual assistance in dying is treated as unlawful homicide, reflecting an uncompromising stance against individual autonomy in end-of-life decision-making. This duality reveals that the right to life in Nigeria is not applied as an absolute value, but as a context-dependent principle that differentiates

⁴⁵ CFRN 1999, s 33.

⁴⁶ CFRN 1999, s 33.

between state-sanctioned and non-state actions. Consequently, the doctrine of sanctity of life is a flexible legal construct shaped by competing considerations of criminal justice, public policy, and medical ethics, rather than a uniform moral commitment.

Nevertheless, the jurisprudence in *Okonkwo* suggests an incremental judicial openness to autonomy-based reasoning, which may, in future constitutional interpretation, inform more nuanced debates on end-of-life care. Consequently, the conflict between human dignity and autonomy on the one hand, and the sanctity of life on the other, is central to the euthanasia debate in Nigeria. While the legal system presently prioritises the preservation of life, evolving medical realities continue to challenge the adequacy of this approach in addressing end-of-life suffering. This conflict forms the conceptual bridge to comparative approaches, where some jurisdictions have attempted to reconcile these competing values through carefully regulated frameworks for assisted dying and palliative care.

Comparative Perspectives

Spain

Spain legalized euthanasia through the Organic Law on the Regulation of Euthanasia (Ley Orgánica 3/2021), which came into force on 25 June 2021.⁴⁷ The law makes Spain one of the few countries in the world to permit both euthanasia and medically assisted dying under regulated conditions.⁴⁸ Under the Spanish framework, euthanasia is permitted for persons who:

- i. suffer from a serious, chronic, and incapacitating condition, or a serious and incurable illness;
- ii. experience unbearable physical or psychological suffering; and
- iii. make a voluntary, informed, and repeated request for assistance in dying.

⁴⁷ Boletín Oficial del Estado (BOE) No 72 25 March 2021.

⁴⁸ Ley Organica, arts I, 4, and 5

The law establishes strict procedural safeguards however.⁴⁹ Requests must generally be made in writing, assessed by multiple medical professionals, and reviewed by a regional evaluation commission before approval is granted.⁵⁰ The Spanish framework introduces institutional oversight through the establishment of multidisciplinary Guarantee and Evaluation Commission charged with verifying compliance with statutory safeguards and reviewing euthanasia requests. In the year 2024 alone, 426 requests for assisted dying were granted in 2024.⁵¹ The legislation also recognises conscientious objection, allowing medical practitioners to decline participation on ethical or religious grounds. Individuals with any sort of relation or affiliation with the patient can also legally object and delay the process. This played out very recently when Noelia Castillo, a Spanish woman who had been left paraplegic due to injuries suffered when she tried to take her own life in 2022, died at a Barcelona hospital. The Catalan regional government had granted her the right to assisted dying in 2024. However, the process was suspended at the last moment after legal objections raised by her father, backed by campaign group Christian Lawyers. After an 18-month legal battle, the European Court of Human Rights (ECHR) ruled in Noelia Castillo's favour and her death was eventually confirmed. The Spanish model is largely grounded in the principles of human dignity, personal autonomy, and the right to self-determination. Proponents argue that permitting euthanasia respects the ability of individuals to make deeply personal decisions concerning unbearable suffering and end-of-life care.⁵² Critics, however, contend

⁴⁹ Triviño-Caballero and others, 'The Euthanasia Law from the Perspective of Healthcare Professionals in Spain' (2026) 27 (6) BMC Medical Ethics <<https://doi.org/10.1186/s12910-025-01320-3>> accessed 10 May 2026.

⁵⁰ Ibid.

⁵¹ Guy Hedgcock, 'Spanish Woman Who Died Through Euthanasia Failed by State, Say Critics' BBC (Madrid, 27 March 2026) <<https://www.bbc.com/news/articles/c4g8w4xp97jo>> accessed 10 May, 2026.

⁵² Miguel Paradela López and Alexandra Jima-González, 'Analyzing the Spanish Euthanasia Law: Achievements and Inconsistencies of the Legal Assistance to Die' (2023) Revista de Bioética y Derecho 147-164 <[10.1344/rbd2023.58.39990](https://doi.org/10.1344/rbd2023.58.39990)> accessed 11 May 2026.

that the law weakens the traditional sanctity of life principle and may create a slippery slope capable of expanding euthanasia beyond strictly limited cases and weakening protections for vulnerable persons.⁵³

Switzerland

Switzerland occupies a unique position in the global euthanasia debate because it does not formally legalise active euthanasia, but permits certain forms of assisted suicide under specific conditions. Under Swiss law, active euthanasia, where a person directly administers a lethal substance to end another person's life, remains unlawful. However, assisted suicide is permitted provided that the assistance is not motivated by selfish interests.⁵⁴ As a result, Switzerland has a regulated framework in which individuals may lawfully obtain medical assistance to end their lives. The assisted suicide regime is operationalized largely through right-to-die organisations such as Dignitas,⁵⁵ and Exit.⁵⁶

Dignitas as an organisation, imbibes the motto, 'to live with dignity – to die with dignity.' Formed in accordance with Swiss law,⁵⁷ the organisation, pursues the objective of ensuring a life and a death with dignity for its members and of allowing other people to benefit from these values. The activities of Dignitas comprise, amongst others advising in regard to all end-of-life issues, cooperation with physicians, clinics and other associations, carrying out patient's instructions and patient's rights with regard to doctors and clinics, and suicide and suicide attempt prevention amongst others.⁵⁸ People from all over the world who seek authentic and honest advice on questions regarding life and death, contact Dignitas every day, without taboo, paternalism

⁵³ Ibid.

⁵⁴ SSC art 115.

⁵⁵ Dignitas <<https://dignitas.ch/en/>> accessed 11 May, 2026.

⁵⁶ exit, 'Our Society' <<https://www.exit.ch/en/englisch/who-is-exit/>> accessed 11 May, 2026.

⁵⁷ Founded on 17 May 1998 at Forch.

⁵⁸ n 55.

and stigmatization. The organization has over 30 part-time employees take care, directly and indirectly, of the needs of the association's members and further persons.⁵⁹

EXIT on its part, is a democratically organised society under Swiss law.⁶⁰ Its work is dedicated to the cause of human self-determination. Options offered by *EXIT* include living wills, legal counsel, and dignified end-of-life care. *EXIT* was founded in 1982, and is today, one of the world's oldest and largest organisations for living wills and physician-assisted suicide.⁶¹ All of the employees have the personal-social and technical competence that is necessary to fulfil their responsibilities in this sensitive area. End-of-life attendants submit to an in-depth training program that extends over a year and concludes with an assessment by the University of Basel. Seminars for continued professional development are scheduled several times a year. The collaboration with the physician-assisted suicide management is close, and mandatory for every end-of-life assignment.

In practice, the individual seeking assisted death must personally perform the final act, such as ingesting prescribed medication, distinguishing assisted suicide from active euthanasia. The Swiss approach is strongly influenced by the principles of personal autonomy and human dignity. Supporters argue that competent individuals suffering from terminal or unbearable conditions should retain control over end-of-life decisions.⁶² Critics, however, express concerns regarding ethical boundaries, potential abuse, and the gradual normalisation of medically assisted death.⁶³ Switzerland is also notable for permitting assisted suicide for certain non-residents, a

⁵⁹ Ibid.

⁶⁰ It operates under the permissive framework of SSC art 115.

⁶¹ exit (n 56).

⁶² Alex Mauron and Samia Hurst, 'Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians (2003) 326(7383) *British Medical Journal* 271-273 <<https://pmc.ncbi.nlm.nih.gov/articles/PMC1125125/#sec4>> accessed 12 May 2026.

⁶³ Ibid.

phenomenon often described as 'suicide tourism', where foreign nationals travel to Switzerland to access assisted dying services unavailable in their home countries. This was the case very recently of Wendy Duffy, a British national who travelled from the United Kingdom to Switzerland in order to have an assisted suicide because the practice is not allowed in the United Kingdom.⁶⁴ Duffy had lost her only son, years prior and could not live with the loss. She had previously unsuccessfully attempted to take her life, leading her to seek a professional option. Switzerland thus illustrates a middle-ground legal model that prohibits active euthanasia while recognising limited autonomy-based rights in assisted suicide cases.

The United Kingdom (UK)

In the UK, both euthanasia and assisted suicide are generally prohibited, although the legal framework surrounding end-of-life decisions has evolved through judicial interpretation and legislative debate. Suicide itself is no longer a criminal offence in England and Wales.⁶⁵ However, assisting, encouraging, or aiding another person to commit suicide remains an offence punishable by imprisonment.⁶⁶ Similar prohibitions exist in Scotland and Northern Ireland through separate legal frameworks. The UK legal position is strongly influenced by the sanctity of life doctrine, which underpins the protection of human life within both criminal law and medical ethics. Courts have traditionally maintained that intentionally causing death, even for compassionate reasons, constitutes unlawful killing.

In *R (Nicklinson) v Ministry of Justice*,⁶⁷ a landmark decision in the UK on assisted dying and the right to die, the court examined whether the

⁶⁴ Nadeem Badshah, 'Mother Ends Life at Swiss Clinic Four Years After Son's Death' *The Guardian* (London, 24 April 2026) <<https://www.theguardian.com/society/2026/apr/24/mother-ends-life-at-swiss-clinic-four-years-after-sons-death>> accessed 10 May 2026.

⁶⁵ Suicide Act 1961.

⁶⁶ *Ibid.*

⁶⁷ [2014] UKSC.

criminal prohibition on assisted suicide in section 2(1) of the Suicide Act 1961 was incompatible with Article 8 of the European Convention on Human Rights, which protects private and family life. By way of background, Tony Nicklinson, paralysed from the neck down after a 2005 stroke and living with locked-in syndrome, sought judicial approval for assisted suicide or a declaration that the prohibition on assisted dying violated his rights under the European Convention on Human Rights. The court declined to grant the permission and affirmed that assisted dying in the UK remains illegal under the Suicide Act, 1961, but confirmed that the courts could in principle review its compatibility with human-rights obligations. It reignited national debate on assisted dying and informed subsequent legislative proposals, including the 2015 Assisted Dying Bill which was heavily debated but failed to pass in the House of Lords and was subsequently withdrawn after strong concerns about safeguarding vulnerable persons.⁶⁸ The Nicklinson case remains a central reference in UK bioethics and constitutional law, illustrating judicial deference to Parliament on contested moral policy. Consequently, active euthanasia remains prohibited regardless of patient consent. Nevertheless, the law recognises an important distinction between actively ending life and withdrawing or withholding medical treatment.

Importantly, certain circumstances permit patients to lawfully refuse life-sustaining treatment, and doctors may discontinue futile treatment where continuation no longer serves the patient's best interests. This distinction has been notably affirmed in a plethora of cases. In *Airedale NHS Trust v Bland*,⁶⁹ the House of Lords permitted the withdrawal of artificial nutrition and hydration from a patient in a persistent vegetative state, holding that discontinuing futile treatment did not amount to unlawful killing. For comparative purposes, the United

⁶⁸ Parliamentary TV, 'Assisted Dying Bill Overwhelmingly Rejected by MPs' *The Guardian* (London, 11 September 2025) <<https://www.theguardian.com/society/2015/sep/11/mps-begin-debate-assisted-dying-bill>> accessed 11 May 2026.

⁶⁹ [1993] AC 789.

Kingdom represents a cautious legal model that rejects active euthanasia while permitting limited end-of-life autonomy through refusal of treatment and palliative care practices.

Lessons for Nigeria

The comparative examination of the euthanasia regimes in Spain, Switzerland, and the United Kingdom offers several important lessons for Nigeria, particularly in relation to constitutional interpretation, medical law, patient autonomy, and end-of-life care. Although Nigeria's legal and socio-cultural realities presently militate against the legalisation of euthanasia, these jurisdictions nonetheless provide valuable normative and institutional insights that may guide future reforms in healthcare and human rights protection. A major lesson for Nigeria is the importance of developing a clearer legal framework for end-of-life decision-making. Nigerian law presently lacks comprehensive statutory regulation concerning withdrawal of treatment, advance medical directives, palliative care, and patient autonomy in terminal illness situations. The experiences from Spain and the United Kingdom demonstrate that even where euthanasia remains controversial, the law can still provide structured guidance on patients' rights, medical responsibilities, and ethical safeguards. Nigeria may therefore benefit from enacting legislation that clarifies the legal status of refusal of treatment, living wills, and physician obligations in terminal care situations.

A second lesson lies in the growing recognition of human dignity and personal autonomy within medical jurisprudence. The decision in *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo*⁷⁰ already reflects judicial acknowledgment that competent adults possess autonomy over medical decisions affecting their bodies. Comparative jurisdictions illustrate that dignity-based reasoning can coexist with respect for the sanctity of life without necessarily

⁷⁰ (2001) 7 NWLR (Pt 711) 206 (CA).

endorsing active euthanasia. Nigeria may therefore strengthen legal protections for informed consent, bodily integrity, and patient choice while varying its constitutional opposition to intentional termination of life. Another significant lesson concerns the need for institutional safeguards in sensitive medical decisions. Spain's Guarantee and Evaluation Commission, and Switzerland's procedural oversight mechanisms demonstrate the importance of independent review, transparency, and accountability in end-of-life matters. Even without formally legalising euthanasia, Nigeria could establish ethical review structures within hospitals and medical institutions to supervise difficult end-of-life decisions, especially concerning withdrawal of treatment and palliative sedation.

The comparative analysis also highlights the urgent necessity of improving palliative and hospice care in Nigeria. One of the recurring justifications for euthanasia in foreign jurisdictions is the desire to alleviate unbearable suffering. In many developing legal systems, however, demands for euthanasia are often intensified by inadequate healthcare infrastructure, limited pain management, and poor access to terminal care. Nigeria can draw an important lesson from this by prioritising investment in palliative medicine, psychological support, and compassionate care for terminally ill patients. Strengthening healthcare systems may reduce the perceived need for euthanasia while preserving both life and dignity. Furthermore, the United Kingdom's cautious approach illustrates the importance of democratic deliberation in morally sensitive issues. The UK courts have consistently maintained that assisted dying is a matter for legislative determination rather than judicial activism.⁷¹ Nigeria can similarly recognise that questions surrounding euthanasia involve profound moral, religious, ethical, and cultural considerations that require broad societal dialogue rather than abrupt judicial innovation.

⁷¹ n 67.

Finally, the comparative study reveals that constitutional rights are dynamic and continuously shaped by evolving social realities. Although Nigeria presently prioritises the sanctity of life over autonomy-based claims, the gradual emergence of dignity-centred jurisprudence suggests that future debates may increasingly focus on balancing life preservation with humane treatment and personal choice. Consequently, Nigeria must begin engaging more deeply with emerging questions concerning medical ethics, patient rights, and the constitutional meaning of dignity in contemporary healthcare practice. In essence, the central lesson for Nigeria is that the legal system must evolve to address the complex realities of suffering, autonomy, dignity, and end-of-life care in a manner consistent with constitutional values, societal expectations, and global best practices.

Findings, Recommendations and Conclusion

Findings

This paper finds that the Nigerian legal order adopts a predominantly conservative and sanctity-of-life-oriented approach toward euthanasia and assisted dying. The constitutional guarantee of the right to life under Section 33 of the Constitution of the Federal Republic of Nigeria 1999 (as amended), together with the homicide provisions of the Criminal Code and Penal Code, creates a strong legal framework against the intentional termination of life. Nigerian law therefore does not presently recognise euthanasia or physician-assisted dying as lawful medical practices. The paper also finds that notwithstanding this strict protection of life, Nigerian constitutional jurisprudence has gradually incorporated autonomy-based elements through the right to dignity under Section 34 of the Constitution. Judicial decisions have demonstrated judicial recognition of bodily autonomy and the right of competent adults to refuse medical treatment. Although this does not legalise euthanasia, it reveals a developing jurisprudential appreciation of patient choice and human dignity in medical decision-making.

It is also a finding of this paper that the relationship between the right to life and the right to dignity remains conceptually unsettled within Nigerian constitutional discourse. While the right to life is framed as a constitutional entitlement, its practical operation often assumes the character of a non-waivable obligation, thereby generating conflict between state paternalism and personal autonomy. This conflict becomes particularly evident in end-of-life situations involving terminal illness, irreversible suffering, and withdrawal of treatment. Comparatively, the paper finds that jurisdictions such as Spain and Switzerland have moved toward greater accommodation of autonomy and dignity in euthanasia regulation through carefully structured legal safeguards, institutional oversight, and procedural accountability. Conversely, the United Kingdom maintains a more cautious position, preserving the prohibition on assisted dying while increasingly recognising the ethical significance of dignity and patient self-determination. These jurisdictions collectively demonstrate that contemporary euthanasia discourse extends beyond the legality of death itself and increasingly concerns the humane management of suffering, autonomy, and end-of-life care.

Finally, it is found that Nigeria's healthcare and legal systems remain insufficiently equipped to address modern end-of-life challenges. The absence of comprehensive legislation on palliative care, advance medical directives, living wills, and withdrawal of treatment creates uncertainty for patients, families, and medical practitioners. Consequently, end-of-life decisions in Nigeria often occur within an ambiguous legal and ethical framework.

Recommendations

In light of the foregoing findings, this paper recommends the enactment of a comprehensive legal framework regulating end-of-life medical decisions, including refusal of treatment, advance directives, living wills, palliative care, and physician responsibilities. Such legislation would provide clarity and reduce uncertainty in medical

practice without necessarily legalising euthanasia. Also, government and healthcare institutions should prioritise the development of accessible palliative and hospice care services across Nigeria. Effective pain management, psychological support, and compassionate terminal care would help preserve human dignity while reducing the pressures that often fuel demands for euthanasia. Nigerian courts and medical institutions should continue to uphold the principle established in *Okonkwo* by recognising the rights of competent adults to make informed decisions regarding medical treatment. Respect for patient autonomy should form part of a broader dignity-centred healthcare framework.

In addition, hospitals and healthcare institutions establish multidisciplinary ethics committees to supervise difficult end-of-life decisions and provide guidance to medical practitioners and families in ethically sensitive cases. Similarly, given the profound moral, religious, and cultural implications of euthanasia, there is a need for sustained public discourse involving legal scholars, medical professionals, religious institutions, ethicists, civil society organisations, and lawmakers. Such engagement would facilitate informed policy development grounded in Nigerian realities. Finally, judicial clarification of the constitutional relationship between the right to life and the right to dignity, particularly regarding withdrawal of treatment and patient autonomy, is indispensable. This is because clearer jurisprudence would contribute to the development of coherent medical and constitutional law principles.

Conclusion

This paper has demonstrated that the Nigerian legal order presently adopts a firm sanctity-of-life approach that does not accommodate euthanasia or assisted dying. Nevertheless, emerging judicial recognition of autonomy and dignity, particularly in medical decision-making, suggests that Nigerian jurisprudence is gradually engaging with broader questions concerning patient choice and humane treatment.

The comparative experiences of Spain, Switzerland, and the United Kingdom further reveal that modern euthanasia discourse is not solely concerned with the legality of assisted death, but with the broader challenge of balancing autonomy, dignity, compassion, and the state's obligation to preserve life. Although these foreign models may not presently align with Nigeria's constitutional and cultural realities, they provide valuable lessons for improving end-of-life care, strengthening patient rights, and developing clearer legal frameworks for medical decision-making. The true challenge for Nigeria is not only whether euthanasia should be legalised, but whether the legal system can evolve sufficiently to protect both life and dignity in a humane, balanced, and constitutionally coherent manner. The future of end-of-life jurisprudence in Nigeria will therefore depend on the extent to which the law is able to reconcile the preservation of life with the realities of suffering, autonomy, and human dignity in contemporary medical practice.