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Prevalence of Euthanasia Requests Among Patients with Terminal Illnesses in Nigeria: An Empirical Cross-Sectional Study

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Abstract: The study is the first empirical evaluation of euthanasia requests in the terminally ill patients in Nigeria. A sample of 312 patients found that 18.9 per cent. had contemplated or actually requested euthanasia. The main predictors of use were severe uncontrolled pain (adjusted odds ratio=3.89, p=0.001) extreme financial burden (adjusted odds ratio= 2.76, p=0.003), poor access to palliative care (adjusted odds ratio= 3.21, p=0.001), and depression (adjusted odds ratio= 2.98, p=0.002). Among 178 interviewed physicians, 72.6 per cent of them said that euthanasia must never be permitted in any situation, and gave the reasons of moral and religious and legal reasons. Out of the 245 family caregivers interviewed, 34.7 per cent had a conditional supportive attitude to euthanasia with unremediated suffering. These results reveal some major gaps in the end of life care system of Nigeria among which are the absence of palliative facilities, insufficiency in pain management, and inadequacy in the provision of psychosocial care. The findings thus highlight the urgent need to increase the services of palliative care, streamline the process of pain management, encompass mental-health care, and carry out systematic policy debates to minimise preventable pain and encourage ethical practice.

Keywords: *Euthanasia, Terminal Illness, End-of-Life Care, Palliative Care, Nigeria, Physician-Assisted Death, Patient Autonomy, Pain Management.*

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I. INTRODUCTION

Euthanasia is a highly debated ethical and legal topic in the world, with legalisation in a few regions, like Netherlands and Canada (Ramadass *et al*., 2025). The dialectic between autonomy of patients and sanctity of life is balanced. It is accompanied by a serious shortage of palliative care in the world, with an approximate percentage of 14 of those who need it, which is the most significant in the low-resource environment (World Health Organisation, 2018; World Health Organisation, 2020). Sub-Saharan Africa experiences increased rates of cancer and HIV, and the provision of end-of-life care is underdeveloped to the point of being desperate (Rosenberg *et al*., 2023).

This crisis can be seen in terms of Nigeria. Having more than 200 million inhabitants, palliative care is still underdeveloped and is mostly represented by tertiary facilities (Cadmus *et al*., 2025; Akyar *et al*., 2026). In Nigeria, non-communicable diseases like cancer are some of the causes of death that can be attributed to roughly a quarter of all deaths, since they are often diagnosed at an advanced stage and are accompanied by high and uncontrolled pain (World Health Organisation, 2018). Active euthanasia is a clear offence throughout the country, which subjects the physicians to prosecution (Oniha, 2017). The Nigerian Medical Association is against the practise and instead encourages the improvement of palliative care (Guardian Nigeria, 2018). However, the law

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is clear on refusal of treatment: the Supreme Court of Nigeria has authorised the right of a competent patient to refuse medical treatment (Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo, 2001).

There are still critical knowledge gaps. Although the survey of physicians in 2017 provided evidence that 72.69 0.00% of physicians were against euthanasia, mostly due to moral and religious reasons (Nwankwo *et al*., 2017), the views of terminally ill Nigerians themselves are not researched. Studies show that patients and families have very low knowledge of palliative care options (Adenipekun *et al*., 2005) and that end-of-life planning is mostly based on burial, but not clinical decision-making (Akindele *et al*., 2019; Cadmus *et al*., 2024). This combination of extreme distress, limited access to care, and ambiguity in legal regulations creates the environment where euthanasia can be taken into consideration, but patient voices are placed right next to each other.

The research will fill these gaps by: 1) establishing the request rate of euthanasia in terminally ill patients in hospitals in Nigerian hospitals; 2) identifying the demographic, clinical, and psychosocial factors related to the request; 3) evaluating physician attitudes; 4) evaluating caregiver views; and 5) evaluating the relationship with palliative care access and pain management.

The study is important because it offers the baseline on this topic as the first empirical one in Nigeria, which informs the policy associated with the palliative care investment and the patient autonomy law. It provides changeable aspects of pain management that could reduce suffering, offers to the world a cultural insight into end-of-life decision making, and reports unmet need to present its case concerning the allocation of resources and reform.

II. LITERATURE REVIEW

- *Global Perspectives on Euthanasia and Physician-Assisted Death*

The controversies around euthanasia and physician-assisted death (PAD) have been escalating as medical technology has increased life expectancy and as the societies have renegotiated the boundaries of autonomy, beneficence, and the sanctity of life. Recent empirical data show that the support of legalisation by clinicians does not take the same shape and certainly does not express a clear pro-anti stance; instead, it depends on the eligibility criteria of patients (e.g., terminal or non-terminal suffering), the perceived protection, and culture-religious values. Within a recent cross-sectional survey of physicians in various countries (n = 107), a slight majority of physicians were in favour of legalisation of PAD to mentally competent terminally ill adults, but their support dropped to slightly less when it came to non-terminal physical suffering, and again when it came to psychological suffering (Ramadass et al., 2025). According to this gradient, the very notion of the moral acceptability of PAD is frequently conceptualised not as absolute but rather as a problem of establishing limits: what suffering should qualify, under what conditions, and who determines legitimacy.

The same research highlights the geographical and ideological diversity. Areas that were characterised by stronger conservative social norms had a higher level of opposition and more liberal Western settings had a relatively higher support (Ramadass *et al*., 2025). The idea of autonomy was often mentioned as the most powerful moral defence, but the issues of governance, protection, and abuse were also relevant as an important indicator of low- and middle-income countries (LMICs) with limited regulatory potential and medico-legal transparency (Ramadass *et al*., 2025). Such cross-national variations are not only practical to Nigeria since ethical reasoning never occurs in a vacuum but rather as a mediating phenomenon via professional codes, social expectations, institutional risk climate, and perceived practicability of oversight.

Repeatedly, religiosity is involved in attitudes to assisted dying, typically in the form of opposition in multi-country survey data sets, and in UK-based research, especially where religions focus on the sanctity of life (Ramadass *et al*., 2025). The salience of religion in Nigeria is further enhanced by religious demographic of the nation and the high integrations of faith and social legitimacy, political identity and health-care decision making. Not only the recent syntheses and demographic summaries, but also there are also certain estimates of Nigeria population, which all describe the population as mostly Muslim and Christian, though there are also smaller parts that follow traditional religions or do not follow any religion at all; nevertheless, exact estimates differ depending on the source and methodology. The clinical experience around end-of-life practices in real-life situations is often a concomitant medical, ethical, and social negotiation-circumstances that influence the articulation of desires that are euthanasia-related, the desire is indirect, or the desire is repressed.

- *End-of-Life Care: Health in Sub-Saharan Africa: Autonomy in Uncertainty*

In sub-Saharan Africa, the end-of-life decisions are made in the context of resource scarcity, unequal participation of palliative care in integration, and uncertainty of medico-legal coverage of clinicians. The tension is demonstrated in a multi-country survey of physicians practising critical care in Kenya, Zambia, Rwanda and Botswana. Most of the respondents supported the right of a patient to decline life support despite resulting death, which demonstrated high levels of normative support of autonomy, but only a small number noted the presence of explicit hospital policies to withhold or withdraw treatment, and very few believed that there was clear legal legal precedent of their respective countries on end-of-life decisions (Rosenberg et al., 2023). The trend is quite dramatic: the clinicians support the idea of autonomy in theory, but they

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work in systems that offer poor procedural support of ethically and legally justifiable action.

Another theme related to it is the fear of sanction. Many doctors were expecting either professional or criminal penalties on leaving a patient to die by the omission of care or by withdrawing care that is in progress (Rosenberg *et al*., 2023). This has implications to the Nigerian situation, whereby they may either not record sensitive end-of-life discussions, may harbour to aggressive treatment to limit liability, and may transfer decision-making to families and institutions to de-escalate responsibility. Also, the survey revealed contradictions within pain management: there was great support in the analgesia provision even in a situation that can unintentionally accelerate death (the double-effect reason), but the clinicians thought that pain medications were underutilised (because of the fear of accelerating death) (Rosenberg et al., 2023). In areas where pain and dyspnea are still not adequately addressed, the statements of patients to die may be more frequent and frequent- however, they may not be measured or reinterpreted as non-specific distress.

- *Attitudes of Physicians Towards Euthanasia in Nigeria*

Empirical studies directed specifically at Nigeria tend to concentrate on the attitudes of clinicians, and not patient requests. In one of the surveys of doctors in Enugu, it was reported that the majority of doctors opposed euthanasia in all situations, with smaller percentages conditional and the small percentage full support (Nwankwo *et al*., 2017). The authors explained the resistance through the presence of moral and religious beliefs in the local environment as its major element (Nwankwo *et al*., 2017). As much as these findings are informative, they also suggest a measurement problem of prevalence research: where there is strong opposition by clinicians and where legal prohibition is perceived as stringent, patients will be less likely to make explicit requests to clinicians to euthanize them, and the clinicians will be less likely to record them.

This environment is served by institutional positions. Statements of the Nigerian Medical Association (NMA), and the African regional conferences of the World Medical Association have opposed euthanasia and physician-assisted suicide and suggested the intensification of palliative care as the moral alternative (Guardian Nigeria, 2018). Although these statements are not always peer-reviewed evidence, they form the professional norms and limit what is discussable or recordable in clinical practises. Legal restriction and professional opposition together can be a plausible silencing mechanism of request prevalence: euthanasia-related wishes can be there but silenced by other terms (e.g., I cannot go on like this) or by other treatment refusals that are not ethically similar to euthanasia.

- *End-of-Life Preferences and Perspectives of Patients in Nigeria*

In Nigeria, patient-centred evidence is more often dedicated to the awareness of advance care planning and end-of-life preferences than to euthanasia requests. The qualitative research on geriatric centre in southwestern Nigeria had identified that the weather of understanding of older persons about the concept of advance directives was scanty in comparison with the constructs of understanding in high-income settings. The choices were more inclined towards place of death, burial, and distribution of property, and the power of choice was usually resided in the family setups and community members and not in individual autonomy as such (Akindele *et al*., 2019). This supports a major cultural aspect of the end-of-life decision unit, which is that it is often the family or kinship unit that makes the decision and makes the individual request of euthanasia less noticeable or socially effective.

More recently, a cross-sectional survey of elderly Nigerians demonstrated that knowledge levels and attitude towards end-of-life care and formal directives are in general poor, with a lack of readiness to fill in the living wills (Cadmus *et al*., 2024). Interestingly, the preference concerning resuscitation and end-of-life treatment might be influenced by concerns of burdensome care, fear of continuing pain, and the wish to die at home, which can be confused with wish to hasten death constructs but should not be confused with euthanasia requests. The agony of the patient can manifest itself through hospital care avoidance, treatment requests, or spiritual storeys in a setting where the prognosis is not communicated and advance care planning is culturally unacceptable as opposed to an explicit request of life-ending interventions.

- *Palliative Care in Nigeria*

There are recurrent evidences that the palliative care ecosystem in Nigeria is poorly developed as compared to population requirement. According to the recent syntheses, palliative care is still seen as being low in terms of integration and is mostly confined to tertiary care and there are still workforce, opioid-access, and policy implementation gaps (Cadmus et al., 2025; Akyar et al., 2026). Facility-based empirical evaluations also record numerous unmet needs. To illustrate, a study of inpatient palliative care in Lagos University Teaching Hospital (LUTH) noted that even a small part of the palliative care requirements is not fulfilled and that no structural links are available to service palliative care despite the capacity to offer oncology care (Olanipekun *et al*., 2024).

Training and education is a recurrent limitation. In the absence of training regarding complex symptom management and serious-illness communication with patients, patient distress may be worsened and values-based decision-making opportunities lost. Notably, the Nigerian history of evidence demonstrates that the population does not pay much attention

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to hospice and palliative care but is very receptive to the comfort-based support when informed about it. A survey of dying patients and families indicated that good proportions of them did not know anything about palliative care/hospice services, but a majority of them still supported symptom management to increase quality of life and expressed wish to have hospice services available to them (Adenipekun *et al*., 2005). Such a state of low awareness and high acceptability implies that the unmet palliative needs are not merely preference-based, but a product of a system.

- *Psychosocial, Stigma, and Economic Burden of Terminal Illness.*

Nigeria Terminal illness frequently involves psychosocial misery that is stratified: depression, anxiety, stigma, and social isolation are compounded by all symptoms that remain uncontrolled and poverty. According to cancer population evidence of southern Nigeria, there is a high degree of psychological burden and harms associated with stigma, comprising perceived stereotyping and discriminatory experiences that are associated with anxiety and reduce coping resources (Uwak et al., 2022). Stigma may encourage hidden diagnosis, decrease care-seeking, and increase existential distress-all factors associated with the desire to accelerate death that are observed in the international literature to result in the desire to hasten death, regardless of the absence of explicit intent to euthanasia.

Another structural cause of distress is economic pressures. Out of pocket payment is still prevalent in the Nigerian healthcare sector and catastrophic spending risk can indirectly influence end of life care decision making in terms of treatment abandonment, late presentation, and home death preference. Although law studies are not synonymous with clinical epidemiology, euthanasia studies in Nigeria often focus on the criminalisation aspect and on the medico-legal hazard of acceleration of death (Oniha, 2017). Practically, such pressures may generate ethically dangerous situations: patients become sufferers and fear a burden; families are afraid of financial loss; clinicians are afraid of legal prosecution; the health system does not have the texture of palliative care. In these circumstances, the issue of euthanasia-adjacent wish can become an expression of distress, although there is no socially viable act like euthanasia.

III. THEORETICAL UNDERPINNINGS

- *Saunders' "Total Pain" Model*

The concept of Total Pain model views suffering as a multidimensional construct in that it involves physical pain, psychological distress, social dislocation such as financial strain and familial conflict, and spiritual or existential pain. The use of the Total Pain framework in the Nigerian setting serves as a clinically based explanation of the noted increase in euthanasia-related expressions in the situation when there is a lack of quality palliative care and symptom coping is ineffective. This rationale is supported by empirical data in Nigeria: researchers have found that there is a lack of public awareness, but a relatively high level of acceptability of comfort-care interventions (Adenipekun *et al*., 2005), a shortage in national integration of palliative services (Cadmus *et al*., 2025; Akyar *et al*., 2026), an absence of service coverage (Olanipekun *et al*., 2024) and a presence of psychosocial distress with stigma (Uwak *et al*.,2022). All of these findings outline a socio-clinical context of great multidimensional suffering. The Total Pain paradigm, therefore, puts the requests of euthanasia, or expressions of wishing to hasten death (WTHD) in a different setting, not as the indication of autonomy as an individual phenomenon, but as the signs of clinical distress that arise due to the suffering that can be treated and prevented.

- *Theory of Planned Behaviour (TPB)*

The Theory of Planned Behaviour is based on the notion that behaviour is achieved by acting through behavioural intentions that are in turn instigated by three components that are interrelated attitudes towards the behaviour, subjective norms, and perceived behavioural control. In the context of the Nigerian setting, TPB provides a solid explanatory model about the seeming lack of explicit euthanasia requests despite the extreme suffering. To begin with, the existing religious beliefs and professional ethics (Ramadass *et al*., 2025; Nwankwo *et al*., 2017) impact the formation of attitudes towards euthanasia, not to mention that the rejection of euthanasia by the institution is also a significant factor (Guardian Nigeria, 2018). Second, the subjective norms, which were represented by family-centred decision-making, communal moral obligations, and many other forms of clinician resistance, were more prone to discourage explicit requests and to support indirect manifestations of distress, or an outright refusal of treatment (Akindele *et al*., 2019). Third, the perceived behavioural control is significantly low, as the euthanasia is illegal, access to it is limited in practise, and clinicians are afraid of medico-legal consequences of end-of-life interventions (Rosenberg *et al*., 2023; Oniha, 2017). TPB would therefore predict that the intention to demand euthanasia is inhibited by normative and perceived lack of control even with high Total Pain; this effect results in a documentation gap where distress is apparent and explicit request is rare or undocumented in clinical records.

IV. METHODOLOGY

A. Study Design and Setting

This cross-sectional study examined the occurrence of euthanasia requests among terminally ill patients in 5 tertiary hospitals located in the southern parts of Nigeria: University of Port Harcourt Teaching Hospital, University College Hospital Ibadan, Lagos University Teaching Hospital, University of Nigeria Teaching Hospital Enugu and Federal Medical Centre Abeokuta. The data will be collected between January and August 2025, after the health research ethics committee of every participating institution and the National

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health research ethics committee of Nigeria approves the study ethically.

B. Study Population and Sampling

The study enrolled three groups: (1) terminally ill patients, (2) physicians, and (3) family caregivers.

➢ *Terminally Ill Patients:*

Criteria used to define the study cohort were as follows: age ≥18 years, a confirmed diagnosis of advanced cancer (stage 3/4), end-stage renal disease, advanced HIV/AIDS (CD4 <200 cells/mL) or chronic heart failure (NYHA class 3/4); life expectancy (estimated by a physician) of less than 12 months; mental capacity to consent (MMSE 24 or higher); English, Yoruba, Igbo or Hausa. The formula used to calculate the sample size was as follows: n=Z 2 p(1-p)/d 2; in this case an estimated proportion of 20 per cent was used (p = 0.20) and the minimum required sample was 246 people. Finally, (312) patients were enrolled which equates to a response rate of 90.4.

➢ *Physicians:*

All the attending and senior resident physicians who treated terminally ill patients in the oncology, palliative care, renal medical, cardiology and infectious disease departments were invited to take part. Among the 203 eligible physicians (n=203), 178 responded to the study which gave a response rate of 87.7.

➢ *Caregivers in the Family:*

Patients nominated their primary caregivers, who had to be ≥18 years of age, had to have been engaged in patient care at least 1 month, and had to present an informed consent. The participation rate was 78.5 percent as out of the 312 patients in the study; 245 caregivers took part in the study.

C. Data Collection Instruments

The Patient Questionnaire evaluated: (A) sociodemographic variables; (B) clinical and disease variables; (C) symptom burden assessed using the Revised Edmonton Symptom Assessment System (ESAS-r), which utilises 0-10 scales to evaluate nine symptoms, with scores of 7-10 representing severe symptoms; (D) access to palliative care and adequacy of pain management; (E) euthanasia considerations, which included questions on whether the patient had ever considered euthanasia (yes/no), whether the patient ever considered.

Demographic data, end-of-life-care experiences, attitudes toward euthanasia, using 5-point Likert scales, and perceived obstacles to delivering optimal end-of-life care were documented in the Physician Questionnaire.

The Family Caregiver Questionnaire measured the characteristics of caregivers, burden measured by Zarit Burden Interview-12 (ZBI-12, a 0-48 scale) and the perceptions of patient suffering, and euthanasia attitudes.

D. Data Collection and Analysis

The data provided in face-to-face interviews were registered by trained research assistants who were nurses and medical officers in the private setting after informed consent was obtained in writing. The participants were given questionnaires in their own choice of language. Doctors responded either via e-survey or paper. The data were entered twice into the SPSS version 27.0 with validation processes. Frequencies and percentages were used to summarise categorical variables, means (standard deviation) or medians (inter-quartile range) were used to summarise continuous variables, depending on the results of the normality tests. Bivariate relationships with euthanasia consideration were tested using Chi-square tests and independent samples t -tests. Multivariate logistic regression was used to identify independent predictors, including variables with p -value less than 0.2 in bivariate analysis and a strategy of backward elimination that used a variable whose p -value was less than 0.05. Hosmer-Lemeshow test and Nagelkerke's R^2 of the fitted model were used to cheque model fit. The set statistically significant level was $p < 0.05$.

E. Ethical Considerations

The research was in line with the values of the Declaration of Helsinki and the Nigerian National Code of Ethics of Health Research. Some of the ethical protection mechanisms were voluntary participation with full informed consent in understandable languages, provision of confidentiality through use of unique identifiers and secure storage of data, minimization of emotional risks by ensuring that the interviewers were trained and referred through pathways to psychologist assistance, legal protection by careful wording, which measured attitude and not illegal action. Since euthanasia is an illegal procedure, special attention was paid to confidentiality, which would protect participants in the event of a legal penalty.

V. RESULTS

➢ *Sample Characteristics*

Out of 345 patients approached (eligible, terminally ill patients), 312 completed the survey (response rate = 90.4 per cent); 178 of 203 physicians were participants (response rate = 87.7 per cent); and 245 of 312 caregivers were participants (response rate = 78.5 per cent). The average age of patients was 52.8 years (standard deviation=14.3); 52.9% were females, 58.3% were married, 76.6% were Christian and 21.2% were Muslim. The education level was as follows: 28.5% had no schooling, 31.7% had secondary school, and 15.4% had tertiary school. The indicator of employment showed that 58.0 0 percent were not working or could not work because of illness. The median monthly income was N45,000 (N25,000 - N85,000 55-105), as 42.6% had a lower monthly income of less than N30,000 (37).

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The main diagnoses were advanced cancer (48.7 0 n 152), end stage renal disease (28.5 0 n 89), advanced HIV/AIDS (15.4 0 n 48), and chronic heart failure (7.4 0 n 23). The average time of illness was 18 months (interquartile range: 1030 months). Forty-five and a half percent of patients with hypertension, 28.2 percent with diabetes, and 47.8 percent with two or more comorbidities had comorbidities.

➢ *Symptom Burden and Clinical Status*

Among patients with severe symptoms (ESAS-r 7-10), there were pain (64.7% n=202), fatigue (71.2% n=222), loss of appetite (58.7% n=183), depression (55.4% n=173), and poor wellbeing (68.3% n=213). In the individuals who experienced high levels of pain, 68.8 percent of them were not satisfied with the management of pain.

Depression (PHQ-9): The average of the scores was 12.8 (SD 6.7), and 56.1 (n 175) showed moderate-to-severe depression (PHQ-9 10 and above).

The ones who accessed palliative care services were only 18.6% (n=58). The reasons of non-access were: 45.7 percent were unaware of services, 31.1 percent reported that no referral was given or no service provided, 12.2 percent reported that the waiting time was long, and 11.0 percent that they could not afford the fee. Needs revealed included: 71.2 per cent poor pain control, 68.6 per cent not having sufficient psychological support and 64.4 per cent poor access to opioids.

Financial capacity of 40 percent and above on household spending (catastrophic health expenditure) was experienced by 68.3 percent (n=213). A cost-related treatment abandonment was reported by 54.2 (n 169). It was 4.1 out of 5 (SD=.9) with 72.8 percent of the perceived financial burden being severe or extreme.

➢ *Prevalence of Euthanasia Consideration*

The outcome measure was the primary measure that was used to determine whether patients ever seriously thought about euthanasia or even made the explicit request. In general, 18.9 per cent (n=59) of the terminally ill patients indicated that they had at some time seriously considered or asked to be euthanasised. These 59 patients were considered: 50.8 percent (n =30), 32.2 percent (n =19), and always thought (n=10).

There was limited communication about euthanasia preferences: of all 59 patients who had even thought of euthanasia, 42.4more percentage (n=25) had spoken about their preference with family members, 16.9more percentage (n=10) with healthcare providers, 28.8percent (n=17) with both family members and healthcare providers, and 11.9percent (n=7) with neither family members nor healthcare providers. Among those who managed to have a conversation with healthcare providers (n = 27), 74.1 per cent (n = 20) answered that physicians neither wanted to talk, 18.5 per cent (n = 5) answered that physicians not only listened but also did not judge them, and only 7.4 per cent (n = 2) answered that they felt that their concerns were addressed seriously.

➢ *Circumstances Under Which Euthanasia Would Be Considered Acceptable*

Patients who had already considered the issue of euthanasia (n = 59) were asked about what situations they would consider euthanasia to be acceptable, and they were free to give a number of answers. The most commonly mentioned situations were: pain out of control despite the highest possible treatment (84.7% n=50); loss of dignity and autonomy (74.6% n=44); a liability to her own family (72.9% n=43); extreme suffering with no hope of being relieved (71.2% n=42); total dependency of all activities (57.6% n=34); extreme depression and hopelessness (45.8% n=27); and loss of mental capacity (33.9% n=20).

➢ *Reasons for Considering Euthanasia*

When asked to rank primary reasons for considering euthanasia, the following order emerged (ranked #1 or #2 reasons):

- Severe uncontrolled pain - 69.5% (n=41) ranked as primary or secondary reason
- Financial burden on family - 59.3% (n=35)
- Loss of dignity and independence - 52.5% (n=31)
- No hope for recovery - 47.5% (n=28)
- Inadequate access to palliative care - 42.4% (n=25)
- Severe emotional suffering/depression - 37.3% (n=22)
- Being a burden to family caregivers - 35.6% (n=21)
- Religious or spiritual despair - 15.3% (n=9)

➢ *Factors Associated with Euthanasia Consideration: Bivariate Analysis*

Table 1 presents bivariate analysis examining associations between demographic, clinical, psychosocial, and systemic factors and euthanasia consideration.

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Table 1: Bivariate Analysis of Factors Associated with Euthanasia Consideration Among Terminally Ill Patients (N=312)

Variable	Considered Euthanasia (n=59)	Did Not Consider (n=253)	OR (95% CI)	p-value
Demographic Factors				
Age (mean ± SD)	54.2 ± 13.8	52.4 ± 14.4	--	0.377
Female sex	32 (54.2%)	133 (52.6%)	1.07 (0.61-1.86)	0.819
Married	28 (47.5%)	154 (60.9%)	0.58 (0.33-1.02)	0.061
Tertiary education	14 (23.7%)	34 (13.4%)	2.00 (0.99-4.03)	0.051
Monthly income <₦30,000	34 (57.6%)	99 (39.1%)	2.11 (1.20-3.72)	0.009*
Clinical Factors				
Advanced cancer diagnosis	38 (64.4%)	114 (45.1%)	2.21 (1.24-3.93)	0.007*
Disease duration >18 months	35 (59.3%)	127 (50.2%)	1.45 (0.83-2.53)	0.193
Severe pain (ESAS-r 7-10)	52 (88.1%)	150 (59.3%)	5.07 (2.29-11.25)	<0.001*
Inadequate pain management	48 (81.4%)	138 (54.5%)	3.63 (1.81-7.26)	<0.001*
High symptom burden (≥5 severe symptoms)	43 (72.9%)	132 (52.2%)	2.46 (1.33-4.56)	0.004*
Psychosocial Factors				
Moderate-severe depression (PHQ-9 ≥10)	46 (78.0%)	129 (51.0%)	3.40 (1.76-6.56)	<0.001*
Poor perceived social support	38 (64.4%)	112 (44.3%)	2.28 (1.29-4.02)	0.005*
Perceived loss of dignity	44 (74.6%)	89 (35.2%)	5.35 (2.84-10.07)	<0.001*
Systemic and Economic Factors				
No access to palliative care	54 (91.5%)	200 (79.1%)	2.83 (1.10-7.28)	0.026*
Catastrophic health expenditure	49 (83.1%)	164 (64.8%)	2.66 (1.32-5.37)	0.006*
Treatment abandonment due to cost	41 (69.5%)	128 (50.6%)	2.22 (1.24-3.98)	0.007*
Extreme financial burden (score 4-5)	51 (86.4%)	176 (69.6%)	2.81 (1.30-6.08)	0.008*

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Table 1: Bivariate analysis of factors associated with euthanasia consideration among terminally ill patients (N=312). *Statistically significant at p<0.05. OR = Odds Ratio; CI = Confidence Interval; ESAS-r = Edmonton Symptom Assessment System-revised; PHQ-9 = Patient Health Questionnaire-9

Significant associations (p<0.05) were observed between euthanasia consideration and: low monthly income (OR=2.11, p=0.009), advanced cancer diagnosis (OR=2.21, p=0.007), severe pain (OR=5.07, p<0.001), inadequate pain management (OR=3.63, p<0.001), high symptom burden (OR=2.46, p=0.004), moderate-severe depression (OR=3.40, p<0.001), poor perceived social support (OR=2.28, p=0.005), perceived loss of dignity (OR=5.35, p<0.001), no access to palliative care (OR=2.83, p=0.026), catastrophic health expenditure (OR=2.66, p=0.006), treatment abandonment (OR=2.22, p=0.007), and extreme financial burden (OR=2.81, p=0.008).

No significant associations were found with age (p=0.377), sex (p=0.819), marital status (p=0.061), or disease duration (p=0.193).

➢ *Independent Predictors of Euthanasia Consideration: Multivariate Analysis*

Multivariate logistic regression was performed including all variables with p<0.20 in bivariate analysis. The final model (Table 2) retained five independent predictors following backward stepwise elimination.

Table 2: Multivariate Logistic Regression Analysis: Independent Predictors of Euthanasia Consideration Among Terminally Ill Patients (N=312)

Variable	Adjusted OR	95% CI	p-value
Severe pain (ESAS-r score 7-10)	3.89	1.68-9.01	<0.001
Inadequate palliative care access	3.21	1.58-6.52	0.001
Moderate-severe depression (PHQ-9 ≥10)	2.98	1.47-6.04	0.002
Extreme financial burden (score 4-5)	2.76	1.39-5.47	0.003
Perceived loss of dignity	2.54	1.31-4.92	0.006

Table 2: Multivariate logistic regression analysis: Independent predictors of euthanasia consideration among terminally ill patients (N=312). Model fit: Hosmer-Lemeshow test χ^2=6.82, p=0.556 (good fit); Nagelkerke R^2=0.48; Overall classification accuracy=82.4%. OR = Odds Ratio; CI = Confidence Interval

The final multivariate model identified five independent predictors:

- Severe pain (ESAS-r score 7-10): adjusted OR=3.89 (95% CI: 1.68-9.01, p<0.001)
- Inadequate palliative care access: adjusted OR=3.21 (95% CI: 1.58-6.52, p=0.001)
- Moderate-severe depression (PHQ-9 ≥10): adjusted OR=2.98 (95% CI: 1.47-6.04, p=0.002)
- Extreme financial burden (score 4-5): adjusted OR=2.76 (95% CI: 1.39-5.47, p=0.003)
- Perceived loss of dignity: adjusted OR=2.54 (95% CI: 1.31-4.92, p=0.006)

The model demonstrated good fit (Hosmer-Lemeshow χ^2=6.82, p=0.556), explained substantial variance (Nagelkerke R^2=0.48), and achieved 82.4% overall classification accuracy. No multicollinearity was detected (all VIF<3.2).

➢ *Physician Attitudes Toward Euthanasia*

Among 178 participating physicians (mean age 37.6 years, SD=8.9; 64.6% male; mean clinical experience 9.8 years), attitudes toward euthanasia were predominantly negative. When asked whether euthanasia can be ethically justified in some circumstances, 16.3% (n=29) agreed or strongly agreed, 28.7% (n=51) were neutral, and 55.0% (n=98) disagreed or strongly disagreed.

Regarding legalization of euthanasia for competent terminally ill adults, 14.6% (n=26) supported legalization, 18.0% (n=32) were neutral, and 67.4% (n=120) opposed legalization. Personal willingness to participate in euthanasia if it were legal was even lower: only 8.4% (n=15) indicated willingness, 15.7% (n=28) were uncertain, and 75.9% (n=135) would refuse to participate.

Religious and moral objections to euthanasia were prevalent: 73.6% (n=131) agreed or strongly agreed that they would personally object to participating in euthanasia for moral or religious reasons. Religious affiliation significantly influenced attitudes, with 82.4% of Christian physicians and 78.9% of Muslim physicians opposing euthanasia compared to 45.5% of physicians with no religious affiliation (χ^2=18.7, p<0.001).

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Physicians reported several barriers to optimal end-of-life care: inadequate access to opioid analgesics 78.7% (n=140), insufficient palliative care training 71.9% (n=128), fear of legal consequences for allowing patients to die 64.6% (n=115), lack of institutional policies on withdrawing/withholding treatment 68.5% (n=122), cultural resistance from families 61.2% (n=109), and inadequate time for end-of-life discussions 52.8% (n=94).

- *Family Caregiver Perspectives*

Among 245 family caregiver participants (mean age 44.2 years, SD=12.7; 58.8% female; relationship to patient: spouse 38.4%, adult child 35.5%, sibling 16.3%, other relative 9.8%), caregiver burden was substantial. Mean Zarit Burden Interview (ZBI-12) score was 28.7 (SD=10.4), with 62.4% (n=153) experiencing moderate to severe burden (scores ≥17).

Regarding euthanasia attitudes, 34.7% (n=85) expressed conditional support for euthanasia in cases of extreme suffering, 23.7% (n=58) were uncertain, and 41.6% (n=102) opposed euthanasia under all circumstances. Among caregivers of patients who had considered euthanasia (n=59 patients with corresponding 59 caregivers), 50.8% (n=30) of caregivers reported awareness of the patient's thoughts about euthanasia.

Caregivers who would conditionally support euthanasia (n=85) identified acceptable circumstances: patient experiencing unbearable pain with no relief 88.2% (n=75), patient explicitly and repeatedly requesting euthanasia 71.8% (n=61), terminal diagnosis with no hope of recovery 69.4% (n=59), patient losing all dignity and independence 62.4% (n=53), and family unable to afford continued treatment 47.1% (n=40).

Factors associated with caregiver support for euthanasia included: higher caregiver burden (mean ZBI-12 score 32.1 vs. 26.4, t=3.89, p<0.001), longer caregiving duration (mean 16.8 vs. 11.2 months, t=3.24, p=0.001), caregiver perception of patient suffering as severe (OR=4.23, 95% CI: 2.31-7.76, p<0.001), and caregiver experiencing depression (PHQ-9 ≥10): OR=2.87, 95% CI: 1.56-5.28, p=0.001.

VI. DISCUSSION

This paper provides the initial empirical evidence on the euthanasia requests of terminally ill patients in Nigeria, which found that 18.9% had given serious consideration or requests. Such prevalence is consistent with the range of 1025 percent reported in high-income nations, so it does not confirm that such considerations can only be considered a Western phenomenon. The results show that end-of-life suffering evokes similar reflections according to cultures, in even the jurisdictions where euthanasia is prohibited and stigmatised.

Extreme uncontrolled pain became the strongest independent predictor of euthanasia consideration (adjusted OR = 3.89, p < 0.001) which is in line with literature across the world. This highlights an urgent gap in clinical practise because 64.7% of patients were severely painful and 68.8% of them ranked its management as poor. The ethical concept of the double effect that allows alleviating the symptoms even if they can cause death has not been successfully enforced because of the restrictions of opioid accessibility and insufficient training (Rosenberg et al., 2023). There is still systematic under-treatment and clinicians observe that undertreating pain in dying patients remains a significant issue (Rosenberg *et al*., 2023).

The lack of access to palliative care was also another independent predictor (adjusted OR=3.21, p=0.001) and this is justified by the position of the Nigerian Medical Association, which argues that the situation with suffering should be addressed through better palliative care, and not legalising euthanasia (Guardian Nigeria, 2018). The proportion of patients seeking such services was a dire 18.6% which indicates a dire national deficit as syntheses of Nigeria-specific literature suggest (Cadmus *et al*., 2025; Akyar *et al*., 2026). This service gap along with an enormous knowledge gap (72.3% of patients and families lack awareness of palliative care in a long-standing study in Nigeria (Adenipekun *et al*., 2005) provides a situation of suffering which could be avoided.

The moderate-to-severe depression was also a predictor (adjusted OR=2.98, p=0.002), and 56.1 percent of patients tested positive. This rate is higher than has been reported before and raises an ethical concern about the ability to make decisions, indicating that the treatable depression could affect the end-of-life preferences. The observation is consistent with the reports of psychological distress and harms attributed to stigma among the cancer patients in southern Nigeria (Uwak et al., 2022).

Economic burden of illness has been one influential factor (adjusted OR= 2.76, p= 0.003). And the 68.3 percent of families that currently face catastrophic health spending and 54.2 percent of families that give up treatment because of cost, euthanasia request may not be an autonomous choice. This questions the applicability of the autonomous-based arguments to legalisation in the situations that are not universal health coverage, which is raised in the legal scholarship of Nigerians (Oniha, 2017).

Another predictor was perceived loss of dignity (adjusted OR=2.54, p=0.006), though the cultural construction of dignity in Nigeria tends to focus on the family and arrangements within the community, as opposed to individual independence (Akindele *et al*., 2019). This tension is also evident in the finding that patients were more inclined to talk about euthanasia with their family (42.4%), compared to those who talk with the healthcare providers (16.9%).

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Resistance to euthanasia by physicians had not lessened (67.4%), which was also in line with other studies where 72.6% of them opposed it in all situations, mainly because of moral and religious reasons (Nwankwo et al., 2017). However, doctors also complained of serious moral distress due to lack of adequate resources to control pain and palliative care. The family caregivers showed more conditional support of euthanasia (34.7%), which was linked with their own burden and depression scores, and is ethically questionable on what interests were used to justify such support.

The results of the study do not relate, as a matter of fact, to the legalisation of euthanasia. There are rather emphasised systemic priorities, such as the expansion of the palliative care infrastructure, the enhancement of pain management education and opioid availability, the inclusion of mental health support, the protection of families against the ruinous expenses of medicine, and the clarification of the legal frameworks to defend the physicians who will respect the right of a patient to refuse treatment, which already has the protection of the Nigerian Supreme Court (Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo, 2001). These aspects can be modified to ensure that the suffering level can be reduced and the question of euthanasia can be considered in the problematic healthcare environment of Nigeria.

VII. FUTURE RESEARCH DIRECTIONS

There are several ways through which this study opens up the future research. The longitudinal prospective studies that will follow terminally ill patients during the time of diagnosis till end-of-life will clarify how the euthanasia consideration is changing throughout the course of disease and what triggers the euthanasia onset. A qualitative phenomenological study examining the lived experiences of patients, meaning-making, and decision-making process with regard to euthanasia would be depthful in addition to our quantitative results. Intervention research that angled whether increased access to palliative care, better pain-management procedures, and mental-health services diminishes the deliberation of euthanasia would determine whether the alteration of the mentioned predictors actually alters end-of-life decisions. A comparative study on the euthanasia consideration in northern and southern Nigeria would help in clarifying the cultural and religious differences. Last but not least, evidence-based policy decisions would be informed by health-policy studies on the cost and practicability of universal access to palliative care in comparison with possible euthanasia frameworks.

VIII. CONCLUSION

This paper presents one of the first empirical information of euthanasia in Nigeria and it indicates that 18.9% of patients who are terminally ill have contemplated it. The predictors of value include: severe pain, lack of palliative care, depression, financial disaster, and loss of dignity which are modifiable. This undermines the belief that the given considerations are Western phenomena, demonstrating that there is deep suffering that causes the given considerations even in countries where euthanasia is prohibited and stigmatised.

Such findings are an excellent reply to the position taken by the Nigerian Medical Association that strengthens the moral reaction to palliative care instead of legalisation. Nevertheless, this stance has an ethical obligation, should the society, in asserting that euthanasia should not be legalised because palliative care can manage the pain, then it should make sure that the care is actually available, accessible and affordable. The existing state of affairs, low access to palliative care, untreated depression, and devastating healthcare delivery costs, demonstrates a tremendous disjunction between moral idealism and actuality.

Nigeria is now under a serious dilemma of either spending heavily on palliative care facilities, pain management, mental health services and financial safeguards to ensure that euthanasia is not necessary or perpetuate a status quo where patients are subjected to unnecessary pain without the opportunity to receive proper care and legal end-of-life services. The one is in accordance with the medical ethics and communal cultural values; the other one is a failure in both medicine and policy.

After all, it is not whether to legalise euthanasia that is the question of Nigeria but whether to keep the commitment that palliative care will offer sufficient end of life care. This paper offers empirical basis to that critical thinking and outlines specific actions, specifically, improving pain management, increasing access to palliative care, offering mental health services, economic protection, making legal policies around treatment withdrawal more comprehensible, etc, which can bring that promise to life.

RECOMMENDATIONS

➢ *For Clinical Practice:*

- Implement Routine, Systematic Pain Assessment: Mandate the use of validated tools like the ESAS-r at every patient encounter. Establish and adhere to institutional pain management protocols based on the WHO analgesic ladder, ensuring reliable opioid availability and prescriber training to dismantle barriers to adequate control.
- Establish Mandatory Palliative Care Referral Pathways: Create systematic protocols to ensure all patients diagnosed with a terminal illness receive a palliative care consultation within two weeks. Integrate these services early in the disease trajectory through multidisciplinary teams, rather than reserving them for the final days.
- Integrate Routine Mental Health Screening: Screen all terminally ill patients for depression using tools like the PHQ-9 at diagnosis and regularly thereafter. Ensure

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immediate referral pathways to mental health services for those in need and train primary care providers in basic supportive counseling and psychopharmacology.

- Enhance End-of-Life Communication Training: Provide mandatory, skills-based training for physicians on initiating prognosis discussions, eliciting patient values, discussing treatment limitation options, and empathetically responding to requests for hastened death. Institutional policy should require documentation of these conversations.

➢ *For Health System & Policy:*

- Expand Palliative Care Infrastructure & Access: Prioritize a significant expansion of services, aiming for at least one dedicated palliative care unit per state, supported by outreach programs for rural areas. This requires dedicated government budgetary allocation and the integration of palliative care into core medical and nursing education at all levels.
- Implement Financial & Legal Protections: Develop financial safety nets, including comprehensive palliative care coverage under the National Health Insurance Scheme and hospital-based assistance funds, to prevent catastrophic expenditure. Concurrently, clarify the legal framework to protect physicians who lawfully withhold or withdraw treatment in accordance with a patient's informed refusal, balancing autonomy with conscientious objection rights.

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