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CRIMINALIZATION OF EUTHANASIA IN NIGERIA AND ITS ETHICAL IMPLICATIONS FOR HEALTHCARE PRACTICE

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ABSTRACT

The criminalisation of euthanasia in Nigeria reflects a complex interplay of colonial legal inheritance, deeply entrenched religious and cultural values emphasising the sanctity of life, and constitutional protections for the right to life under Section 33 of the 1999 Constitution (as amended). This article examines how Nigeria's penal laws, the Criminal Code Act (applicable in the South) and the Penal Code (in the North), treat euthanasia and assisted suicide as forms of unlawful killing or murder, with consent offering no defense and penalties ranging from life imprisonment to death penalty. While passive euthanasia has seen limited judicial accommodation in cases like Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo (2001), where competent patients may refuse life-sustaining treatment on religious grounds, active euthanasia remains strictly prohibited. Drawing on the works of Nigerian scholars such as Ayantayo and others, the study explores the ethical tensions this legal stance creates for healthcare practitioners, who must navigate the Hippocratic Oath's imperative to preserve life against patients' demands for autonomy and relief from unbearable suffering amid resource constraints, poverty, and inadequate palliative care. The analysis reveals that criminalisation upholds societal values of human dignity and communal responsibility but imposes significant ethical burdens on physicians, including moral distress, fear of prosecution, and potential underground practices. By integrating doctrinal legal analysis with bioethical principles and African perspectives on life and death, this article argues that while outright legalization risks a slippery slope in Nigeria's socio-economic context, the current framework demands enhanced palliative care infrastructure and clearer guidelines to mitigate ethical dilemmas in clinical practice. Ultimately, the criminalisation of euthanasia underscores Nigeria's commitment to the inviolability of life but calls for balanced reforms to align legal rigidity with compassionate healthcare realities.

Keywords: bioethics, euthanasia, criminalization, Nigeria, ethical implications, healthcare practice, palliative

Introduction

"Euthanasia," derived from the Greek words *eu* (good) and *"thanatos"* (death), refers to the deliberate act of ending a life to alleviate suffering, typically in cases of terminal illness, unbearable pain, or irreversible loss of quality of life (Beauchamp & Childress, 2019). Globally, the practice has sparked intense debate, with jurisdictions like the Netherlands, Belgium, Canada, and parts of Australia legalizing forms of voluntary active or assisted euthanasia under strict safeguards (Emanuel et al., 2016), while others maintain prohibitions rooted in religious, moral, or cultural convictions (Keown, 2018). In Nigeria, however, euthanasia occupies a particularly contentious space, firmly embedded within a legal framework that criminalizes it outright, even as healthcare realities, marked by rising incidences of chronic diseases such as cancer, HIV/AIDS complications, and end-stage organ failure, force practitioners and families into agonizing ethical choices (Ogunbanjo & van Bogaert, 2014).

The criminalisation of euthanasia in Nigeria is not merely a statutory artifact but a reflection of the nation's postcolonial legal heritage, intertwined with indigenous African worldviews, Christian and Islamic doctrines, and constitutional imperatives that prioritize the sanctity of human life (Ayantayo, 2009). Inherited from British common law traditions during colonial rule, Nigeria's penal statutes view any intentional or assisted termination of life as homicide, irrespective of motive or consent (Okonkwo & Naish, 1990). This stance persists despite evolving global norms toward patient-centered end-of-life care, creating a profound disconnect between legal prohibitions and the lived experiences of patients enduring prolonged agony in under-resourced hospitals (Agom et al., 2019).

For instance, in urban tertiary centers in Lagos or Abuja, families of terminally ill relatives often grapple with the high costs of life-support systems, while in rural areas, limited access to pain management exacerbates suffering, leading some to informally "allow nature to take its course," a practice that skirt the edges of legality (Akpomiemie & Odukoya, 2020). This article posits that the criminalisation of euthanasia, while safeguarding societal values against abuse, generates significant ethical implications for healthcare practice in Nigeria.

Physicians, bound by the Medical and Dental Practitioners Act (Cap M8, LFN 2004) and the Code of Medical Ethics (Medical and Dental Council of Nigeria, 2015), face a professional imperative to "preserve life" that clashes with emerging bioethical emphases on autonomy, beneficence, and non-maleficence (Ogundiran, 2004). The result is moral distress: doctors risk criminal liability for acts perceived as merciful, yet withholding futile interventions may invite accusations of negligence or complicity in passive euthanasia (Oladipo, 2017). Moreover, Nigeria's pluralistic society, comprising over 250 ethnic groups with diverse beliefs about death, suffering, and the afterlife, amplifies these tensions (Makinde, 2015).

Yoruba traditions, for example, emphasize harmonious communal living and acceptance of fate, while Igbo and Hausa-Fulani perspectives, influenced by Christianity and Islam, reinforce the idea that only the divine determines the hour of death (Ayantayo, 2011; Gbadegesin, 1991). Extensively discussed in scholarly and policy circles, the issue gains urgency amid demographic shifts: an aging population, urbanization, and the double burden of communicable and non-communicable diseases strain Nigeria's fragile healthcare system (National Population Commission & ICF, 2019). Without robust palliative care frameworks, criminalization may inadvertently prolong suffering, erode trust in medical institutions, and push desperate families toward unregulated alternatives (Umeh & Adebayo, 2021).

This introduction sets the stage for a comprehensive exploration: clarifying concepts, grounding the analysis in theoretical frameworks, reviewing pertinent literature by African and Nigerian scholars (with particular emphasis on Ayantayo's contributions to religious ethics), dissecting the criminalisation process and its drivers, analyzing implications through results and discussion, and offering targeted recommendations. By adopting a scholarly lens that

balances legal doctrine with ethical humanism, this work contributes to ongoing discourses on bioethics in sub-Saharan Africa, advocating for nuanced reforms that honour life's sanctity while addressing human vulnerability in healthcare settings (Tangwa, 2007; Fayemi, 2016).

Conceptual Clarifications

To ensure analytical precision, key terms require clarification. Euthanasia encompasses the intentional termination of life to relieve intractable suffering and is classified into active (direct intervention, e.g., lethal injection) and passive (withholding or withdrawing treatment, e.g., removing ventilators) (Picón-Jaimes et al., 2022; Riisfeldt, 2023). It further subdivides into voluntary (with competent patient consent), nonvoluntary (e.g., for incompetent patients), and involuntary (against the patient's will) (Wooddell & Kaplan, 1998).

Assisted suicide involves providing the means for self-termination, a concept distinct from euthanasia but often conflated in legal contexts (Riisfeldt, 2023). In Nigeria, these distinctions blur under broad homicide provisions, with no statutory recognition of "mercy killing" (Ahaneku & Arinze-Umobi, 2024; Antom & Umar, 2020; Grace, 2025; Legal Ideas Forum, 2024; Mamah, 2024).

Criminalisation refers to the legislative and judicial embedding of euthanasia within penal codes as unlawful killing, rendering it punishable irrespective of intent or consent (Ahaneku & Arinze-Umobi, 2024). Ethical implications denote the moral dilemmas arising for healthcare professionals, including conflicts between deontological duties (preserve life), utilitarian outcomes (minimize suffering), and principlist balances (autonomy vs. non-maleficence) (de Zoysa, 2016; Lee, 2013; Prager, 1975; Smith, 2012).

Healthcare practice in this context encompasses clinical decision-making, palliative interventions, and end-of-life care within Nigeria's public and private sectors, influenced by resource scarcity, cultural norms, and professional codes (Mahmoud & Oluwagbemiga, 2025; Olasinde et al., 2025; Panapress, 2026; The State of Palliative Care in Nigeria, 2026). These clarifications frame the subsequent analysis, distinguishing legal prohibitions from ethical nuances in a resource-constrained, religiously pluralistic society.

Theoretical Framework

This study adopts two complementary theoretical frameworks: deontological ethics and principlism (biomedical ethics). Deontological ethics, rooted in Immanuel Kant's *Groundwork of the Metaphysics of Morals* (1785), holds that moral actions derive from absolute duties and universal rules, not consequences. Kant's categorical imperative requires treating humanity as an end in itself, never merely as a means. Applied to euthanasia, this theory imposes an inviolable duty to preserve life, rendering active or assisted termination impermissible even for compassionate reasons. This framework explains Nigeria's criminalisation regime, where penal laws reflect deontological absolutes aligned with constitutional right-to-life protections, prioritising societal duty over individual suffering and protecting vulnerable populations amid weak regulatory oversight. Contemporary deontologists defending duty-based moral frameworks include Józef Maria Bocheński, Thomas Nagel, T. M. Scanlon, and Roger Scruton.

The second framework, principlism, was developed by Tom L. Beauchamp and James F. Childress in *Principles of Biomedical Ethics* (1979, with subsequent editions). This mid-level approach balances four non-hierarchical principles: autonomy (patient self-determination), beneficence (doing good), non-maleficence (avoiding harm), and justice (fair resource distribution). In Nigeria's healthcare context, criminalisation often prioritises non-maleficence and sanctity of life over autonomy, creating ethical conflicts for practitioners treating terminal patients seeking relief.

Principlism enables nuanced discussion of passive euthanasia's judicial tolerance (as in *Okonkwo*) while critiquing how resource inequities undermine justice, thereby suggesting pathways for palliative care reforms that reconcile legal prohibitions with compassionate ethics. Recent extensions include Marco Annoni's critical examination of principlism as a

foundation for global bioethics, noting its limitations in addressing ethical pluralism, and the proposal of "compassionate principlism," which modifies beneficence as an arbitrating principle to reduce inconsistencies and offer more action-guiding prescriptions. Together, deontology justifies criminalisation's protective intent, while principlism exposes its practical ethical strains in Nigeria's healthcare landscape.

Literature Review and Methodology

The literature on euthanasia in Nigeria and Africa reveals a predominant consensus against active forms, rooted in religious, cultural, and legal imperatives, while acknowledging ethical grey areas in passive practices and end-of-life care. This section integrates a comprehensive review of existing scholarship with the methodological approach adopted in the present study, presented in seamless prose to highlight interconnections. Nigerian and African scholars have extensively interrogated the topic, emphasising the sanctity of life and contextual realities. Ayantayo, a leading voice in religious ethics and sociology of religion at the University of Ibadan, provides foundational insights in his seminal chapter “The Sanctity of Life: A Religious Dogma with Moral Implications for Biomedical Practices” (Ayantayo, 2003).

Ayantayo argues that life is a divine gift, valued intrinsically as humanity bears God’s image, rendering euthanasia incompatible with Judeo-Christian and broader African religious ethics. He extends this in Fundamentals of Religious Ethics (Ayantayo, 2009), critiquing deontological motives in end-of-life decisions and warning that passive euthanasia risks utilitarian justifications that undermine communal humanism. Ayantayo’s work is particularly germane, as it bridges theology with biomedical practice, highlighting how Nigerian healthcare providers confront religious taboos against hastening death amid rising terminal illnesses.

Complementing Ayantayo, other Nigerian scholars offer legal and bioethical perspectives. Bright E. Oniha (2017), in “Legality of Euthanasia and the Right to Die in Nigeria,” dissects the Criminal and Penal Codes, concluding that euthanasia equates to murder under Sections 306, 308, 311, and 326 of the Criminal Code Act (Cap C38, Laws of the Federation of Nigeria, 2004), with no consent defense per Section 299. Oniha notes constitutional tensions with rights to dignity (Section 34) and liberty, advocating limited exceptions, yet affirms criminalisation’s necessity given Nigeria’s socio-economic vulnerabilities.

Similarly, Ikono (n.d.) in “Criminalising Euthanasia in Nigeria: A Stitch in Time” and Fatimat Nene Abubakar (2025) in her appraisal of legal status urge explicit statutory definitions to close interpretive gaps, warning of judicial inconsistencies post-Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo (2001), where the Supreme Court upheld a Jehovah’s Witness patient’s refusal of blood transfusion, implicitly tolerating passive euthanasia without deeming the physician infamous. African scholars broaden the discourse. Omonzejele (2004) in “African Ethics and Voluntary Euthanasia” examines West African norms, arguing that communal ethics, prioritizing relational harmony over individual autonomy, reject voluntary euthanasia as disruptive to vital force and ancestral continuity, though passive forms may align with “letting die” in hopeless cases.

Jegede (2016) explores Yoruba perspectives on end-of-life decision-making, documenting cultural beliefs in fate and advance directives as alternatives to euthanasia, while noting modernization’s erosion of traditional safeguards. Adebayo Adejumo’s bioethics contributions (e.g., on moral and Islamic perspectives) reinforce prohibitions under Sharia-influenced Northern codes, emphasizing Allah’s sole authority over life’s duration. This study employs a doctrinal and qualitative synthesis approach characteristics of legal-ethical scholarship. Primary sources include Nigeria’s 1999 Constitution (as amended), Criminal Code Act, Penal Code, Medical and Dental Practitioners Act (2004), and the Okonkwo judgment. Secondary sources encompass peer-reviewed articles, books, and reports by the aforementioned scholars, supplemented by comparative African literature. Data analysis

involved thematic coding of legal provisions, ethical principles, and scholar arguments, ensuring exhaustive coverage of pro- and anti-euthanasia stances.

This hybrid methodology, doctrinal for legal rigor, prose synthesis for scholarly depth, facilitates critical interrogation without empirical fieldwork, aligning with the study's focus on implications rather than prevalence. Limitations include reliance on secondary data amid sparse empirical studies on Nigerian practitioners lived experiences, gap future research could address. Collectively, the literature underscores criminalization's dominance while exposing ethical fissures, setting the stage for deeper analysis.

Ethical Implications for Healthcare Practices in Nigeria

Nigeria's criminalization of euthanasia stems from a confluence of historical, religious, cultural, and pragmatic factors, profoundly shaping healthcare ethics. The idea crystallized during colonial rule, as British common law, prohibiting suicide and assisted dying, was transplanted via the Criminal Code Ordinance of 1916 (later codified). Post-independence, this persisted in the Criminal Code Act (Southern states) and Penal Code (Northern states), viewing life as inviolable under constitutional mandate (Section 33). No specific "euthanasia law" exists; instead, Sections 306 (unlawful killing), 308 (causing death by any means), 311 (acts/omissions hastening death in disease), and 316 (murder via stupefying or breath-stopping) encompass active euthanasia as murder, punishable by death.

Section 326 criminalizes aiding suicide with life imprisonment, while Section 299 nullifies consent as a defense. Sharia Penal Codes in states like Zamfara further prohibit it as defying divine will. This framework arose from fears of abuse in a society plagued by poverty, corruption, and weak institutions, colonial administrators and postcolonial lawmakers alike prioritized sanctity to prevent eugenics-like practices or familial exploitation. What led to this entrenchment? Religious pluralism is pivotal: Christianity (dominant in the South) invokes biblical sanctity (e.g., "Thou shalt not kill"), while Islam (North) affirms Allah's exclusive dominion over life and death per Qur'anic teachings. African traditional religions emphasize ancestral continuity and communal vitality, rejecting premature termination as disruptive.

Culturally, death is communal; hastening it severs relational bonds. Pragmatically, Nigeria's healthcare deficits, overburdened facilities, absent universal palliative care, and economic barriers fuel slippery-slope concerns: legalization could target the poor, elderly, or disabled amid "economic euthanasia" (implicit withholding due to cost). The Okonkwo case (2001) exemplifies nuance: a doctor's deference to a Jehovah's Witness patient's refusal of transfusion was upheld, suggesting passive euthanasia's legality when rooted in autonomy, yet active forms remain prosecutable, creating double standards that confuse practitioners.

Ethically, this criminalization imposes heavy burdens on healthcare practice, generating dilemmas across clinical, professional, and societal levels. Consider a terminally ill cancer patient in a Lagos teaching hospital, writhing in pain despite morphine; the oncologist contemplates dose escalation, risking respiratory failure (active euthanasia), but fears murder charges and Medical and Dental Council sanctions under the Code of Ethics, which prohibits "mercy killing." Withdrawal of futile ventilation (passive) might evade liability post-Okonkwo but invites family accusations of abandonment if death follows swiftly.

In rural Northern clinics, a Muslim family's request to "let Allah decide" clashes with a physician's training to intervene, exacerbating moral distress, studies document burnout among intensivists torn between non-malefience and prolonged suffering. Further examples abound: an HIV patient in end-stage AIDS, ventilator-dependent and cognitively impaired, prompts debates on non-voluntary euthanasia; criminalization forces resource allocation away from salvageable cases, violating justice. Assisted suicide requests in private practices risk felony charges, driving underground referrals to unregulated herbalists or abroad.

Ethically, this undermines autonomy (Beauchamp & Childress, 1979), as competent patients cannot exercise dignified death wishes, fostering paternalism. Beneficence suffers

when palliative alternatives are underdeveloped. Nigeria lacks national hospice policies, leaving families to shoulder burdens. Non-maleficence is double-edged: prolonging life harms via iatrogenic pain, yet hastening invites harm to the profession's healer image. In resource-scarce settings, "do no harm" becomes performative, as doctors document "natural causes" to avoid scrutiny.

Broader implications include eroded patient trust, professional secrecy erosion, and policy inertia. Healthcare workers report ethical paralysis, prioritizing legal compliance over compassion, potentially delaying palliative referrals. Culturally, it reinforces taboos; euthanasia-linked deaths invite stigma or improper burial, yet modernization (urbanization, Western media) fuels covert demands. Ultimately, criminalization protects against abuse but at the cost of compassionate care, demanding scholarly scrutiny of its sustainability.

Results and Discussion

The doctrinal analysis and literature synthesis yield clear results: euthanasia remains comprehensively criminalized in Nigeria, with active and assisted forms unequivocally treated as homicide under penal codes, while passive forms enjoy tenuous judicial carve-outs via patient autonomy rights (Okonkwo, 2001). This produces ethical implications manifesting as practitioner dilemmas, systemic healthcare strains, and unresolved bioethical tensions. These findings reveal a protective yet rigid framework ill-suited to contemporary realities. Results indicate robust legal safeguards, consent irrelevant, penalties severe, aligned with deontological imperatives and Ayantayo's (2003, 2009) sanctity-of-life dogma.

However, discussion uncovers paradoxes: the Okonkwo precedent implicitly endorses passive euthanasia in religious refusals, exposing "double jeopardy" (Oniha, 2017; Ikono, n.d.) where statutes criminalize omissions hastening death (Criminal Code s. 311) yet courts defer to constitutional dignity. This ambiguity fosters ethical inconsistency; physicians in ICUs must weigh documentation risks against patient suffering, leading to defensive medicine, over-treatment or premature discharges. Ethically, principlism illuminates imbalances: autonomy yields to non-maleficence in law, yet beneficence demands relief unavailable without palliative infrastructure.

In Nigeria's context, high terminal disease burden, poverty-driven care rationing, and criminalization exacerbate disparities. Rural practitioners face "economic euthanasia" accusations when families cannot afford ventilators; urban specialists navigate informed consent amid low health literacy. Discussion of Omonzejele (2004) and Jegede (2016) highlights African ethics' communal tilt: Ubuntu-like values prioritize relational harmony, viewing euthanasia as isolating, yet modernization erodes this, pressuring individualistic demands. Ayantayo's religious ethics (2003) reinforce that biomedical practices must honour divine prerogative, but empirical gaps (scarce data on covert practices) suggest underground erosion of prohibitions.

Broader discussion addresses slippery-slope risks: in a corruptible system, legalization could disproportionately affect marginalized groups (poor, elderly, and disabled), echoing global concerns. Conversely, prohibition perpetuates suffering, undermining healthcare's humanistic core and fueling calls for reform. Results affirm criminalization's cultural resonance; taboo status persists across ethnic lines, but discussion critiques its ethical toll on practitioners, advocating integrated palliative models to reconcile sanctity with compassion. Overall, the framework protects life but demands ethical recalibration for equitable healthcare.

Recommendations

In Nigeria, where euthanasia remains criminalized due to a deep-seated respect for the sanctity of life, there is still an urgent need to address suffering at the end of life through lawful, compassionate means. The following recommendations aim to enhance ethical healthcare delivery and mitigate distress without undermining core cultural and legal values.

1. Strengthen national palliative care infrastructure through policy and funding, prioritizing pain management training and hospice integration in public hospitals 'to address suffering at end-of-life through compassionate, licit means'
2. Develop clear clinical guidelines for end-of-life care, distinguishing passive from active interventions and incorporating advance directives to empower patient autonomy within legal bounds.
3. Launch public education campaigns via religious and community leaders to foster informed discussions on dignified dying, drawing on cultural and faith-based perspectives to reduce stigma.
4. Amend professional ethics codes for healthcare workers to include explicit protections for conscientious objection and documentation in passive cases, alleviating moral distress.
5. Invest in research and capacity-building for bioethics committees in teaching hospitals to guide case-by-case resolutions, ensuring justice in resource allocation.

Conclusion

In summary, the criminalization of euthanasia in Nigeria upholds the sanctity of life through robust penal provisions and religious-cultural imperatives yet imposes notable ethical strains on healthcare practice by constraining autonomy and exacerbating suffering amid systemic limitations. This study has clarified concepts, applied deontological and principlist frameworks, reviewed extensive scholarship (notably Ayantayo's sanctity-of-life contributions and African ethics insights), traced criminalization's colonial-religious origins with illustrative cases, and analyzed implications through doctrinal synthesis.

While protecting vulnerable populations, the regime highlights needs for palliative advancements and nuanced guidelines. Suggestions for further research include empirical studies on practitioners' attitudes, comparative analyses with other African nations (e.g., South Africa's evolving debates), and explorations of indigenous end-of-life frameworks to inform culturally sensitive policies.

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