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Examining Euthanasia through the Lenses of Nigerian and Islamic Laws

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Abstract:
The right to life is the most fundamental of all human rights. But, while the sanctity of life is globally protected, there is no global consensus on the right to die. Despite the fact that every human being would prefer to die in a painless and dignified manner, many legal systems do not permit a person to choose when and how to die. Euthanasia is the exercise of one's right to end his life as he chooses. Euthanasia is fraught with cumbersome medico-legal, religious, and ethical issues, that weigh upon both the patient who desires to die a dignified death, and the physician who may be called upon to actualize this end. But this method to a painless death is illegal under Islamic law and Nigerian law. Employing doctrinal methodology, this paper examined the concept of euthanasia, drawing from Nigerian law and Islamic law, as well as related medico-ethical issues. The conclusion is that the debate on the legality of euthanasia would continue, as it is influenced by complex moral and ethical considerations. Although in a few clear cases, patient autonomy favoring passive euthanasia would appear to be implicitly accepted, yet biomedical technology for hospice and palliative care is key to ensuring dignified lives at end-of-life situations.

Keywords: Euthanasia, Nigeria, Islamic law, medical law, right to die

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1. INTRODUCTION

In the constitutions of most modern nations, the right to life is guaranteed as the most fundamental of all human rights, without which all other human rights are either less meaningful or less effective.[1] Both international instruments and municipal laws emphasize the sanctity of human life. Given the normal human instinct to cherish life and live it to the fullest, the answer to the question whether the right to life should co-exist with the right to die, becomes problematic. However, while the sanctity of human life indicates that it should be lived in dignity, there are situations under which a person might prefer death as the only viable option for escaping loathsome suffering. As Woodman observed,[2] modern biomedical technologies, thought to prolong human lives, may only succeed in prolonging the dying process with the concomitant pain and agony. Accordingly, persons experiencing such trauma could ask their physicians to help them die rather than live.[3] This would be true of terminally ill persons, in particular, persons who are brain dead or in a persistent vegetative state.

Given the sanctity of life, euthanasia or the right to die, is fraught with several medico-legal, ethical and moral challenges. For example, the debate whether to legalize euthanasia has, in recent years, taken a pivotal stage of intellectual discourse in medical jurisprudence. Some countries, such as Netherlands and Belgium have recognized the right to die, accepting euthanasia. In 2002, the Netherlands became the first country to legalize voluntary euthanasia and assisted suicide under strict conditions. Termination of Life on Request and Assisted Suicide (Review Procedures) Act allows for voluntary euthanasia for adult, mentally competent persons who suffer unbearable physical or mental pain, as well as assisted suicide for adult mentally competent persons.

Moreover, the Netherlands has a specialized end-of-life care system, which includes palliative care, hospice care, and terminal sedation. In all, the Dutch approach prioritizes patient autonomy, dignity, and quality of life. Still in 2002, Belgium enacted its Euthanasia Act, allowing for voluntary euthanasia and assisted suicide under specific conditions similar to Netherlands. Belgium's euthanasia law is considered one of the most permissive in the world, and in 2014, Belgium extended the right to voluntary euthanasia to minors, making it the first country to do so. Other countries, such as Nigeria and United States do not accept euthanasia. In Nigeria, euthanasia is considered a crime, as the law prohibits aiding and abetting suicide, which includes assisting in

[1] Menghistus, F. 'Satisfaction of Survival Requirements' in Ramcharan, B.G, (ed), *The Right to Life in International Law* (Dordrecht: Martinus Nijhoff Publishers, 1985) 63-83.

[2] Woodman S., *Last Rights: The Struggle over the Right to Die* (New York: Plenum Trade, 1998)19.

[3] Ibid.

euthanasia.[4] In the United States, euthanasia is a complex and controversial issue. While there is no federal law explicitly legalizing or prohibiting euthanasia, some states have enacted laws allowing for physician-assisted dying (PAD) or aid-in-dying, namely Oregon, Washington, Vermont, New Mexico, California, Colorado, Hawaii, New Jersey, Maine, and District of Columbia.

In these states, eligible patients can request a prescription for medication to end their lives, provided they meet specific criteria, such as having a terminal illness with prognosis of six months or less; being mentally competent, making an informed decision, and receiving confirmation from two physicians. Nevertheless, it must be stressed that euthanasia in the sense of active mercy killing, is illegal in all states. Moreover, PAD laws are subject to ongoing legal challenges and debates.

In view of the foregoing, this paper examines euthanasia through the lens of Nigerian law and Islamic Law. The next section is a comprehensive conceptual discourse on euthanasia including the arguments for and against it, as well as similarities with related practices. Subsequently, section three examines the medico-legal issues related to euthanasia. Section four treats euthanasia from Islamic law perspectives, while section five examines euthanasia and Nigerian law. The conclusion of the paper is in section six.

2. CONCEPTUAL DISCOURSE ON EUTHANASIA

Etymologically, the word euthanasia is derived from the Greek root words “eu” meaning “good” or “well” and “thanatos” meaning “death”. Together, “euthanasia” literally means “good death” or “dying well”. In ancient Greece, the term was used to describe a peaceful and painless death in the context of philosophical discussions about the nature of death and the ideal way to die. While the concept of euthanasia has evolved over time, its etymology remains rooted in the idea of a “good death”.[5] In modern usage, euthanasia refers to the practice of ending a person’s life, usually to end their suffering, often through medical means.

The term gained popularity from the 19th century in the context of debates about assisted dying and medical ethics. The term is used globally to discuss and navigate complex end-of-life issues. By its common usage, euthanasia refers to the termination of a person’s life, in order to end the person’s suffering, usually from an incurable or terminal sickness. Euthanasia may also be referred to as “mercy killing”, and as such, it is the act of a deliberate intervention or assistance to terminate a person’s life for the purpose

[4] Section 225 of the Criminal code and section 204 of the Penal Code.
[5] Riisfeldt TD. Overcoming Conflicting Definitions of "Euthanasia," and of "Assisted Suicide," Through a Value-Neutral Taxonomy of "End-Of-Life Practices". J Bioeth Inq. 2023 Mar;20(1):51-70. doi: 10.1007/s11673-023-10230-1. Epub 2023 Feb 2. PMID: 36729348; PMCID: PMC10126086.

of relieving that person of intractable pain and suffering.[6]

There are three main types of euthanasia, namely, voluntary euthanasia, non-voluntary euthanasia, and involuntary euthanasia. In voluntary euthanasia, the person requests euthanasia themselves, having made an informed decision to end their lives. In non-voluntary euthanasia, the person in unable to request euthanasia, for example due to coma or dementia, and the decision is made by others, such as family member or healthcare providers. In *Airedale NHS Trust v Bland*[7], the patient, Anthony Bland, suffered severe brain damage that left him in a persistent vegetative state as a consequence of which the hospital, with the support of his parents, applied for a court order allowing him to 'die with dignity'. In involuntary euthanasia, the euthanasia is performed against the person's will, which is a highly controversial and unethical scenario.

There are two methods of performing euthanasia, namely, active euthanasia, and passive euthanasia. Active euthanasia is done by directly causing death through medical means, such as lethal injection or assisted suicide by prescribing lethal medication. Passive euthanasia is performed by withholding treatment or allowing a person to die naturally, such as withdrawal of life support or palliative care. Physician-assisted dying and aid-in-dying are concepts that refer to the aid or facilitation given by physician or other person to a patient who is to die as a result of euthanasia.

The practice of euthanasia has both proponents and opponents. The major arguments in support of euthanasia are autonomy, compassion, and quality of life. The autonomy argument is that individuals have the right to control their own bodies and lives, including the right to die with dignity. Thus, to maintain life-support systems against a patient's wish is considered unethical within medical philosophy. If a patient has the right to discontinue treatment, the patient should equally have the right to shorten his lifetime in order to escape unbearable anguish associated with a prolonged wait for death. The compassion argument is that euthanasia eases anguish for those with terminal or debilitating conditions as it would be inhumane to allow patients in a persistent vegetative state to continue to live with such agony. Euthanasia relieves the patient's anguish, and the fundamental moral values of society, compassion or mercy, require that no patient be allowed to suffer unbearably, thereby justifying mercy-killing.[8] Finally, the quality-of-life argument favors allowing terminally ill persons whose quality of life can no longer be affected by treatment, to die with dignity, rather than prolonging suffering.

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[6] House of Lords Select Committee on Medical Ethics (1993*) Report of the Select Committee on Medical Ethics (*HLPaper *21*-1 of 1993-*4).*

[7] [1993] 1 All England Reports 821.

[8] Bulow, H H, *et al,* The world's major religions' points of view on end-of-life decisions in the intensive care unit(Intensive Care Med. 2008 March; 34(3) p. 423-30

On the other side of the divide are those against euthanasia, and their arguments can be surmised in three major points of sanctity of life, slippery slope, and alternative solutions. The argument on sanctity of life considers human life as sacred and that it should be preserved regardless of circumstances. Active euthanasia and mercy-killing are morally wrong and as such should be forbidden by law. Euthanasia is murder simpliciter and the intentional killing of another person, even where consent is provided, is inherently wrong. The human society recognizes the sanctity of human life. Human life stands to be respected and not abused since it is the sole prerogative of God to bestow life and to cause death.[9] Active voluntary euthanasia and physician-assisted suicide goes against the ethics of the doctor- patient relationship. The physician is to be of benefit to the patient and not to harm him by acts of physician-assisted suicide.

The slippery slope argument raises concerns about abuse or expansion to non-terminal patients, potentially leading to a devaluation of human life. There is no way one can ascertain that the patient's inclination towards assisted-suicide was voluntary or was due to over-bearing influence of family members who are bent upon the patient's death just to satisfy their personal whim. The legalization of mercy-killing could cause a drastic decline in medical health care and thus lead to an avalanche of victimization of the most vulnerable members of society. The term "right to die" may transform to "right to kill" under the concept of physician-assisted suicide as the legalization of euthanasia may lead to wanton abuse by health care professionals. An assessment of the mental balance of a patient, particularly a patient with a pain threshold that is below the optimum level, who perceives his circumstances not worthy of living anymore and desires to die, could present a difficult situation. Such a patient's unbalanced thought process could propel him towards making an illogical decision bent on suicide.

Finally, the argument on alternative solutions, posits that palliative care and support can improve the quality of life, thereby making euthanasia unnecessary. The role of adequate and smooth-running palliative care made available for the benefit of the aged, the terminally sick and other vulnerable groups could undermine the option of euthanasia and physician-assisted suicide as the way out to end pains and sufferings, ensuring a dignified death.

Moving on, there some practices that appear like euthanasia, but which should be contextualized side by side with euthanasia. One is refusal of life-saving therapy by competent adults. A competent adult's right ofautonomy entitles such adult to refuse a life-saving therapy except in emergency and under public health considerations.[10] The

[9] Euthanasia and the Slippery Slope- JSTOR <https://www.jstor.org> accessed 25 March, 2024.
[10] *Marshall v Curry* [1933] DLR 260 ;*Parmley v Parmley* [1945] DLR 81.

fundamental right to privacy of citizens in section 37 and right to freedom of thought, conscience and religion in section 38 of the 1999 Constitution taken cumulatively entitle a citizen of Nigeria to reject any course of medication which he feels invades his privacy or is against his thought, conscience, and religion. This was accepted by the Supreme Court of Nigeria in *Esabunor and Anor v Faweya and Ors*.[11]

Moreover, a patient's refusal to submit to treatment by the physician makes any further contact on him by the physician tantamount to battery in civil law or assault in criminal law, and continuous detention in the medical facility would amount to the tort of false imprisonment. This exposes the doctor to grave legal liability. A treatment which would otherwise be lawful by the consent of the patient is made unlawful as a trespass.[12] Once the competency of the patient is established,the irrationality or foolishness of the result of his rejection of life-saving treatment, becomes immaterial. [13] The Nigerian Supreme Court in *M.D.P.D.T v Okonkwo*[14] accepted the right of a Jehovah's Witness member to reject a medically indicated and life-saving transfusion. The patient firmly held to her opposition of blood transfusion by brandishing a signed card prohibiting any blood transfusion upon her, even in the face of imminent death. This Supreme Court's decision suggests that a competent patient in Nigeria can lawfully demand the termination of any life prolonging treatment or any life support apparatus, and this demand must be complied with even in the face of the patient's imminent death.

On another angle, a person who suffers from a disease of the mind or body which acutely impairs his reasoning power or ability to make a decision on whether to accept or reject a form of medical treatment would be incompetent to have control over his medical care.[15] Decisions on treatment regime to be adopted on behalf of such a patient are to be taken by family and his medical team who acts paternalistically.[16] Above all, a judicially appointed proxy could act for the patient, if need be. The point is that during a period of mental competency, a person could give advance directives regarding acceptable and unacceptable medical treatment that could be administered to him in the event of his mentalincompetency.[17]

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[11] (2019) Law Pavilion Electronic Law Reports LPELR-46961(SC).
[12] Neil L.J *in Re- F* (Mental Patients Sterilization) [1989] 2 FLR376.
[13] S.1(3) Mental Capacity Act 2005- A person is not treated as unable to make a valid decision merely because he makesan unwise decision.
[14] *M.D.P.D.T v Okonkwo* [2001] 7 NWLR 206 (SCN).
[15] Arinze-Umobi "Decisions made on behalf of those who lack Capacity (in the Medical Context) under the English and Nigerian Legal Systems Nnamdi Azikiwe University Journal of International Law and Jurisprudence / Vol. 6 (2015) https://www.ajol.info/index.php/naujilj/article/view/136283
[16] Uwakwe Abugu, P*rinciples of Medical Law an*d *Ethics* (Pagelink Publishers Nigeria Limited 2018)
[17] Nwabueze, R N, 'Euthanasia, Assisted Suicide and Decision-Making at the End of Life' in F N Ackerman, 'Patient andFamily Decisions about Life Extension and Death' in R Rhodes *et al(*eds), *The* Blackwell Guide to Medical Ethics (Oxford: Blackwell Publishing 2007) accessed on 15 March, 2024.

There are basically two types of advance directives: the proxy directive and the instructional directives. Both directives are fraught with uncertainties therefore, a combination of both forms of advance directives is needed to maximize the maker's control over future medical care and attention. The person who made the advance directive could authorize a proxy to fill the gaps left in the instructional directive where there are gaps.[18] The legal status of advance directives in Nigeria is not yet the subject of any statute or judicial decision. However, the decision in the *Okonkwo's case* is a recognition of advance directive by the Supreme Court. The Nigerian constitution lends further credence to the validity of advance directives as it secures the right to self-determination and the right of autonomy of a person.[19]

In most developed countries, with advanced health care delivery systems coupled with vibrant judicial systems, the power to terminate life-saving medical treatment on a patient in persistent vegetative state, lies with the doctor who may eitherdecide to continue or withdraw such treatment.[20] In Nigeria, the power to authorize the prolongation or withdrawal of a life-saving support system attached to a patient lies mostly with the family of the patient. The belief in the sanctity of life by majority of Nigerians precludes any authorization or endorsement of a proposal to terminate a life support system attached to any oftheir relatives who may be in an irreversible vegetative state. Thus, the role of the doctor in thedecision-making process about the sustenance or termination of the life support apparatus attached to the patient is diminished within the Nigerian context. Any direct action leading to the termination of the life of a terminally sick patient is viewed as a direct endorsement of euthanasia which is viewed as murder in Nigeria. Again, the legal position on Do Not Resuscitate (DNR) orders in Nigeria is not explicit. However, the principles of patient autonomy, informed consent, and medical ethics provide a foundation for respecting patient's wishes regarding end-of-life care.

Sometimes, patients who once considered death too unpalatable to contemplate realize that living can be worse than dying. Accordingly, such patients who experience excruciating agony may ask their physicians to help them die, and not to keep them alive.[21] While patients who are active and competent can end their lives by themselves, those who suffer incapacitation would require assistance. Assisted suicide could be occasioned when a physician gives a patient information about how to take a lethal dose of a drug and equally writes a prescription for the drug, knowing that it is the intention of the patient to kill

[18] Sneiderman B, Decision-Making at the End of Life, Downie, J, and Canfield, T, (eds), Canadian *Health Law andPolicy (*Toronto: Butterworths 1999) 397-425.
[19] Ss 34 & 37 Nigerian Constitution 1999.

[20] Canadian Courts have said that doctors and other health care providers must respect valid advance directives; *Flemingv Reid* [1991] Can LII 2728 (ON CA). End - of – Life Law and Policy in Canada Health Law Institute Dalhouse University. <eol.law.dal.ca> accessed 15 March 2024.
[21] Woodman S, *Last Rights: The Struggle Over the Right to Die* (Plenum Trade 1998)19.

himself with the drug, and the patient subsequently takes the lethal dose and dies as a result.[22] Assisted suicide is an offence under the Nigerian Criminal law. Given the above, the option of suicide is available only to the person who can procure suicide without the assistance of another person. Therefore, whoever assists a disabled or incompetent person to commit suicide violates the provisions of section 326 of the Criminal Code.

Another concept that is linked to end-of-life decision which should be differentiated from euthanasia proper, is the doctrine of double effect. This doctrine excuses the death of the patient that may result as a secondary effect from an action taken by the physician with the primary intention of alleviating pain. The concept of double effect has been defined by some protagonist of euthanasia, as a case where a doctor administers medication to thepatient knowing that there is a reasonable foreseeability that this would hasten the patient's death. In such a scenario, the patient's death is attributable to the underlying disease rather than murder by the doctor. This concept thrives on two edges; first the primary intention behind it which is to relief persistent pain, and the secondary intention, which is the intention to kill implied from the reasonable foreseeability of death. Thus, in Airedale NHS v Bland, Lord Goff observed that: A doctor may, when caring for a patient who is, for example, dying of cancer,lawfully administer pain-killing drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life.

Although, there may be no official documentation of cases by Nigerian physicians bordering on the doctrine of double effect, however, any Nigerian doctor who voluntarily adopts the common law doctrine of double effect in his relationship with his patients, would not be availed of any defense by the law. The physician should be guided by the fact that, if doing something morally good has a morally bad side effect, it is ethically appropriate to do it provided that no bad side effect was intended. This is anchored on the hallowed principle of non-malfeasance.

Nevertheless, there are several criticisms of the double effect doctrine.[23] One is moral ambiguity whereby the doctrine is employed to justify morally questionable actions, like killing, by claiming a noble intention. The second is the is the "intent as opposed to outcome question" as the distinction between intended and unintended consequences can be blurry, making it difficult to determine the true intention behind an action. The third is proportionality, whereby even if the intention is good, the outcome may not be proportionate to the action taken. The fourth is the slippery slope argument which posits that allowing euthanasia based on double effect could lead to a slippery slope where the boundaries of acceptable killing are constantly expanded. Fifthly, there is a lack

[22] Report of the Special Committee on Euthanasia and Assisted Suicide, *of Life and Death* (Ottawa: Minister of Supplyand Services Canada 1995) 51. <https://nla.gov.au> accessed 17 March, 2024.
[23] For criticisms of this view, see https://plato.stanford.edu/entries/double-effect/

of clarity in the sense that the principle can be vague and open to interpretation, leading to inconsistent applications. Sixthly is patient autonomy since the prioritizes the intention of healthcare providers over patient self-determination. The last criticism concerns medical ethics and law because the double effect doctrine compromises medical ethics by permitting harmful actions, even if unintentional, while also raising legal questions about the boundaries of acceptable killing.

3. MEDICO-LEGAL ISSUES RELATING TO EUTHANASIA

Euthanasia indicates issues of patients-rights, namely, autonomy, informed consent and dignity. It also implicates issues of medical ethics, namely beneficence (doing good), non-maleficence (not causing harm), and justice. Again, euthanasia has societal implications, which include an impact on vulnerable populations, for example, the elderly and the disabled; healthcare systems, and cultural values. In this section, the research examines these issues. At all times, the consent of the patient or the patient's proxy in the medical treatment and decision is paramount.[24]

One medico-legal argument against the legalization of euthanasia and physician-assisted suicide is anchored on the slippery slope argument, which asserts that "that although some acts of euthanasia may be morally permissible, to allow them to occur will set a logical precedent for, or will casually result in, consequences that are morally repugnant".[25] The argument is that if euthanasia and physician-assisted suicide were legalized, it will lead to a general decline in respect for human life. This could be a shortcut process for physicians who may see euthanasia as the solution to every treatment problem they cannot solve or as a means to cover up their medical mistakes.

In conjunction with the slippery slope argument, the doctrine of *primum non nocere,*[26] which although is not contained in the original Hippocratic Oath, is a medico-ethical injunction to physicians not to do harm to their patients. This is interpreted in the modern era to be "may the benefits (of medical treatment) out-weigh the risks".[27] This principle translated into the arena of euthanasia and physician-assisted suicide, could mean that any action undertaken by the physician to influence the dying process of the terminally diseased patient, could be a breach of this ancient principle of "first do no harm". Any physician faced with a patient under suicidal tendencies, has a better option

[24] Oluchi, Aniaka, Patient Right and the Socio-Cultural Challenges to Informed Consent in Nigeria (May 20, 2013). Available at SSRN: https://ssrn.com/abstract=2267336 or http://dx.doi.org/10.2139/ssrn.2267336

[25] First, do no harm- Every weapon in the physician's armamentarium is double-edged; every cure has a potential harm.Culled from Lecroy, K. *The lie of primum non nocere* (Am Fam Physician 2001

[26] Robert, H S,*First, do no harm* (Harvard Health Publishing, Harvard Medical School 2020 June, 22) Also available@ <*www.health.harvard.edu*> accessed 23 March, 2024.

[27] See *Olanrewaju Oni v the State* [2008] (WHRC) Vol 1 p.1. where the appellant poured acid chemical on his daughterand eventually caused her death, he was tried and found guilty of murder and was sentenced to death. See also the case of*Joshua v the State* [2009].

to cling to the more preferred ethical principle of "try to help your patient when you can, and when you can't, at least try not to make things worse". Thus, the physician is up against odds in giving any passive or active assistance to the patient to complete and achieve his suicide.

The medico-legal responsibility of the doctor to the patient is partly derived from the core ethical values of beneficence, non-maleficence, justice, respect for human autonomy, liberty, utility, solidarity, confidentiality and, preservation of human life; while on the other hand, being guided by the principles of Good Clinical Practice (GCP).[28] The doctor-patient relationship and the responsibilityof care of the physician towards the patient lies even upon a patient in a contemplative mood of euthanasia. In Nigeria, likewise many other jurisdictions, euthanasia or any other form of murder is illegal.[29] Thus, any deliberate act of the physician resulting in the death of his patient is defined as murder.[30]

The guiding principle of the doctor-patient relationship is anchored on the Hippocratic Oath which is virtually taken by every physician and adhering to the principle of "be of benefit, do not harm". Laying the foundation for the duty to preserve life, every physician swears under the oath Hippocratic Oath as follows; "I will neither give a deadly drug to anybody who asks for it, nor will I make asuggestion to this effect"[31]. The original lines of the Hippocratic Oath are deemed to be anti-euthanasia and other forms of physician-assisted suicide. By this oath, the physician is enjoined not to take any passive or active action to assist his patient to end his or her life. The later version of the wordings of the oath gives a leeway to endorse euthanasia or physician-assisted suicide by stating that:[32] "if it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of frailty."

The world has changed since the time of Hippocrates and some medical jurisdictions like the Netherlands and Belgium) feel that the original version of this oath

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[28] Netherlands legalizes euthanasia <https://www. bbc.com> accessed 18 March, 2024.

[29] Good Clinical Practice (GCP) is a combined medico-legal principles and quality standard that serve to protect the rights, integrity, autonomy and confidentiality of the patient. <https://www.ncbi.nlm.nih.gov> accessed 18 March 2024

[30] Section 316 of the Nigerian Criminal Code 1990- which defines murder as the intentional killing of anotherirrespective of the motive of the killer.

[31] The Hippocratic Oath is an oath of ethics historically taken by physicians. In its original form, it requires a new physician to swear, by a number of healing gods, to uphold specific ethical standards. <https:///www.medicinenet.com>accessed 19 March, 2024.

[32] Medical futility: definition, determination, and disputes in critical care – PubMed - Medical futility is when treatment cannot, within a reasonable probability cure the patient. Physicians may employ this concept to justify a decision not to pursue ceryain treatments that may be requested or demanded by a patient. <https://pubmed.ncbi.nlm.nih,gov> accessed20March, 2024.

is outdated and thus, adhere to this later version.[33] However, in jurisdictions like Nigeria, any doctor that relies on this updated version of the Hippocratic Oath to undertake physician-assisted suicide by providing the patient with the means, such as provision of a lethal drug, for the patient to kill himself is liable for murder.[34] Thus, the physician stands out to offer all life-saving care to his patient as the doctor is deemed to have the best interest of his patient at heart; "guiding such patients firmly through the decision making process as they do not always know what is best for them".[35]

Ethics are established moral principles and rules that guide the doctor-patient relationship. The five basic principles of autonomy, beneficence, non-maleficence, justice, and competence, are binding in the doctor-patient relationship unless they fall in conflict with moral principles, in which case the physician has to strictly choose what is in the best interest of the patient. They are now discussed below:

a. Respect for human autonomy

According to Beauchamp and Childress, autonomy is "a form of personal liberty of action where the individual determines his or her own course of action in accordance with a plan chosen by himself or herself. A person's autonomy is his or her independence, self-reliance and self- ability to decide".[36] It entails self-rule making and decision taking by an individual based upon informed consent. In doctor-patient relationship, this concept could be improved to the level of mutual decision making by the patient and his physician for the benefit of the patient. The principle of medical autonomy is intertwined with other ethical principles such as confidentiality, informed consent, adequate communication and trusting relationship between the doctor and the patient.

Respect for human autonomy is anchored upon the patient's capacity to think, decide or act on the basis of such thoughts and decision freely and independently, and was manifested in the case of *Schloendorff* v *Society* of New York Hospital, where it was held that every human being of adult years and sound mind has a right to determine what shall be done with his own body, which is the essence of respect for bodily autonomy.[37] A physician, faced with a patient's request for physician-assisted death, has to choose between recognizing the importance of the respect for the patient's autonomy or, adhering to the value of a paternalistic beneficence; which overrides the wishes of even a competent patient, when medical treatment not desired by the patient, could provide him with some measures of physical benefits. The physician standing his grounds against euthanasia as demanded by the patient, may argue that medical paternalism goes beyond the patient. The physician may seek the protection of the patient's family, public order

[33] Ibid.
[34] Beauchamp, T, *Paternalism and Bio-Behavioural Control* (in the Monist, 60, 1976) 67.
[35] Beauchamp and Childress, *Principles of Biomedical Ethics* (1st ed. 1979) 56.
[36] *Schloendorff v Society of New York Hospital* (1914) 105 NE 92 (NY).
[37] Beauchamp, T, *Paternalism and Bio-Behavioural Control* (60, The Monist, 62 1976)

and morals. This paper adopts the position that a physician may cause harm to third parties by performing euthanasia because a patient demands in exercise of the patient right to autonomy. Such harm could be in the form of the mental suffering of relatives and friends of an euthanized patient.[38]

b. Beneficence

The most salient ethical values anchored around the Hippocrates oath is the ethical mandate of beneficence, that is, doing good for the benefit of the patient. The physician is bound to provide the best medical treatment and care for their patients. The Hippocratic Oath, states that physicians "will follow that system of regimes which according to their ability and judgment, they consider for the benefit of their patients, and abstain from whatever is deleterious and mischievous".[39] Ethically, the physician who endorses physician-assisted suicide for the benefit of his patient may not have adhered to his sworn declaration and allegiance to the Hippocratic principles of"be of benefit, do-no- harm" to your patient. The physician in his medical judgement must strive to offer hopes of saving life, re-establishing health and alleviating the suffering and agony of his patient. Beneficence goes against euthanasia.

c. Non-maleficence

The ethical principle of non-maleficence, an aspect of the ancient Hippocratic principle is summarized by the statement, "be of benefit, do- no harm". There is no doubt that some medical interventions carried out by the physician for the benefit of the patients, come with risks of harm, for example, the inconvenient side effects of drugs. This side effect as implied by the principle of non-maleficence should with all efforts, not be disproportionate to the benefit of the treatment administered on the patient. The physician not acceding to euthanasia supposedly in the interest of the patient and with the intention of doing- no- harm to him, may in certain circumstances come into conflict with the respect for a person's autonomy. A treatment regimen prescribed by the physician might initially be unpleasant, uncomfortable or even painful, but eventually lead to good health and wellbeing for the patient.

Problems may arise which may put the physician in dilemma as when a person has requested in an advance directive for a painless death, and what in the physician's view is in the best interest of the patient particularly, when the physician is acting within the confines of the hippocratic oath he took as a medical Partitioner". Since ethics considers physician's-assisted suicide as an act done to harm the patient, it contradicts the dictates

[38] The Hippocratic Oath.
[39] Fisher C B, *Integrating Science and Ethics in Research with High-Risk Children and Youths* (Social Policy ReportVol. VII… 4 1993)

of non-maleficence which aim at preventing intentional harm and minimizing potential harm to oneself or by others to the same person. The ethical principle of non-maleficence is much pronounced in cases involving vulnerable patients. Fisher classified "vulnerability" as one characteristics of people unable to protect their own rights and welfare.[40]

d. Justice

The ethical value of justice demands fairness in the physician-patient's relationship particularly, when the physician is encountering a terminally ill patient who is under terrible persistent pain and suffering. Justice has also been defined as "the fair treatment of people; the quality of being fair or reasonable".[41] Thus, the ethical concept of Justice demands humane, fair and reasonable response by the physician to the distress experienced by the diseased patient, which in a way, may dissuade such a patient from contemplating suicide.

e. Competence

The determination of the patient's competence can neither be consistent nor standardized in a legal sense. Competence in bioethics means the mental ability to distinguish right from wrong and to manage one's own affairs.[42] Competence is decision-specific in practice, as a person may possess the mental capacity to make his or her last will or to stand trial, and yet be found incompetent to make a treatment decision. On the other hand, the legal criteria for competence are cognitive. Therefore, as long as a person is able to reach a logical decision, the law is not concerned with whether the decision is reasonable or not. Upon the patient's request for euthanasia, the physician must decide whether the patient is legally competent, whether the request is reasonable or not.[43] This is problematic since the reasonableness of the request is inevitably subject to the physician's social and moral values. Hence, issues arise as to how physicians perceive what causes and constitutes incompetence.

[40] Hornby, AS, *Oxford Advanced Learner's Dictionary* (International Student's Edition 8th ed. Oxford University Press)813

[41] Eareckson Tada, J. *When is it Right to Die? Euthanasia on Trial* (Marshall Pickering 1992)

[42] Jenny Ko "*Legalization of euthanasia violates the principles of competence, autonomy, and beneficence*" BC Medical Journal (March 2010) vol. 52 No.2 accessed from https://bcmj.org/mds-be/legalization-euthanasia-violates-principles-competence-autonomy-and-beneficence#:~:text=Upon%20the%20patient's%20request%20for,that%20is%2C%20having%20sound%20reasoning.

[43] Ibid

In the Netherlands, the complexities of determining competence are side-stepped in two ways.[44] First, the physician who determines whether euthanasia is to be performed does not have to evaluate competence based upon a specific set of standards since the law simply states that "voluntary, well-considered, and lasting" requests are competent enough, and the judgment is strictly at the discretion of the physician, although he is to consult with another experienced physician.[45] Secondly, Netherlands deals with the issue of competence by asserting that the nature of unbearable suffering does not have to be somatic. Severe psychiatric suffering is sufficient to allow euthanasia, as established in the Cabot case in which Dr. Cabot was sanctioned only for not consulting another physician and not for giving a lethal injection to a patient suffering severe depression.

4. EUTHANASIA AND ISLAMIC LAW

Islam considers medical ethics the same as ethics in other areas of life.[46] Accordingly, Islam prohibits euthanasia, as the core belief is that all human life is sacred because it is given by Allah, and that Allah chooses how long each person will live.[47] Human beings should not interfere in how long a person should live. As life is sacred, euthanasia and suicide are not included among the reasons allowed for killing in Islam. Qur'an 17:33 states that "Do not take life, which Allah made sacred, other than in the course of justice." Qur'an 16:61 states that "When their time comes, they cannot delay it for a single hour nor can they bring it forward by a single hour." Qur'an 3:145 also states that "And no person can ever die except by Allah's leave and at an appointed term." Moreover, suicide and euthanasia are expressly forbidden. Qur'an 4:29 states "Destroy not yourselves. Surely Allah is ever merciful to you."

In the Hadith of Sahih Bukhari 4.56.669, it is stated that "The Prophet said 'Amongst the nations before you there was a man who was wounded, and roaring in pain, he took a knife and cut his hand with it and the blood did not stop till he died. Allah said, 'My Slave hurried to bring death upon himself so I have forbidden him to enter Paradise.'" While many devout Muslims believe that Do Not Resuscitate (DNR) Orders represent a soft form of euthanasia, the Islamic Code of Medical Ethics states that "it is futile to diligently keep the patient in a vegetative state by heroic means… It is the process of life that the doctor aims to maintain and not the process of dying."[48] Hence, the physician can stop trying to prolong life in cases where there is no hope of a cure.

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[44] Ibid
[45] Ibid
[46] BBC "Euthanasia, assisted dying, suicide, and medical ethics" accessed from https://www.bbc.co.uk/religion/religions/islam/islamethics/euthanasia.shtml#:~:text=is%20not%20euthanasia.-,Euthanasia%20and%20suicide%20in%20Islam,should%20not%20interfere%20in%20this
[47] U Tun Aung, M. A. S. @ . (2018). Euthanasia from the Islamic Perspective: Ending Life of a Patient whose Recovery is Absolutely Impossible. *IIUM Medical Journal Malaysia*, *17*(2). https://doi.org/10.31436/imjm.v17i2.952
[48] Ibid.

Furthermore, the America Islamic Association "When death becomes inevitable, as determined by physicians taking care of terminally ill patients, the patient should be allowed to die without unnecessary procedures."[49] Hence, turning off life support for patients deemed to be in a persistent vegetative state is permissible since mechanical life support procedures are themselves temporary measures. Notwithstanding, hastening death with the use of certain painkilling drugs is not allowed as this would amount to euthanasia.

From the above, it is clear that Islam condemns euthanasia, and any form of physician-assisted killing, or even suicide.[50] Muslims have no right to end their lives. From a legal perspective, Islamic countries like Saudi Arabia, [51] have not legalized euthanasia or physician-assisted suicide. However, in certain rare situations, when a patient is in a persistent vegetative state, it may be permissible to authorize the withdrawal of a futile medical treatment, which prolongs pain or suffering. Islam values compassion, mercy, and palliative care, and encourages providing comfort and support to patients and their families during end-of-life situations. The prohibition of euthanasia in Islam is based on the following principles:

a. Prohibition of killing (qatl): Islamic law strictly prohibits taking a life, including one's own, as mentioned in Quara 5:32 "take not life, which Allah has made sacred".
b. Sanctity of human life (hifz al-nafs): Islam considers human life sacred and precious, and the taking of life is only allowed in exceptional circumstances, such as self-defense and punishment for serious crimes;
c. Trustee of Allah (khalifah): Humans are considered trustees of Allah's creation, and have a responsibility to protect and preserve life as stated in Qur'an 2:30;
d. No harm principle (la darar): Islam prohibits causing harm to oneself or others, and euthanasia is seen as a form of self-harm or harm to others;
e. Allowing the natural course (tawakkul): Islamic teachings emphasize allowing nature to take its course, rather than intervening to end a life prematurely.
f. Accountability: Muslins believe in accountability before Allah, and euthanasia may be seen as an attempt to escape or avoid this accountability.
g. Palliative care: Islamic bioethics emphasizes the importance of providing comfort and support to patients and their families during end-of-life situations.
h. Islamic view on suffering: some scholars argue that suffering can have spiritual

[49] Ibid.
[50] Legal Issues in End – of – Life Care; *Perspectives from Saudi Arabia*. <https:///www.researchgate.net> accessed 20 March, 2024 @ 2:23. In the Kingdom of Saudi Arabia, it is illegal to terminate a person's life or assist therein in order toend pain and suffering.
[51] Criminal Code Cap38 LFN 2004.

benefits, such as purification of the soul, and that euthanasia would deprive the patient of these benefits.

i. Islamic view on suicide: suicide is considered haram in Islam, and it is argued that euthanasia is a form of suicide.
j. The role of prayer and spirituality: Islamic teachings emphasize the importance of prayer and spirituality in end-of-life care, which may be seen as incompatible with euthanasia.

From the Islamic perspective, the difference between euthanasia and suicide could be seen from legal and ethical grounds.[52] Suicide is prohibited self-killing, while euthanasia would be prohibited for both the one who seeks self-killing as well as the one who assists such a person committing suicide. Similarities between suicide and euthanasia however are the wishes for death and ending of a life. The Islamic Code of Medical Ethics states that "mercy killing like suicide finds no support except in the atheistic way of thinking that believes our life on this earth is followed by void. The claim of killing for painful hopeless illness is also refuted, for there is not human pain that cannot be largely conquered by medication or by suitable neurosurgery…" the Islamic Code of Medical Ethics further states in Article 61 that "A physician should not take part in terminating the life of a patient… This particularly applies to the following cases of what is known as mercy killing: (a) the deliberate killing of a person who voluntarily asks for his life to be ended, (b) physician-assisted suicide, and (c) the deliberate killing of newly born infants with deformities that may or may not threaten their lives."

It is submitted that on the basis of the above code, a physician would be said to have committed an immoral and illegal act if he involves himself in killing a patient whether directly or indirectly.[53] Mercy killing is ethically wrong and it comes under the broader guidelines of the Qurán and *Sunnah* which are against killing innocent beings and against participating or collaborating in committing sin (*ithm*) as in Qurán 5:2. Hence, it is submitted that the debate on what constitutes active euthanasia remains irrelevant to seeking Islamic ethical guideline on how a physician should perform his responsibilities while dealing with terminally ill patients. That includes every act on the part of the physician which involves any assistance or guidance in killing terminally ill patients, which is ethically prohibited in Islam. Islamic scholarship indicates that the following forms of euthanasia are prohibited: voluntary euthanasia, involuntary euthanasia, non-voluntary euthanasia and physician-assisted suicide. The position of Islam on the conception of life and its sanctity makes killing or mercy killing prohibited.[54]

[52] Mahmud Adesina Ayuba "Euthanasia: A Muslim's perspective" Scriptura vol.115 Stellenbosch 2016 http://dx.doi.org/10.7833/115-0-1175 Accessed from https://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2305-445X2016000100001
[53] ibid.
[54] Ibid.

5. Euthanasia and Nigerian Law

The term "euthanasia' itself, is not contained in any of the criminal legislations in Nigeria. There are two primary criminal legislations in Nigeria, namely the Penal Code which is applicable in the 19 states of northern Nigeria, and the Criminal Code which applies in the 17 states of southern Nigeria. Euthanasia is not directly mentioned in the criminal codes, but euthanasia would fall within the scope of homicides. The Criminal Code recognizes the act of killing another person as being unlawful unless such a killing is authorized, justified or excused by law.[55] Therefore, all unjustified killings are classified as murder or manslaughter, depending on the circumstances of the killing. Thus, a physician in Nigeria who goes ahead to facilitate the death of a patient, even if the patient is under extreme conditions of ill health, through physician-assisted killing, has committed murder or manslaughter, depending on the circumstances of the killing.[56] Murder is intentional killing while manslaughter is killing resulting from negligence.[57] Motive is not an element of an offence under Nigerian criminal jurisprudence; hence, it is no less a murder because the motive of the physician-killer was sympathetic or noble, for example, alleviating the misery of the patient-victim.

Euthanasia could thus, be classified as a grievous crime which may attract the mandatory death sentence notwithstanding that the deceased consented to his death. Consent to murder does not absolve the murderer of criminal liability, which may include, death. In *State* v *Okezie*,[58] the Supreme Court of Nigeria upheld the constitutionality of the death penalty, holding that it cannot be regarded as a degrading or inhumane treatment. Up to the time of writing this paper, questions on the legality of euthanasia have not been directly presented before Nigerian courts. Nevertheless, the criminalization of euthanasia can be gleaned from Nigerian criminal laws on murder. The position in Nigeria can be contrasted with the position in the Oregon in the United States of America. The Oregon Death with Dignity Act,[59] views physician-assisted suicide as an aspect of medical treatment and not a crime as long as the physician acted in consultation with the patient's family.

The position of the Penal Code on euthanasia and physician-assisted killing is similar to the position of the Criminal Code. Under Sections 220 and 221 of the Penal

[55] S. 326 (3) of the Criminal Code, LFN 2004. See also, S. 33 (1) & (2) CFRN, 1999.
[56] *State* v *Okezie* [1972] 2 ECSLR 419.
[57] Section 316 Criminal Code.
[58] Oregon Health Authority: Oregon's Death… <*https://www.oregon.gov*> accessed 21 March, 2024 @ 4:40pm. On October 27 1997, the USA State of Oregon enacted the Death with Dignity Act which allows terminally ill Oregonians toend their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.
[59] Penal Code Cap P3 L.F.N 2004

Code,[60] any form of unjustified killing amounts to culpable homicide. Section 220 of the Penal Code provides that "whosoever causes death (a) by doing an act with the intention of causing death or such bodily injury as is likely to cause death; or (b) by doing an act with the knowledge that he is likely by such act to cause death; or (c) by doing a rash or negligent act, commits the offence of culpable homicide. From this provision, it is clear that there is no statutory excuse for euthanasia. Neither the patient nor his family can consent to euthanasia. Thus, it is a crime for someone to facilitate the killing of another person even if the person is in a persistent vegetative state. The combined reading of sections 222 (5) and 224 of the Penal Code shows that the offence of killing a person of full age and capacity, whether the deceased was sick or gave his consent, is criminalized under the Penal Code and punishable for a term which may extend to ten years in addition to a fine.[61]

Chapter IV of Nigeria's 1999 Constitution guarantees human rights, which are termed as fundamental rights. These provisions, to the extent that they have pronouncements on the fundamental rights of the individuals, also have a direct bearing on the law and practice of euthanasia and assisted suicide.[62] Specifically the right to life under section 33(1) of the constitution provides as follows: "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 offence of which he has been found guilty in Nigeria."

However, what could be interpreted as a legal recognition to passive euthanasia in Nigeria is reflected in the reasoning of the Supreme Court in M.D.P.D.T v Okonkwo.[63] In this case, the Supreme Court, per Ayoola JSC, held thus:

> Prevailing medical-ethical practice does not, without exception demand that all efforts towards life prolongation be made in all circumstances, but seem to recognize that the dying is more often in need of comfort than of treatment. If a competent adult patient exercising his right to reject life-saving treatment on religious grounds thereby chooses a path that may ultimately lead to his death, in the absence of judicial intervention overriding the patient's decision, what meaningful option is the practitioner left with other than,

[60] Ss. 33 (1) and (2) CFRN 1999
[61] See sections 33, 34 and 35 CFRN 1999
[62] *M.D.P.D.T. v Okonkwo* [2001] 7 NWLR 206 at 226- 7 (SCN)

[63] The Supreme Court gave a judicial analysis of the right of a patient to reject medical intervention, even in the face ofimminent death. Religion plays a significant role in an African's decision to accept or reject a life-saving medical procedure. The Supreme Court ruling (supra) was in relation to the right of a Jehovah's Witness to reject medically indicated and life-saving blood transfusion.

perhaps than to give the patient comfort?[64]

The right to reject medical intervention even in the face of imminent death as endorsed by the Supreme Court ruling in *M.D.P.D.T v Okonkwo* could be interpreted as a judicial endorsement of the right of a person, whether terminally sick or not, to reject life-saving therapy. This may be loosely interpreted as an endorsement of an individual's right to passive euthanasia. However, the Supreme Court emphasized upon the competency of the patient to give an advance directive. The Supreme Court further observed that conflicts between the patient's rights and public health are constitutionally resolved by balancing several interests such as the patient's constitutionally protected rights, the State's interest in public health, safety and welfare of the society; and the interest of the medical profession in preserving the integrity of medical ethics and, thereby, its own collective reputation. The Supreme Court further warned that the liberty of the individuals should not be threatened by giving undueweight to other interests over the rights of a competent patient. In the words of Justice Ayoola: The direct consequence of a decision not to submit to medical treatment is limitedto the competent adult patient alone, no injustice can be occasioned in giving individual right primacy.[65]

We note that the Supreme Court's decision affirming the patient's right of autonomy exercised to reject a life prolonging therapy, is consistent with the opinion of Lord Scarman in *Sideway v. Board ofGovernors Bethlem Royal Hospitals* where he said that: "… the court should not allow medical opinion of what is best for the patient to override the patient's right to decide for himself whether he will submit to thetreatment offered him."[66] In sum, the issues highlighted in *M.D.P.D.T. v. Okonkwo,* drew the line between what the physician in his paternalistic view, believes is good and would be for the best interest of the patient; and on the other hand, what the competent patient in exercise of his autonomy, is free to accept or reject. Thus, this case implied that even outside the realm of blood transfusion, a competent patient in Nigeria can lawfully demand the termination of a life prolonging or saving treatment. Such a decision must be complied with by the physician in obedience to the patient's exercise of his power of autonomy even in the face of imminent death.[67]

The Supreme Court by implication is saying that passive euthanasia is not a crime as primacy is accorded to the autonomy of the patient far above other considerations.More so,

[64] *M.D.P.D.T. v Okonkwo (*note 58*).*

[65] *Sideway v Board of Governors Bethlem Royal Hospitals [*1985] 1 ALL ER. P 645

[66] Remigius N Nwabueze "Euthanasia, Assisted Suicide and Decision-making at the End of Life in Irehobhude O Iyioha and Remigius Nwabueze (eds), *Comparative Health Law and Policy* (Ashgate Publishing Limited 2015)

[67] Ss 23 (1) (c) and (d) National Health Act, 2014- which require information on benefits, risks, costs, consequences andthe right of refusal of treatment…

Nigeria has promulgated the National Health Act,[68] which affirms a patient's right to refuse health treatment and services.

6. Conclusion

This paper examined the concept of euthanasia, and utilized the lenses of Islamic law and Nigerian law to situate the practice. As a controversial medico-legal issue, the legality and ethicality of euthanasia would continue to receive both knocks and kudos. The key finding is that there is no medico-legal consensus on euthanasia. While some countries have allowed the practice, many countries frown at it. What is important to note is that even in the countries that prohibit euthanasia, passive euthanasia, especially in the sense of withdrawal of life support and treatment in deference to patient autonomy, seem to be implicitly acceptable. Hence, both in Islamic Law and Nigerian Law, such an end to life is generally not approved.

Above all, the competence of the patient as well as the patient's informed consent to give directives for end-of-life decisions are paramount considerations. In the context of Nigeria, it is suggested that there should be a medico-legal definition of "advance directives" and "persistent vegetative state". For the advance directives, a code of practice embracing its vital issues should be developed to guide the physician when confronted with situations like the *Martha and Okonkwo Case,* while a code of practice relating to the management of patients in persistent vegetative state should be developed. The need to value and respect the sanctity of human life remains, but in appropriate circumstances withdrawal of life support or other form of treatment to terminally ill patients in vegetative state with the necessary consent and directives could be a choice. Alternatives to euthanasia should be pursued whereby the government invests in modern palliative and hospice care facilities to facilitate end-of-life care. When biomedical technologies that can extend human life in dignity become fully operational in Nigeria, more Nigerians would not see euthanasia as a valuable option for surviving end-of-life.

[68] *Re T* (adult: refusal of medical treatment) [1992] 4 All ER 649.