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Research Paper

A Legal Examination of The Law on Euthanasia and Patient's Autonomy in Nigeria

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Abstract
This paper provides a legal examination of the law on euthanasia and patient's autonomy in Nigeria. It explores the global legal frameworks on euthanasia, contrasting countries that have legalized it with those that have not. It analyzes Nigeria's constitutional framework and the protection of human rights, determining if euthanasia can be justified within the existing legal framework. The paper also examines the role of medical ethics and patient autonomy in relation to euthanasia. It assesses the ethical and legal challenges, including religious factors, and discusses potential avenues for legal reform while considering patient welfare and societal values.
Keywords: *Autonomy, Euthanasia, Examination, Law, Legal, Nigeria*

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I. Introduction

The term euthanasia is commonly associated with a peaceful, tranquil, and pain-free passing. The problematic nature of Euthanasia and assisted suicide arises from the fundamental value of sanctity of human life, which is upheld by legal, societal, and religious institutions. Euthanasia refers to the culmination of a series of actions resulting in the deliberate termination of the life of an individual, typically afflicted with an incurable or terminal ailment. This procedure may be instigated by the patient, a knowledgeable individual, or a medical practitioner. The recognition of the right to life is often regarded as the utmost fundamental human right in the majority of legal systems. On a global scale, the concept is widely regarded as sanctimonious, thus meriting acknowledgment and safeguarding in international human rights treaties, as well as in the domestic Constitutions and legal frameworks of nearly all nations. The right to life clause can be found in several international human rights instruments, including the Universal Declaration of Human Rights of 1948[1], the American Convention on Human Rights of 1969[2], the European Convention for the Protection of Human Rights and Fundamental Freedoms of 1953[3], and the African Charter on Human and People's Rights of 1981.[4]

The 1999 Constitution of Nigeria (as amended)[5] has a provision that guarantees the right to life for every individual, with the exception of cases when the death penalty is imposed by a court following a conviction for a criminal offense. The Indian[6] and Malaysian[7] Constitutions, among others, also include comparable sections. The principle of the sanctity of life is widely acknowledged and accepted by a vast majority of individuals. However, the inquiry into the existence or recognition of a potential right to die typically elicits a contentious discourse involving legal, ethical, moral, religious, and intellectual proponents and opponents. In the majority of

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[1] Article III
[2] Article 4
[3] Article 2
[4] Article iv
[5] Section 33(1)
[6] Article 21 of the Constitution of India, 1950
[7] Article 5 of the Constitution of Malaysia, 1957

jurisdictions worldwide, there exists a widely accepted perspective and legal framework that deems euthanasia and assisted suicide as unlawful acts that are subject to criminalization. Euthanasia and assisted suicide have been legalized in only a limited number of jurisdictions. The countries and regions encompassed in this list are the Netherlands, Belgium, Luxembourg, Switzerland, Estonia, the state of Oregon, the state of Montana, and the Canadian province of Quebec.

The progress in contemporary medicine, along with the implementation of palliative care, has led to the extension and preservation of life beyond previously inconceivable limits. The consequence of this phenomenon is a concomitant prolongation of affliction, distress, and discomfort, particularly among individuals who are terminally sick and lack any prospects for survival or recuperation. Occasionally, individuals in a condition of unconsciousness or persistent vegetative state (PVS) prompt ongoing discussions over the ethical considerations surrounding the right to die through euthanasia and assisted suicide. The inquiry has also become more pressing due to the increasing advancement of domestic and global human rights legislation. As a result of these developments, ethical ideals like as death with dignity, the right to self-determination, and informed consent have emerged as counterarguments to the existing legal framework that fully criminalizes euthanasia and assisted suicide. The inquiry pertains to the rationale behind denying a terminally ill individual the autonomy to determine the manner and timing of their own death, particularly when all prospects of recovery have been exhausted. Instead, they are compelled to endure excruciating pain, distress, and loss of dignity, potentially reliant on life-sustaining medical devices that merely prolong a life marked by suffering, occasionally spanning several decades. The proponents argue that it is imperative to shift the focus from merely measuring life in terms of its duration to also considering its quality, which is derived from the acknowledgment of the right to self-determination.

II. Conceptual Framework

2.1 Euthanasia

The name "euthanasia" originates from the Greek words "eu" and "thanatos," denoting a "good death" or "easy death" in etymological context. Given the universal inclination of individuals to want a desirable and painless death when confronted with its unavoidable occurrence, it is insufficient to classify euthanasia solely as a "good death" without further elaboration. Consequently, it is imperative to continue our pursuit in order to attain a more comprehensive and elucidating definition. According to Black's Law Dictionary[8], euthanasia is defined as the deliberate act or practice of causing or expediting the death of an individual who is afflicted with an incurable or terminal disease or condition, particularly one that is accompanied by significant pain, motivated by compassionate reasons. Similarly, the Encyclopedia Britannica[9] describes euthanasia as the act of painlessly causing the death of individuals who are suffering from a painful or incurable disease or a debilitating physical disorder, or alternatively, permitting them to die by withholding treatment or withdrawing artificial life support measures. It is important to emphasize that although the majority of euthanasia cases involve a desire to end an incurable or terminal condition, this is not necessarily a prerequisite. Euthanasia and assisted suicide have been documented and observed as being performed in medical contexts that are less severe.

2.2 Assisted Suicide

Assisted suicide, as its name implies, refers to the deliberate act of facilitating an individual's access to medical resources or knowledge for the purpose of self-inflicted death. When a medical practitioner facilitates the process, it is commonly known as "physician-assisted suicide." Euthanasia and assisted suicide are distinct in that, in the latter scenario, an individual actively and voluntarily brings about their own demise by means of assistance from another person who provides the necessary means to terminate the patient's life. This assistance is provided with full awareness of the individual's intention to commit suicide, which is motivated by a medical condition. In contrast to euthanasia, it is not required for the provider to function as the immediate cause of death.[10]

III. Forms of Euthanasia

The act of euthanasia can be categorized into either active or passive forms, which are determined by the specific method employed for its implementation.

3.1 Active Euthanasia

According to the definition provided in Black's Law Dictionary[11], this particular type of euthanasia refers to a process wherein a facilitator, typically a physician or healthcare practitioner, not only supplies the necessary tools

[8] Garner, B.A., Black's Law Dictionary (9th edition, Law Prose Inc. 2009) 634
[9] Encyclopedia Brittanica, 'Euthanasia' available at www.britannica.com accessed on the 10th of November, 2023
[10] Ibid, (n 8), 1571
[11] Ibid

to cause death but also actively performs out the ultimate act resulting in the individual's demise. Euthanasia involves the deliberate implementation of affirmative measures to induce the demise of another individual, such as the administration of a lethal injection, the dispensation of lethal pills, or the intentional overdose of pain-relieving or sedative drugs.

3.2 Passive Euthanasia

Passive euthanasia refers to the practice of permitting a terminally sick individual to pass away by either refraining from or ceasing the provision of life-sustaining interventions, such as the removal of a respirator or feeding tube, in cases where the person is incapable. This particular modality of euthanasia is frequently observed in instances involving patients who lack consciousness or are in more severe conditions characterized by a chronic vegetative state. The differentiation between this particular form and active euthanasia lies in the fact that, in the case of the latter, an action is taken to withhold or withdraw a measure that could have potentially maintained or prolonged the life of another individual.

IV. Categories of Euthanasia

There exist three fundamental categories of euthanasia. There exist three distinct categories of euthanasia, namely Voluntary, Non-voluntary, and Involuntary euthanasia.

4.1 Voluntary Euthanasia

Voluntary euthanasia refers to the act of administering medical assistance to end the life of a patient with their explicit agreement.[12] A patient has the ability to provide consent when they are in a state of mental clarity and competence. This can be done through the use of an Advance Directive or a living will, which explicitly states their preference for either terminating their life or refraining from receiving life-sustaining treatment in the event that they become incapacitated or unable to communicate their wishes. One prominent illustration of this category of euthanasia is to the renowned case of D. Cox (1992) conducted a study. Dr. Cox openly demonstrated noncompliance with legal regulations by granting consent to Mrs. Boyes, a 70-year-old individual, who persistently requested active voluntary euthanasia. The individual's illness was of such severity that any physical contact elicited a vocal response like to that of a canine, characterized by loud and distressing screams. The use of conventional drugs failed to alleviate her symptoms of agony. During the final stages of her life, subsequent to her persistent plea for euthanasia. Dr. Cox administered a dose of potassium chloride, resulting in her tranquil transition. Subsequently, Dr. Cox was convicted and received a suspended sentence. This particular case serves as a prototypical illustration of a patient's autonomy in the decision-making process about medical treatment or intervention, specifically in relation to euthanasia. The conviction of Dr. Cox is untenable due to the fact that his actions were in accordance with his patient's exercise of their right to self-determination. Hence, it is not surprising that his conviction only results in a minor punishment.

Another noteworthy instance of deliberate euthanasia is shown by the Belgian twins, Marc and Eddy Yer-bessem. Marc and Eddy Yer-bessem, a pair of 45-year-old identical twins, were both born with a congenital hearing impairment. In light of their imminent loss of vision, they endeavored to terminate their lives. Additionally, it has been documented that they experienced a succession of medical conditions, such as spinal and heat disease. The brothers argued that the absence of being able to see each other would result in experiencing intolerable suffering, as outlined under the legal framework surrounding euthanasia in Belgium. The request made by the individuals was approved, resulting in the administration of deadly injections by medical professionals at Brussels University Hospital in Belgium. In contrast to the aforementioned case involving Dr. Cox, the Belgian twins' exercise of their right to bodily autonomy was conducted in accordance with the provisions of the Belgian Act on Euthanasia enacted on May 28th, 2002. Nevertheless, both situations share a commonality in that the legal and ethical rationale for their decision is grounded in the idea of upholding their right to bodily autonomy.

4.2 Non-voluntary Euthanasia

The act being discussed involves the practice of euthanasia on an individual who lacks the capacity to provide informed consent.[13] This issue may emerge in circumstances where the consent of the individual or patient in question is not obtainable, such as when they are unconscious or otherwise unable to provide consent due to factual or legal incapacity. In the present study, we examine the instance *of Airedale N.H.S. v Bland*[14] as resolved by the House of Lords, exemplifies a common occurrence of euthanasia in this particular context. In the aforementioned incident, an individual named Anthony Bland, aged 17, and identified as a supporter of the Liverpool football club, was among those who suffered fatal injuries during the Hillsborough football club

[12] Garner, B.A., Black's Law Dictionary, 1571
[13] Garner (n 8)
[14] (1993) All ER 82(HL)

catastrophe on April 15th, 1989. During the course of this regrettable calamity, his pulmonary organs experienced compression and perforation. The provision of nutrients to his brain was disrupted. Consequently, he experienced severe and permanent impairment to his cerebral functions. Over a span of three years, the individual remained in a state of persistent vegetative state (PVS), resulting in the absence of visual, auditory, and tactile sensory perception. To sustain his condition, he received nutrition and hydration through the utilization of a nasogastric tube. Based on authoritative medical perspectives, it was determined that there was no foreseeable possibility of his health improving. However, there was a high probability that he would continue to live for an extended duration, contingent upon the ongoing implementation of medical interventions. In the present jurisdiction, medical professionals adopted the perspective, endorsed by the parents, that the continuation of medical intervention would not yield any beneficial outcomes. Consequently, they recommended the cessation of artificial feeding and other interventions intended to prolong the patient's life. Nevertheless, due to uncertainty over the potential classification of this action as a violation, the hospital pursued a formal request for a legal determination from the high court in order to clarify this matter. The case was brought before the House of Lords. All members of the House of Lords reached a unanimous decision to grant permission for Anthony Bland to be permitted to pass away. The case of *Aruna Shanbaug v Union of India*[15], which has gained significant recognition in India, also comes within this category.

4.3 Involuntary Euthanasia

Involuntary euthanasia refers to the act of administering euthanasia to an individual who is competent but has not provided consent for the procedure. This particular form of euthanasia pertains to those who possess the capacity to offer informed permission but refrain from doing so either due to their lack of desire for death or the absence of a request for consent. The act of involuntary euthanasia is frequently met with criticism and is considered a criminal offense in all legal jurisdictions. It is common for individuals to cite or express concerns about involuntary euthanasia as a justification for their opposition to other forms of euthanasia. It is imperative to differentiate this form of euthanasia from non-voluntary euthanasia, as the patient in the former scenario lacks the capacity to provide informed permission.

V. Self Determination

As to the definition by Chambers 21st Century Dictionary, self-determination refers to the autonomy to independently make choices without external interference.[16] Regarding the rights of patients in medical contexts, it can be understood that patients possess the entitlement and capacity to exercise autonomy in making choices and decisions pertaining to their medical care and treatment, provided that such decisions adhere to legal constraints.[17]

The idea of self-determination or patient autonomy is a key tenet within the realm of medical law and ethics. This particular right is derived from common law and statutes that pertain to constitutional law. One fundamental element of the principle of self-determination is manifested through the authority of a capable adult to provide informed permission for medical treatment or intervention, encompassing the right to refuse life-saving treatment as well. In the realm of medicine, the doctor-patient relationship is typically characterized by a strong basis of trust and respect, with the doctor acknowledging and upholding the patient's autonomy over their own body. End-of-life decisions, such as the choice to seek resort or request euthanasia or assisted suicide, provide a challenge to the adherence and reverence for this principle, particularly in light of a physician's commitment to the Hippocratic Oath.

5.1 Historical Background

The concept of self-determination can be traced back to its roots in various sociological, ethical, legal, and, more recently, health-care contexts.[18] The pattern of safeguarding and advancing self-determined choice is particularly evident when addressing the oppression faced by individuals or groups, irrespective of the specific circumstances. The emergence of the notion of self-determination in healthcare cases originated from the imperative to uphold the rights of individuals, particularly patients. Prior to the emergence of medical breakthroughs pertaining to the prevention and treatment of fatal ailments, individuals afflicted with diseases such as cancer underwent a process of decline and ultimately succumbed to mortality. The primary responsibility of

[15] (2011) 4 SCC 454

[16] Mairi Robinson, *Chambers 21st Century Dictionary* (Rev edn., Chambers Harrap Publishers Ltd, 1996) 1273

[17] US Legal, 'Right to Autonomy and Self Determination' available at https://healthcare.uslegal.com accessed on the 18th of September, 2023.

[18] Bakitas M.A., 'Self-Determination: Analysis of the Concept and Implications for Research in Palliative Care' CJNR 205 37, No. 2, 22-29 available at www.igenta.com accessed on the 18th of September, 2023

medical professionals, namely doctors and nurses, was to offer solace and support along the course of the individual's journey towards the inevitable occurrence of "natural death".[19]

With the advent of various medical advancements such as antibiotics, vaccinations, chemotherapy, and cardiopulmonary resuscitation, patients are no longer able to passively anticipate death while being attended to by compassionate healthcare professionals. During this era, the conventional principle governing the behavior of physicians permitted doctors to act or enforce a course of action or treatment without the need to gain the previous agreement of their patients. During this period, physicians were primarily focused on adhering to the principles of the Hippocratic Oath, which emphasized the importance of avoiding any harm to the physical well-being and overall health of their patients. This age was characterized by a notable disdain for the patient's autonomy and his right to self-determination over his own body. In the present era, there has been a significant transformation in this regard. Within the realm of medical law, ethics, and practice, the patient's permission has emerged as a vital aspect. Any infringement of this right places the practitioner at risk of legal consequences, as well as disciplinary responsibility and sanctions. This holds true, regardless of the good or beneficent intentions of the physician. Even in cases where the patient has not experienced any bodily harm or damage and may have actually derived significant advantages. According to Professor Vera Lucia Raposo[20], the transformation of the doctor-patient relationship is driven by the recognition that the patient's fundamental rights, such as the freedom to make decisions regarding their health and even life, must be respected. This understanding is supported by a legal precedent established in 1914 by the New York Supreme Court in the case of *Schloendorff v Society of New York Hospital*[21]. In this case, Justice Cardoza asserted that every mentally competent adult has the right to determine the course of medical treatment for their own body and cannot be subjected to medical interventions without their consent.

In a similar vein, Will J.F.[22] postulated that the period from the Hippocratic tradition to the conclusion of the 19th century witnessed a consistent adherence to a medical ethic centered around beneficence. The period under examination did not exhibit the presence of a significant role for the patient in the decision-making process. Indeed, the act of benign deception, which involves the intentional withholding of any information deemed harmful to the patient's prognosis by the physician, was actively promoted.[23] Nevertheless, due to the recognition by philosophers of an intrinsic worth in upholding the self-determination of patients, legislation mandated that physicians acquire informed permission. Consequently, the beneficence model, which had prevailed for approximately 2,400 years, was replaced by the autonomy model. Beneficence refers to actions that are aimed at enhancing the welfare of others.

Within the realm of medicine, the term refers to the actions undertaken by a physician that prioritize the well-being and welfare of their patients. During its dominance, the beneficence model was defined by the authoritative physician being granted significant discretion by their patient who placed confidence and obedience in them. The transition from the beneficence model to the patient autonomy model is legally regulated through the dissemination of the doctrine of informed consent. This doctrine prioritizes the provision of adequate information to patients, enabling them to make informed decisions about their treatment options. As the legal doctrine gained recognition, scholars recognized the intrinsic importance of honoring patients as autonomous individuals, especially in situations where their choices appear to contradict the physician's obligation to act in their best interest. While the beneficence model has traditionally assumed that physicians possess the knowledge necessary to determine what is in the best interest of their patients, the autonomy model operates on the principle that patients themselves are best equipped to make treatment decisions aligned with their own genuine sense of well-being, even if such decisions involve refusing treatment and potentially resulting in the patient's death. Autonomy serves as the fundamental principle behind the concepts of informed consent and advanced directives, such as living wills.[24]

VI. The Doctrine of Informed Consent

According to Chambers 21st Century Dictionary[25], the term "consent" refers to the act of granting permission or agreeing to a particular action or decision. In addition to the aforementioned description, the concept of informed consent encompasses a more profound significance. Obtaining informed consent from patients is a

[19] US Legal, (n 18)

[20] Raposo, V.L., 'When Life is Not Life (End of Life Decisions is Doctor-Patient's Relationship) available at www.researchgate.net accessed on the 19th of September, 2023

[21] 105, N.E. 92, 93 (N.Y. 1914)

[22] Will J.F., A Brief Historical and Theoretical Perspective On Patient's Autonomy and Medical Decision Making; Part II: The Autonomy Model. Available at www.ncbio.com accessed on the 19th of September, 2023

[23] Ibid

[24] Will, (n 22)

[25] Mairi Robinson, (n 16)

legal and ethical need that physicians must fulfill before to giving any type of therapy. This concept originates from a fundamental principle in the field of medical ethics. Engaging in physical contact or providing medical care to a patient without obtaining their explicit consent may result in legal consequences, both in terms of civil liability and potential criminal charges, regardless of any potential benefits the patient may have derived from such actions. In order for consent to be deemed valid, it is imperative that it meets the criteria of informed consent. In order for this assertion to hold true, it is necessary that:

(1) Provided willingly, without any form of deception, fraud, compulsion, or similar factors.

(2) Provided by an individual who possesses the necessary capability.

(3) Provided by an expert who possesses comprehensive knowledge regarding the matters at hand.[26]

6.1. Types of Consent

The Nigerian Supreme Court, in the case of *Okekearu vs. Tanko*[27], provided a generic definition of consent as the act of granting approval or acceptance for an action that has been carried out or suggested. The act of granting consent is a direct manifestation of an individual's volition. Consent can be either explicitly stated or inferred.

i. Express Consent

Express consent can be given either orally or in writing. The concept of permission is expressed in a clear and unambiguous manner. In the realm of healthcare delivery, the concept refers to the explicit authorization granted for a certain medical intervention or procedure. Typically, those having invasive medical procedures will provide explicit consent, either through the act of signing a consent form or explicitly expressing their agreement to proceed with the prescribed therapy.

ii. Implied Consent

Implied consent refers to a type of consent that is not explicitly provided by a patient, but can be deduced from the patient's conduct and the contextual details surrounding the situation. For example, when a patient voluntarily exposes their arm for the purpose of obtaining a blood sample, it can be inferred that they have provided implied permission.

6.2 Competency to Consent

The concept of competence to consent refers to an individual's ability to hold the following attributes:

- The capacity to comprehend the circumstances, evaluate different options, and assess the associated risks and advantages.
- The capacity to employ information in a logical and rational manner in order to arrive at a choice.
- The capacity to effectively convey the decision, whether through verbal communication or other suitable methods.

In jurisdictions that follow the common law tradition, it is generally considered that individuals possess the capacity to provide consent. However, it is important to note that this presumption can be challenged in cases where there is evidence of legal incompetence, such as a diagnosis of insanity. In contrast, children or minors are commonly regarded as lacking the capacity to make informed decisions, thus necessitating the acquisition of informed consent from their parents or legal guardians.

6.3 Informed Consent

The concept of informed consent is a fundamental principle in ethical research and medical practice. Under what conditions will consent to medical treatment be considered lawful when the patient is located or determined to be competent? According to medical law and ethics, health care professionals cannot avoid accountability solely by obtaining general permission. In an article authored by Chris Cox[28], the director of Legal Services at the Royal College of Nursing, it is asserted that there exist two other crucial prerequisites for the establishment of a legally sound consent. In order to ensure the ethical validity of the patient's consent, it is imperative that it was not obtained through fraudulent or deceptive means by the healthcare professional. This includes any misrepresentation regarding the nature of the treatment, the identity of the professional, or the specific care to be provided. Furthermore, the patient's consent must have been given voluntarily, without any external coercion or influence. The adequacy of information provided to the subject regarding the treatment, potential adverse effects, and other treatment choices is a crucial factor in determining the validity of consent. This factor ensures that permission is obtained in a proper and appropriate manner. This highlights the significance of the idea of informed consent within the field of medicine.

[26] Lawal Y.Z., and others, 'The Doctrine of Informed Consent in Surgical Practice.' Available on www.annalsframed.org accessed 19th of September, 2023

[27] (2002) FWLR Part 131, 1888

[28] Cox C., 'Law of Consent in Health Care' Journal of Diabetes Nursing (2015) 314-7 available at www.thejournalofdiabetesnursing.co accessed on the 20th September, 2023

Informed consent refers to the ethical principle and legal need in medical and research settings when individuals are provided with comprehensive and understandable information about a particular procedure, treatment, or study, enabling them to make an autonomous and As per the definition provided by Black's Law Dictionary[29], informed consent encompasses:

i. An individual's consent to permit a particular event to occur, made with complete awareness of the associated hazards and other alternatives...

ii. A patient's informed decision regarding a medical treatment or procedure is based on the disclosure of relevant information by a healthcare provider, which aligns with the standard practice of the medical community in terms of informing patients about the associated risks of the proposed treatment or procedure. The concept of informed consent is alternatively referred to as knowing consent. The foundation of the patient-physician relationship is established through the process of obtaining informed consent.

6.4 The Components of Informed Consent

The principle of informed consent is founded upon the concept of patient autonomy. Based on the research conducted by Y.Z. According to Lawal et al. (year), the components of informed consent encompass:

i. Elucidation of the prescribed methodologies to be adhered to, along with a delineation of the underlying objectives for each procedure. It is imperative to appropriately designate procedures that are of an experimental nature.

ii. Elucidation of potential discomfort and risk that can be reasonably anticipated.

iii. Elucidation of potential advantages that can be reasonably anticipated.

iv. The provision of information regarding any suitable medical protocols that may be beneficial to the patient.

v. The individual is informed that they have the autonomy to revoke their consent or terminate their involvement in the project or activity at any point, without facing any negative consequences.

Numerous judicial rulings have emerged pertaining to the interpretation, extent, and implementation of the principle of informed consent within the realm of medical law and ethics.

In the case of *Truman v. Thomas*[30] in the United States, a medical professional advised a female patient to undergo a pap smear procedure. The individual declined the offer and subsequently developed cervical cancer. The plaintiff initiated legal proceedings against the physician, asserting that he had a duty to disclose the potential risks associated with her decision to decline the Pap smear. The Court ruled in favor of her application. This particular case is commonly known in academic circles as the doctrine of informed refusal.[31] The present case can be regarded as a comprehensive illustration of an individual's entitlement to bodily autonomy, akin to an X-ray examination. When a patient deliberately disregards medical advice, they forfeit their entitlement to file a complaint when adverse consequences arise as a direct consequence of their decision. The initiation of a course of action should only occur in instances where a physician intentionally or malevolently withholds information from a patient.

In the case of *Hidding vs. Williams*[32], the Court mandated that the surgeon divulge his condition of alcoholism. This case implies that in addition to the surgical risks, the personal and professional attributes of a physician are integral to the process of obtaining informed consent. Also in this regard, courts have also construed the doctrine of informed consent to include a disclosure of a surgeons H.I.V. status as was the case in the case of *Scoles v. Mercy Health Corporation of South Eastern Pennsylvonia*.[33] Under English common law a physician carrying out treatment without the informed consent of a patient in non-emergency circumstances may be liable for assault, battery or an action in negligence. This is the case whether or not the motive of the physician was hostile. This quite clearly also obtain in a situation where the doctor obtained consent from the patient to perform one type of treatment and subsequently performs a substantially different treatment for which consent was not obtained. This was the issue in the case of *Mary Schloendorff vs. Society of New York Hospital*.[34] In this case, the plaintiff was admitted into hospital for medical examination under anaesthetic to assess the cause of her abdominal pain. Whilst under anaesthetics, the surgeon removed a fibroid that was discovered during the examination. There were post-operative complications leading to the institution of an action against the hospital. The Court held as follows:

[29] Ibid

[30] 611 P2d 902 (Cal. 1980) available at www.caselaw.findlaw.com accessed on the 20th of September, 2023

[31] Cox, (n 28)

[32] 578 so 2d 1192 (1991) available at www.courtlisteners.com accessed on the 21st of September, 2023

[33] 887 F. Supp. 765 (E.D. PQ. 1994) available at www.lawjusticia.com accessed on the 21st of September, 2023

[34] 105 N.E. 92 (N.Y. 1914)

'patient who clearly went against medical advice loses her right to complain when something goes wrong as a result of the exercise of that right. The course of action ought to arise only when there has been a deliberate or malicious withholding of information from a patient by his physician. '[35]

In the case at hand, the wrong complained of is not merely negligence, it is trespass. Every human being of adult years and sound mind has a right to determine what shall be done to his body and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

To a reasonable man, the claim of the plaintiff in this case would appear unreasonable and illogical, after all the intention of the physician in this case was simply to save life more so against the backdrop by the observance by the physician of the tenets of the Hippocratic oath. The terms of this universal oath imposes an obligation on every physician to strive to do the needful at all times to save lives. By the adoption of the reasonable man's test, nothing should therefore stop a physician for example, from removing a life-threatening tumour while a patient is under anaesthetics without his prior consent if in doing so it will be in the best interest of the patient.

VII. Advance Directives or Living will

This represents another avenue recognized by law through which informed consent may be granted by a patient to a physician. As we have seen, an incompetent person is incapable of giving informed consent to medical treatments or procedure. Under the law, liberty is conceded to a competent adult at a time of legal competence to exercise a right to issue advance directive or 'a living will' outlining the mode of treatment or non-treatgment they wish to receive if a situation of incompetence arises. Such directive is usually in writing. A physician is legally obliged to act within the confines of the directive of the patient unless there is evidence that the patient revoked same while competent. Practical application of advance directives can be very difficult to interpret and follow. Unclear wordings like 'no life prolonging treatment' leaves room for different interpretations, depending on the underlying conditions.

In the South African case of *Clarke v. Hurst*[36], a well-known medical practitioner and politician, Dr. Frederick Clerk, suffered a sudden drop in blood pressure and went into cardiac arrest whilst undergoing epidural treatment; his heart and breathing stopped, resuscitative measures were instituted but by the time his heart beat and breathing were restored, he had suffered serious and irreversible brain damage due to prolonged oxygen shortage. He was in Coma and remained in that condition permanently. While still active and competent, he had a living will. Three years after the tragedy, his wife applied for an order of court appointing her as curatrix to her husband's person with special powers to authorize the withdrawal of any artificial medical treatment including any nasogastric feeding. The application was opposed by the Attorney-General. One of the main grounds of opposition of the A.G. was that the withdrawal of any life sustaining treatment would hasten his death and would therefore be the cause of his death as a probable result of the withdrawal of the artificial treatment, making her liable to be guilty of murder. The specialist physicians and neurologists who examined him were in agreement that he was in a persistent vegetative state. They also agreed that his condition was irreversible and no improvement was possible. He was incapable of movement, could not speak, did not have any sense or sensory capacity and could not communicate. He also could not swallow and take fluid naturally. In spite of all of these his automatic nervous system was largely impaired. His respiratory system, kidney, heart and lungs were functioning satisfactorily.

The court held that judged by the legal convictions of the society, the feeding of the patient did not serve the purpose of supporting human life as it is commonly known. Accordingly, Dr. Clark's wife would be acting reasonably and would be justified in discontinuing his artificial feeding. No wrongfulness would attach to her conduct. Dr. Clarke was therefore discharged after artificial treatment was withdrawn and taken home to be treated. He died at his home in August 1992. 4 years after he suffered the cardiac arrest.

VIII. The Right to Refuse Medical Treatment

The concept of the right to refuse medical treatment is a fundamental aspect of medical ethics and patient autonomy. It refers to the legal and ethical principle that individuals have the authority to decline or reject medical interventions, even if such interventions are deemed necessary by healthcare professionals.

The recognition of an individual's right to decline medical treatment is firmly established under the common law. The aforementioned entitlement, which is grounded in the principle of informed consent, is an essential component of an individual's self-determination or autonomy.[37] In the context of medical treatment, it is widely acknowledged that informed consent is a fundamental requirement. Conversely, it is equally recognized

[35] 105 N.E. 92 (N.Y. 1914), (n 34)

[36] (1992) (4) SA 630 (D)

[37] Stamatakis, C. 'Beyond Advance Directives: Personal Autonomy and The Right to Refuse Life Sustaining Medical Treatment' *New Hampshire Bar Journal*, [2007] available at www.nhbar.org accessed on the 21st of September, 2023

that patients enjoy the right to refuse treatment, thereby withholding their consent. The landmark case of *Cruzan v. Director, Missouri Department of Health*[38], marked the initial instance in which the United States Supreme Court deliberated upon the constitutional right to decline life-sustaining medical intervention.[39] The central matter in this particular case pertained to a petition seeking the cessation of artificial sustenance and hydration for Nancy Cruzan, an individual in a state of enduring vegetative consciousness. The constitutional and common law right to refuse unwelcome medical treatment has been acknowledged and affirmed by the US Supreme Court. This right is protected under the due process clause of the fourteenth Amendment. However, it is important to consider that this right must be balanced against the state's interest in saving life.

The acknowledgment by the majority on the state's interest in upholding the preservation of life elicited a vehement dissent. The dissenting opinion raised doubts regarding the constitutional protection of the concept of 'life' as an interest. In his dissenting opinion, Justice Brennan expresses his viewpoint on this particular matter as follows:

"The advancements in medical science have successfully established a state of suspended animation, sometimes referred to as the twilight zone, when the process of death initiates while a semblance of life persists. Certain patients may express a preference for a medical treatment approach that embraces the natural progression of their condition, enabling them to pass away with a sense of dignity. It is worth considering that extensive and invasive interventions could potentially extend human life by merging the physical body with mechanical components. However, it is reasonable to argue that such measures may be perceived as a derogation of life rather than a means of its preservation. However, in the case of patients who lack consciousness and any prospects of recovery, a significant inquiry arises over whether the continued existence of their physical bodies constitutes "life" in the conventional sense of the term, as well as in the context of both the Constitution and the Declaration of Independence. The existence of lives cannot be detached from individuals, and any attempt to do so is not a respectful acknowledgment, but rather a violation of the state's duty to safeguard life".[40]

The presence of controversy and conflict arises when there is a clash between advance directives and the responsibilities of physicians, particularly in situations when these advance directives or living wills are based on religious beliefs. This is due to the potential contradiction between the patient's religious beliefs and their perception of their best interest, which may differ from the perspective of physicians or conventional medical practices. The dispute around advance directives or living wills is particularly pronounced in the context of religious beliefs, specifically among believers of the Jehovah's Witness sect. The rigid principles upheld by the group, which forbid the practice of blood transfusion, frequently result in conflicts with the field of medicine.

8.1 The Controversy Surrounding the Right to Refuse Consent to Treatment Based on Religious Beliefs: A Case Study of Jehovah's Witnesses

According to Charles H. Baron, a scholar from the Boston Law School[41], the religious organization known as the Watch Tower Bible and Tract Society, commonly referred to as "Jehovah's Witnesses," is considered to be one of the thriving religious groups in the United States. Originating in the early 1870s as a Christian Bible Study group in western Pennsylvania, it has experienced significant growth and now boasts a global presence with over 4 million followers spread across more than 200 countries. A fundamental principle embraced by the group is a dedication to the Bible as the divine scripture (Jehovah), embodying an absolute veracity. The group's members demonstrate a significant level of dedication towards disseminating biblical knowledge to others who are not part of their group. They disseminate written materials by delivering them to individual residences and by placing them in public locations. Government agencies have frequently endeavored to impose regulations on these entities due to their actions, resulting in a significant amount of litigation.[42] One distinguishing belief held by Jehovah's Witnesses is their strong adherence to the biblical prohibition against accepting blood transfusions, even in life-threatening situations, as they consider it a violation of the scriptural injunction against the consumption of blood. The rationale behind this conviction can be attributed to two main factors:

i. According to witnesses, the Bible is interpreted as explicitly forbidding Christians from consuming blood.
ii. According to their perspective, the concept of 'eating blood' encompasses not alone oral consumption, but also alternative methods such as blood transfusion.

[38] 497 US 261 (1990)
[39] Stamatakis, (n 37)
[40] Stamatakis, (n 37) 285-287
[41] Baron, C.H. 'Blood Transfusion, Jehovah's Witness and The American Patient's Rights Movement', Boston College Law School Faculty Papers available at www.worksbepress.com accessed on the 22nd of September, 2023
[42] Ibid

In accordance with this theological perspective, frequent allusion is made to the scriptural passage found in Leviticus 17:10-12.[43] This particular excerpt recounts a divine communication wherein God conveyed a message to Moses:

"Regarding any male individual from the lineage of Israel or any foreign resident who is currently residing among them, and who consumes any form of blood. I will unequivocally oppose the individual who consumes blood, and I will effectively exclude them from their community. The essence of the physical body resides within its blood, and I, as the speaker, have willingly offered myself as a sacrifice on the altar for the purpose of enabling you to seek redemption for your souls. This is due to the fact that it is the blood, containing the soul within it, that serves as the means of achieving atonement. Hence, I have expressed my sentiment to the offspring of Israel. According to this passage, it is prohibited for any anyone, regardless of their origin or residency status, to consume blood".

Likewise, the text alludes to the biblical passage in Genesis 9:1-4[44], in which God addresses Noah following the deluge, stating, *"Just as I have given you all green plants, I now give you all living creatures. However, you must not consume the flesh along with its lifeblood."* One prominent early American legal case that exemplifies the clash between the religious convictions of Jehovah's Witnesses and contemporary medical practices is *the Application of the President and Directors of Georgetown College Inc*.[45] In this particular instance, a female individual named Mrs. Jesse Jones was accompanied by her spouse to the emergency department at Georgetown Hospital. The individual experienced a significant reduction in their body's blood volume, estimated to be approximately two-thirds, as a result of a perforated ulcer. The medical professionals responsible for her case held the belief that her likelihood of survival would significantly increase with the administration of a blood transfusion, while the absence of such intervention would result in her demise. Mr. and Mrs. Jones identified themselves as adherents of the Jehovah's Witness faith. The individuals had a strong desire for medical intervention from the doctors, although they declined to provide consent for a blood transfusion. The medical professionals deemed the Jones' rejection to offer consent as medically unreasonable and endeavored to overrule it. Consequently, they endeavored to obtain a court order granting them permission to proceed with their intended action. The order sought was granted by the United States Federal Appeal Court. The aforementioned conclusion is evidently inconsistent with the principle of patient autonomy, which will be demonstrated to no longer align with current legal standards.

Nevertheless, there has been a notable shift in case law within the United States and many other jurisdictions globally regarding the absolute prohibition of Jehovah's Witness adherents from refusing blood transfusions. This shift acknowledges the right to refuse such medical interventions, attributing it to the principles of patient autonomy and self-determination. As exemplified by the *Re Hughes*[46] case, which pertains to a patient adhering to the Jehovah's Witness faith, the surgeon involved administered a blood transfusion to the patient despite having received prior instructions to the contrary, due to the emergence of difficulties. Upon her arrival, she endeavored to request a reversal of the judge's ruling that granted her transfusion when she had the capacity to make decisions. With regard to the right to refuse transfusion, the court determined a Jehovah's Witness or an individual with similar beliefs who is competent has the legitimate entitlement to decline certain or all forms of medical intervention, even if it means risking their life. If a patient, fully aware of the potential consequences, decides to reject life-sustaining medical treatment and effectively communicates this decision through explicit and persuasive verbal directives, actions, or written expressions, it is imperative to honor the patient's wishes.

IX. Nigerian Context of Patient Autonomy and Informed Consent

The legal framework of patient autonomy and informed consent in Nigeria is established within the common law, statutory provisions, and the 1999 Constitution (as amended). In Nigeria, the regulation of medical practice and the professional conduct of doctors is governed by the Medical and Dental Council of Nigeria in accordance with statutory provisions. One of the official functions of the organization is to periodically review and prepare a statement regarding the code of conduct that the council deems necessary for the professional practice in Nigeria.[47]

In accordance with its legally mandated responsibilities, the council has periodically formulated and evaluated statements regarding the code of conduct that it deems necessary for the professional practice of medicine and dentistry in Nigeria. The council has published a Code of Medical Ethics in Nigeria. The code includes detailed requirements that expand upon the notion of informed consent. According to the regulations outlined in this code, healthcare professionals engaged in procedures that necessitate the consent of the patient, their family member, or the relevant public authority must ensure that the necessary consent is obtained prior to

[43] King James Version (Bible)
[44] Ibid
[45] 331 F. 2d 1000 (D.C. Cir 1964)
[46] 611 A. 2d 1148 (NJ Super ct. App Div, 1992)
[47] MDPA, CAP M8 LFN 2004, s. 1(20)(C)

conducting such procedures, whether they are invasive or non-invasive, and whether they are intended for surgical or diagnostic purposes. According to the law, it is required that the consent form be presented in either printed or written format, either as an integral part of the case notes or as separate sheets clearly indicating the name of the institution. The process of obtaining consent from patients necessitates clear, succinct, and unequivocal explanations regarding the anticipated outcomes and requirements. It is imperative that individuals receive appropriate counseling prior to the execution of the permission form. In cases when the patient is considered a minor according to Nigerian law (below 18 years of age), or is unconscious, or is experiencing a mental impairment, it is necessary for a next of kin to assume responsibility. In situations when there is no available next of kin, the individual holding the highest seniority among the medical professionals within the hospital may provide suitable instructions for the preservation of life. In certain exceptional circumstances, it may be necessary to get a court order in order to facilitate the implementation of life-saving medical interventions. The stance articulated in the medical code of ethics, which suggests that the patient's autonomy is subject to certain limitations, contradicts the ruling of the Supreme Court in the case of *Medical and Dental Practitioners Disciplinary Tribunal vs. Okonkwo*.[48] This is because the Supreme Court's decision in that particular case affirms that patients possess an unconditional and constitutional right to bodily autonomy, even if it results in their own demise.

Regarding the clinical handling of those who adhere to religious beliefs, the guideline explicitly addresses those who follow the Jehovah's Witness Faith. This entity offers practitioners should possess an understanding that both society and the legal system acknowledge an individual's entitlement to either accept or decline medical intervention. Among other religious groups, the Jehovah's Witnesses stand out as a notable community when it comes to their preferences for medical treatment options. The objections raised by other groups primarily revolve around dietary components that are of minimal concern to the practitioners. However, the Jehovah's Witness community poses a significant challenge when it comes to providing them with medical treatment in surgical, anesthesiologic, or medical fields due to their equating of blood transfusion with the consumption of blood.[49]

When managing patients of this nature, it is imperative to ascertain their religious beliefs and thoroughly document them in the medical records. The documentation and observation of patients' acceptance or refusal of treatment should be conducted in a thorough manner.[50] The healthcare professional must carefully consider whether they are willing to acknowledge and work within the constraints of the treatment plan. If they choose to proceed, the practitioner should develop and provide the highest quality of care possible. If the practitioner determines that they are unable to provide appropriate care, it is advisable for them to discontinue treatment and send the patient to other healthcare facilities or professionals who may be better equipped to address the specific issue.

Furthermore, in accordance with common law principles and the provisions outlined in sections 37 and 38 of the Nigerian Constitution (as amended), the right of a patient to provide informed consent and to refuse life-saving medical interventions that conflict with their religious convictions is granted legal and constitutional recognition. The right to privacy is guaranteed to all Nigerians under Section 37 of the 1999 Constitution, as amended. Additionally, Section 38 safeguards the right to freedom of thoughts, conscience, and religion.

In the case of *Okekearu vs. Tanko*[51], the plaintiff experienced an injury to their left finger and subsequently sought medical attention at the defendant's clinic. The defendant, in a manner lacking appropriate care and skill, negligently performed the amputation of the plaintiff's finger, resulting in a permanent disfigurement and impairment of the plaintiff's ability to manipulate objects. The defendant neglected to get the plaintiff's agreement prior to performing the amputation of the finger, contending that the plaintiff's aunt had instructed him to proceed with "any necessary treatment". In a legal case concerning battery, the plaintiff pursued legal action against the defendant, ultimately reaching the Nigerian Supreme Court. The highest court, in its ruling, established that in cases where a doctor intentionally amputates a patient's finger without the consent of the patient or their guardian, the doctor can be held legally responsible for battery.

In the case of *Medical and Dental Practitioners Disciplinary Tribunal vs. Okonkwo*[52], the Nigerian Supreme Court affirmed the constitutional entitlement of patients to refuse medical treatment, specifically blood transfusion, based on religious beliefs. This right is grounded in fundamental rights safeguarded by the Nigerian Constitution.[53] The court also determined that due to the patient's voluntary agreement with the practitioner, it logically follows that an adult patient of sound mind has the right to decline informed consent for medical treatment. Unless the state intervenes through legal proceedings, healthcare providers are unable to enforce

[48] (2001) 6 NWLR Pt. 710, 206
[49] (2001) 6 NWLR Pt. 710, 206
[50] Ibid
[51] Ibid
[52] (2001) 6 NWLR Pt. 710, 206
[53] S.37, 38 CFRN,1999

treatment against the patient's wishes. In situations where a competent adult patient, in accordance with their religious beliefs, exercises their right to refuse potentially life-saving treatment, and in the absence of legal intervention to override the patient's decision, healthcare practitioners may find themselves with limited alternatives. One possible course of action for the practitioner could be to provide the patient with comfort and support. As per the findings of Uwaifo JSC, he opined that he is fully convinced that, in most situations, it is impermissible for a medical practitioner to administer therapy to a mentally competent patient without their explicit consent, especially when the treatment involves drastic measures like amputations or extensive surgical procedures.

X. Legalization of Euthanasia/Assisted Suicide in Nigeria

In Nigeria, the practice of euthanasia and assisted suicide is prohibited by law. According to the provisions outlined in the Criminal Code Law, the act of causing the death of an individual is considered to be illegal, unless it is sanctioned, justified, or exempted by legal means. Hence, with the exception of situations outlined in the law (except euthanasia), any individual who directly or indirectly causes the demise of another individual, regardless of the method employed, is considered to have committed the act of killing that individual. The culpability of an individual accused of a crime might vary depending on the specific circumstances of the case, perhaps resulting in charges of either murder or manslaughter.[54] The lack of intention on the part of the offender to cause harm to the individual who was killed is inconsequential. In accordance with the clause on the acceleration of death outlined in the Criminal Code, one who expedites the demise of another person afflicted with a disorder or disease resulting from a separate cause is legally considered responsible for causing the death of said individual. Furthermore, it is noteworthy that aided suicide is specifically penalized according to section 326 of the code. The consent of an individual to their own demise does not alter the criminal liability of any one who is responsible for causing that death.[55] The penal code, which is applicable to the Federal Capital Territory and the Northern states of Nigeria, has comparable rules.

Based on the aforementioned penal rules, individuals who engage in euthanasia or aid others in the act of suicide will incur criminal liability, either for the offense of murder or manslaughter, contingent upon the specific circumstances surrounding the incident. Notwithstanding the aforementioned legal stance, the patient's right to autonomy, as manifested through the ability to provide informed consent for medical procedures and to decline potentially life-saving treatments, frequently clashes with the implementation of euthanasia and assisted suicide in jurisdictions where such practices are prohibited. This phenomenon is notably evident in jurisdictions that follow the common law legal system, including but not limited to the United Kingdom, Canada, India, Nigeria, Ghana, and others.

In the aforementioned nations, judicial bodies have demonstrated a willingness to permit passive euthanasia, which involves the cessation of life-sustaining interventions or other artificial methods of providing sustenance. This is typically allowed in situations involving patients who are either terminally ill or incapacitated. The legal basis for such decisions stems from the recognition of individuals' rights, as established by common law, statutes, and constitutional provisions, to withhold consent or refuse medical treatment, even if it ultimately results in their demise. In the legal case *of Airadale NHS Trust vs. Bland*[56] in the United Kingdom, the House of Lords ruled in favor of a patient's right to self-determination through the withdrawal of life-sustaining treatment. This decision was made despite the general criminalization of euthanasia in the United Kingdom. The patient in question was in a persistent vegetative state, and the withdrawal of treatment was deemed permissible even though it would inevitably result in the patient's death. The present statement unequivocally pertains to the endorsement of euthanasia, specifically in its passive manifestation. In a notable ruling, the India Supreme Court legalized passive euthanasia in India in the influential case of *Aruna Shanbaug vs. Union of India*.[57] The court drew upon the legal arguments presented in the Airedale's case and various other relevant precedents to support its conclusion.

In the aforementioned case of Medical and Dental Disciplinary Tribunal, the Nigerian Supreme Court rendered a decision that affirmed the right to refuse medical treatment, including blood transfusion, even if it resulted in the death of Mrs. Okorie. This decision aligns with the principles established in the two aforementioned cases, which recognize the right to passive euthanasia as an inherent aspect of a patient's right to self-determination.

[54] CFRN 1999, S. 319
[55] Ibid, S. 299
[56] (1993) All ER 82(HL)
[57] (2011) 4 SCC 454

XI. Conclusion/Recommendations

Based on the preceding discussion, it is evident that the fundamental right to self-determination, as exemplified by the right to provide informed consent and to decline medical treatment, has not only surpassed customary legal rights but has also gained recognition and protection in statutory and constitutional frameworks across various jurisdictions, including Nigeria. Physicians and other healthcare providers no longer hold exclusive authority in determining what they regard as the optimal course of action for their patients. The act of exercising this right has formed the foundation upon which courts in areas where euthanasia is prohibited have sought to legitimize a kind of euthanasia known as passive euthanasia, but only in circumstances that are deemed deserving and compelling.

The initial casualty of the current legal stance on passive euthanasia as a constitutional prerogative, in accordance with a patient's right to self-determination, pertains to the penal statutes of Nigeria. The aforementioned statutes encompass a comprehensive classification of all variations of euthanasia as acts of homicide. In light of recent court rulings, particularly the Supreme Court decision in the Okonkwo case, there is a pressing need to revise Nigeria's criminal and penal codes. This revision should involve the exclusion of passive euthanasia from the definition of murder, or alternatively, the establishment of a distinct and comprehensive passive euthanasia law in Nigeria. These amendments are necessary to align the legal framework with the prevailing judicial interpretations in this domain. Furthermore, this measure will effectively align those specific sections of the regulations with the stipulations outlined in the Constitution.