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Ascertaining the Contours of the Rights of Terminally Ill Patients to Medical Self Determination in Nigeria: Lesson from Canada

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ABSTRACT

The practice in the medical profession has been that of prolongation of the life of a terminally ill patient through medical technology. This seems ironical as the life of such patient is only sustained for a period before his last breathe as the death of the patient is certain. There is total absence of direct provision in the Constitution of the Federal Republic of Nigeria 1999 or any other legislation in Nigeria for the recognition of the right of terminally ill patients to medical self determination. This was also the situation in Canada before the decision of the Supreme Court of British Columbia in *Cater v Attorney General of Canada* which led to the amendment of section 241of the Criminal Code 1892 and subsequent enactment of a federal legislation on medical assistance in dying on 17/6/2016 hence, making end of life through medical assistance for Canadians possible, especially for terminally ill patients passing through excruciating pain. This can be made possible in the Nigeria with the decision of the Supreme Court in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* which recognised the right of a patient to refuse treatment on grounds of religion. It is recommended among others that there should be enactment of a law for the recognition of the right of terminally ill patients in Nigeria in the form of Medical Self Determination Act, the 1999 Constitution should be amended with the insertion of a direct provision for the recognition of the rights of a terminally patient to refuse or withhold medical treatment and exercise of the right to medical self-determination.

Keywords: Contours, Terminally Ill Patients, Medical Self Determination, Patient Bill of Rights, Palliative and Hospice Care

INTRODUCTION

The right of patient to reject any form of medical treatment no matter how detrimental such decision will turn out to be is a basic right that ought to be recognised in Nigeria through specific legislation. No medical procedure is to be administered on a patient against his consent. This is another basic right of the patient. Ironically, the recognition of these rights is not total in Nigeria. There are countervailing state interest limiting the exercise of these rights in Nigeria.

Emanating from the above, therefore, it is intended by this article, to delineate the contours of the right of terminally ill patients to medical self-determination. It is equally of interest to define the category of patients; emphasis is on terminally ill patients, what actually constitutes terminal illness that deserves distinctive attention. From the outset, the terminally ill patients must have a grievous and irremediable medical condition which is a serious and incurable sickness that is in "advance stage of irreversible decline in capability and their death has become reasonably foreseeable".[1]

Comparatively, the concept of right of terminally ill patients to medical self determination has generated intensive debate particularly as touching what constitutes its elements. By this article, certain distinct rights of patients will be extensively examined with reference to the peculiar status of terminally ill patients and the contours of such rights will be particularly delineated. Such rights include the right of informed consent in the healthcare system and the question of whether it is legally

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[1] R M Carter and B. Rodgerson, 'Medical Assistance in Dying: Journey to Medical Self Determination' [2018] (55) (3) *Alberts Law Review*;795.

enforceable?;the right to refuse medical treatment and whether it is constitutional? Going further, if this right is constitutional, what are the boundaries?, is it a logical corollary to hotly debated concept of right to die?, or could right to die be derivable therefrom? What about the rights of those whose terminal ailments have made them physically challenged? The rights of patients to palliatives and hospice care are examined and same ought to be recognised in Nigeria. Judicial responses in this respect will be critically evaluated. Justification or otherwise for judicial intrusion are highlighted and a call for legislative enactment to reflect changed realities will be strongly recommended.

There are countervailing state interests, about four in number which seem to limit patients' right to self determination. The interests concern the state's interest in preserving life, and sanctity of human life, and interest in safeguarding the integrity of the medical profession, interest to protect innocent third parties.

Generally, it is intended to explicate these highly debated concepts in the light of what the national laws like the constitution and other relevant instruments provide the decision of courts within Nigeria and outside, and in the light of common reality. It is equally strong opinion that developments arising from the celebrated Canadian apex court decision in *Carter v Attorney General of Canada*,[2] which ushered in the new era of end-of-life care for Canadians particularly those who are terminally ill and passing through intractable pain could be juxtaposed with the Nigerian Supreme court case of *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*,[3] and by this juxtaposition, a distinct regime of right of patients could be vividly gleaned, delineated and legislatively isolated by way of enactment.

Ascertainment of the Contours of the Right Terminally Ill Patients to Refuse Treatment and Countervailing State Interests

The right to refuse medical treatment is a fallout of an integral part or consequence of the informed consent doctrine which in general term refers to the right of a patient to be at liberty to refuse a particular form of treatment. The patient is free to exercise this right in spite of the opinion of the doctor under whose care he or she has been placed for treatment and it based on the recognised right of a patient to autonomy, bodily integrity and self determination. It implies the right of a patient to be free from bodily intrusion that is not wanted by him or her no matter how good such intention is.[4] This right has been described as the most sacred, properly guarded and protected by the common law and therefore everyone possesses a right to be free from every interference or restraint from every other person save such interference or restraint is done by legal authority that is very clear and unquestionable in nature.[5]

It is important to note that this right is not explicitly recognised under common law or the Constitutional of the Federal Republic of Nigeria (CFRN) 1999. In the absence of such express recognition, cases bordering on this right have always been based on the right of bodily integrity under common law and the rights to privacy, freedom of thought, religion and conscience in the constitution.[6] It was pointed out in the Nigerian Supreme Court case of *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* that the right of a patient to refuse treatment or consent are concepts which have been determined in various cases in the courts in the USA because this area of law has received reasonable judicial attention in that jurisdiction.[7] However, a medical paternalist would always be against this to the extent that situations might arise in medical practice where treatment will be administered on a patient without the observance of this right will be justified in spite of any objection from the patient.[8] When argued from this angle that sometimes a patient may not be able to appreciate whether a particular medical treatment is in his or her best interest, the action of a physician to impose a particular treatment considered to serve the interest of the patient despite

[2](2015) SCC 5.
[3] (2001) 6 NWLR (pt 710) 2.
[4] *Re Brown* (1985) 478 So. 2d 1033.
[5] *Union Pacific Railway Co. v Botsford* (1891) 141 US 250-251.
[6]E O C Obidimma, 'Right of A Patient to Refuse Medical Treatment: Justification for Intrusion' [2014] *NAUJILJ;*157; *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2001)7 NWLR (pt 711) 206 at 244; CFRN 1999, ss 37 and 38.
[7]*Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2001) 7 NWLR (pt 711) 206 at 245.
[8]E O C Obidimma, 'Right of A Patient To Refuse Medical Treatment: Justification For Intrusion' [2014] *NAUJILJ*;151.

what may likely turn out to be short term objections. A paternalist would always justify the fact that this type of action cannot be considered wrong in spite of the fact that such action constitutes an invasion of the right of the patient. For such paternalist, it is believed that the patient will be very active when treated more than when untreated as physical comfort and good health are preferable to physical discomfort and ill health.[9]

No matter how good the intention is, paternalism cannot be considered a defence to the action of a physician to invade into the right of a patient to privacy and the denial of the patient's right to refuse a particular medical treatment. This right of refusal of a treatment has been sustained by the court in plethora of cases. A good example of such case is the American case of *Natanson v Kline,*[10] where the supreme court of Kansa summarised this issue in the following words:

> Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.

There is a reflection of the principles enunciated in the above in the case of *Sidaway v Board of Governors, Bethlehem Royal Hospital*,[11] where Lord Scarman stated in the report that "the courts should not allow medical opinion of what is best for the patient to over-ride the patient's right to decide for himself whether he will submit to treatment offered him".[12] On the part of Lord Templeman, he was of the opinion that:

> The patient is free to decide whether or not to submit to treatment recommended by the doctor. If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject the advice for reasons which are rational or irrational or for no reason.[13]

When considering the concept of right to refuse treatment in the case of *Bouvia v Superior Court (Glendur)*,[14] the court extended medical treatment to also include nourishment. The facts of the case were that a woman of the age of twenty eight (28) years and a quadriplegic by name Elizabeth Bouvia was suffering from degenerative arthritis and cerebral palsy which were severe in nature. She was unable to move most parts of her body except few of the fingers of one of her hands, facial movement and some slight head and she was living in continual chronic pains. In order to aid her feeding since she could not make use of her mouth, a feeding tube was inserted on her in spite of her refusal to such medical technique. Therefore, she protested against it and wanted it to be removed from her body. The court frowns at the action of the physician for the insertion of the tube. The decision of Bouvia/plaintiff was approved by the court to the effect that a competent patient of sound mind has the right to refuse a particular medical treatment such as nourishment or hydration as in the instant case and that such right must be respected by a physician. There was serious debate on whether a physician can unilaterally administer a particular form of medical treatment on a patient even against his/her refusal to such medical procedure before the Canadian Panel of Royal College of Physician and Surgeons.

The above Canadian panel condemned the action of the physician for operating on the patient and described such action as an inappropriate one. One of the arguments of members of the panel was that a physician cannot unilaterally overrule decision of a competent patient on the reason that such person will be very grateful about such decision later. The right of a patient to refuse treatment is constant hence, it does not lie within the power of a physician to decide. It is not even proper for a court to interfere with the decision of the patient no matter how foolish and unwise it would turn out to be so far as such patient was competent at as the time he or she was presented with the decision and within

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[9] J K Mason and A M Smith, *Law and Medical Ethics* (2nd edn, Butterworths 1987) 140.

[10](1960) 350 P.2d 1093, 1104; R B Standler, 'Legal Right to Refuse Medical Treatment in the USA' [2012] <www.rbs2.com/rrmt. pdf> accessed 10 February 2020.

[11](1986) 1 All ER 637.

[12]*Ibid*, 643.

[13](n11) 666.

[14](1986) 225 Cal Rptr 297 (App 2d Dist).

the time such decision was made.[15] The right of a person to refuse any medical treatment is so fundamental that it has been identified and recognised in major international human rights instrument such as the International Covenant on Civil and Political Rights 1966.[16] Historically, this right is not new.[17]

A patient's refusal to medical treatment is commonly based on the individuals' religious belief. One of such instances is the case of a patient's decision not to accept blood transfusion based on his or her religious belief where such belief forbids a believer in the faith from accepting blood transfusion or any other blood products.[18] A very good example of such religious group in Nigeria and many other countries of the world is the Jehovah's Witnesses whose decision to refuse blood transfusion is very known and has been tested and pronounced upon in court. This is considered one of the bedrocks of the beliefs of every witness. Apart from Jehovah's Witnesses, many other religious groups equally have similar belief relating to sicknesses. Examples of such groups include the Church of Christ, Scientist (Christian Science) and Faith Tabernacle Congregation which believers believe that all sicknesses are caused by the devil hence refuses some forms of medical treatment or any form at all. Members of these denominations promote the healing of mental and physical illness with prayers and do not go to hospital to seek medical attention.[19]

In considering the above, the question that begs for answer is: is it proper for a medical practitioner to honour the objection to treatment by a patient on grounds of religion? There seems to be no straight forward answer to this question. People who believe in the exercise of this right argue that they need not accept some forms of medical treatments on ground of the religions they practice in the society. The freedom of an individual to practice any religion of her choice is entrenched in the CFRN 1999 as a human right that is to be respected by all.[20] It has been argued that religious values and beliefs are too special that they ought to be honoured and respected when manifested in the action of a patient to reject or object to the administration of any particular form of medical treatments on such grounds. Religious values and beliefs are considered special and they are given pride of place because of important reconciling and integrating function they play in the lives of people. Religious beliefs are integral to peoples' identity and fill them out. Refusal to respect the right of people to refuse medical treatment is likened to not respecting them as a people and members of the human family mostly when the reason for such refusal to treatment is based on religious grounds. It is like an insult to a person for his or her refusal to treatment not to be honoured and respected by a physician mostly where the reason for such action by a person or patient is on religious grounds.[21] The special nature of religious beliefs as well as values of patients or people was reiterated by the Supreme Court of Nigeria in the case of *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* thus;

> The right to privacy implies a right to protect one's thought, conscience or religious belief and practice from coercive and unjustified intrusion, and, one' body from unauthorised invasion, the right to freedom of thought, conscience or religion implies a right not to be prevented, without lawful justification, from choosing the course of one's life, fashioned on what one

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[15]*Re Yetter* (1973) 62 Pa.D and C.2d 619, 623-624; J A Sata, *Legal Aspects of Medical Practice in Nigeria* (2nd edn, Calabar: University of Calabar Press 2013) 213; F O Emiri, *Medical Law and Ethics in Nigeria* (Lagos: Malthouse Press Ltd. 2012) 300.

[16]Article 7.

[17]J S Mill, 'On Liberty' in R Hutchins (ed), *Great Books of the Western World* (New York: Enclopedia Britannica 1952) 271.

[18]J Kasprak, 'Refusal of Medical Treatment on Religious Grounds' [1999] *OLR Research Report* <http://www.ega .ct.gov/Ps99/rpt/olr/htm/99-R-180.htm> accessed 10 February 2020; F A Rozovsky, *Consent to Treatment: A Practical Guide* (4th edn, New York: Aspen Publishers 2007) 336; F Cranmer, 'Jehovah's Witnesses and Objections to Blood Transfusion' [2014] <www.lawandrelionuk.com/2014/03/10jahovas-witnesses-and-objections-to-blood-transfusion/> accessed 10 February 2020.

[19]J G Anderson, 'Refusal of Medical Treatment on Religious Grounds' <www.web.ics.purdue.educ/.../SOC% 2057 39020-%20 Refual%20 of %20Medical> accessed 10 February 2020.

[20] S 38.

[21]M J Wreen, 'Autonomy, Religious Values, and Refusal of Lifesaving Medical Treatment' [1991] 17 *Journal of Medical Ethics*;124 <www.ncbin/m.nih.gov/pmc/articles/PMC1376028/pdf/jmedth00278-0014.pdf> accessed 10 February 2020.

> believes in, and a right not to be coerced into acting contrary to one's religious belief.[22]

Apart from Nigeria, this right is also respected in other jurisdictions. This is an established principle as the right of patient who refused medical treatment on grounds of religion has been recognised and such decision upheld by appellate courts. In the case of *Malette v Shulman*,[23] a Canadian court recognised the right of a patient to refuse treatment on ground of religion. In this case, a patient who was a Jehovah's Witness was brought into a hospital while unconscious as a result of a car injury. Blood was administered on her by the physician in the medical facility in the process of her treatment. This action was taken by the physician despite the fact that the he had been informed that the unconscious patient was a Jehovah's Witness who would never consent to blood transfusion no matter the condition she finds her as found on a Medical Alert Card that was found in the purse she came to the hospital with. Upon recovery, she sued the physician for administering blood transfusion on her which was totally against her religious background and wish. The argument of the physician was that approved clinical procedure which required a physician to administer urgent lifesaving procedure such as blood transfusion in the instant case was undertaken. This argument was rejected for being untenable by the court and awarded damages against the physician.

American courts had also decided on issue relating to a patient's right to refuse treatment on grounds of religious beliefs. This was well settled in the case of *Stamford Hospital v Vega*.[24] The facts of this case were that a hospital/plaintiff initiated a law suit seeking for an injunction to enable it administer a blood transfusion on a patient, who had refused such form of treatment on religious grounds being a Jehovah's Witness. The decision of the defendant to consider blood transfusion as the only option of treatment to the patient was because she had heavy blooding after child-birth. The doctor and other colleagues from different hospital unanimously suggested that the only best solution to the medical challenge of the woman was blood transfusion so that she and even the newborn baby could be save and properly taken care of. This application was granted by the trial court considering the interest of the state in the preservation of life and protection of innocent third parties, the baby in this case. Dissatisfied with the decision of the trial court, the defendant filed an appeal at the Court of Appeal. The decision of the trial courts was affirmed by the Court of Appeal. This led to the decision of the defendant/appellant to further appeal to the Supreme Court. The appeal was allowed by the apex court.

The right to refuse treatment, particularly blood transfusion on grounds of religion was recognised in Nigeria in the case of *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*,[25] where the court recognised that in a situation where a patient raises objection to treatment on religious grounds several interests are to be balanced in such situation namely, the constitutional right of the person to be free from any form of coercion capable of making him/her to act contrary to his religious beliefs as well as values; the interest of the state in public safety, health as well as the general welfare of the society at large, including to maintain the reputation and ethical integrity of the medical profession, and possible rejection of treatment based on ignorance and depression.

It follows therefore, that for a medical practitioner to carry out treatment on a patient who has refused such treatment on grounds of religion, such action by the medical practitioner might result to a violation of the right of a person to freely exercise a religion of his/her choice as guaranteed by the CFRN 1999 under section 38. Meanwhile, it is important to note that this constitutional guaranteed right cannot be fully or totally described to be absolute as the right provided under section 38 can still be derogated from under certain circumstances.[26] One can argue that by virtue of the derogation in the constitution, religious practice seems not to be absolute.[27]

From the discussion so far, it is very clear that a terminally ill patient in particular and patients in general have right to refuse treatment even if such treatment is a lifesaving one. This is a notion predicated on the common law right of a person to self-determination. As noted in the preceding

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[22](n7) 244.
[23](1990) 47 DLR 18.
[24](1996) 236 Conn 646.
[25](n7).
[26] CFRN 1999, s 45(1).
[27]K F Hegland, 'Unauthorised Rendition of Life Saving Medical Treatment' [1965] 53(3) *Can. Law Rev*;860 <http://scholarship.law.berkeley.edu/californialawreview/vol53/iss3/4> accessed 10 February 2020.

paragraph, this right of an individual to refuse any medical treatment seems not to be absolute in the strict sense of the word as other states interests and constitutional safeguards are likely to be put into consideration when faced with such situation. The interests used as reasons for such intrusion into this right of a patient include maintenance of ethical integrity of the medical profession, preservation of life and protection of innocent third parties. These state's interests are usually used as the basis of judicial intrusion in permitting a patient or person to take necessary treatment in spite of one's religious beliefs or values.[28]

Maintenance of ethical integrity of the medical profession is one of the reasons for judicial intrusion in matters relating to patient's refusal to take any medical treatment. It has been argued that this cannot be used as a proper reason for overriding the right of a patient to refuse treatment even if the court may use it as a basis when faced with such matter. Although, the state may likely have a good or valid interest in protecting physicians from criminal or civil liability by allowing them to freely operate in taking care and treatment of patients, but from available literatures, this seems not to be a valid ground for the justification of judicial intrusion of the right to bodily integrity and self-determination of a person/patient to refuse treatment as guaranteed in the constitution.[29]

The interest of the state in maintaining the ethical integrity of the medical profession is not in doubt. It also tries to allow hospitals to have the latent freedom and opportunity to care for every patient brought to them for treatment. This interest is considered a limitation on the right of a competent person/patient to refuse treatment. This very state's interest will be seriously threatened where a patient is permitted to refuse treatment, mostly a life-sustaining one.[30] It is submitted that it would not be a proper intrusion for the right of a competent person/patient to decide the type of treatment to accept to be overridden. The question that one may ask here is: do medical ethics require intervention in a disease at all costs? Of course, the answer to this question is no. Therefore, it is unnecessary for a patient to be denied the right to self-determination as expressed in refusing treatment just for the recognition of the doctors' interest, medical staff and hospital. It has been held that the right to informed consent of a patient must be accorded due respect for it to be meaningful, and that this right must be accorded such respect even if doing so would amount to conflict with the values of medical professional advice of the medical doctors.[31]

The need to preserve life is one of the countervailing state interests for intrusion in the exercise of the right of a patient to refuse treatment in Nigeria. Nigeria like many other jurisdictions of the world sees the preservation of life as one of the core purposes of government. This implies that, it is the responsibility of government to preserve the lives of everyone who desires to live.[32] Preservation of life is held to high esteem in Nigeria that it is guaranteed under section 33 of the CFRN 1999. In order to ensure proper protection and preservation of life in Nigeria, the Constitution also provides to the effect that the primary purpose of every government in the country shall be the welfare and security of every Nigerian.[33] This is a clear indication that the interest of the state to protect and preserve life is very high and considered paramount. On this note, in the recognition of the right of a person/patient to refuse any medical treatment the court may where such need arises, such as where the safety and health of the society is threatened, make necessary order to override the patient's right or autonomy to freely choose or decide what will happen to his or her body.[34]

The reason for this intrusion is the state's interest in preserving the lives of every citizen. It is submitted that the reason for the intrusion must be balanced against the right of a patient to self-determination as well as bodily integrity as guaranteed in the Constitution. So such intrusion cannot be justified except where there is a reason so overwhelming to override the right of the patient.

Another good reason for intervention in the right of a patient to refuse treatment that equally serves as a justification for intrusion by the court is interest of the state to protect innocent third parties mostly when the life of a minor is involved. There is plethora of judicial authorities, especially in jurisdiction

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[28]*A C v Manitoba (Director of Child and Family Services)* (2009) SCC 30.

[29] S M Davis, 'The Refusal of Life –Saving Medical Treatment Vs The State's Interest in the Preservation of Life: A Clarification of the Interests at Stake' (1980) (58) (1) *Washington University Law Review*;102.

[30]E O C Obidimma (n8) 162.

[31]*Matter of Claire C. Conroy* (1985) 486 A. 2d 1209, 1224.

[32]S M Davis (n29) 103.

[33](n26), s 14 (2) (b).

[34](n7) 241.

like America showing great respect for the interest of the state in support for children as well as dependents. It is a state's interest to ensure protection of the welfare of children (minor) and dependents who would refuse to take life-prolonging or life- saving treatment and such action leads to his or her death. This fact has been judicially noticed in the case of *Holmes v Silver Cross Hosp of Joliet, III,*[35] where the court held that the interest of the state in the preservation of life of a person was not in itself sufficient enough to outweigh interest of a person in exercising his free choice, rather the possible impact of such action on children (especially minor) would be a very good factor which might likely have negative effect on the result of the balancing process.

The America's case of *Application of President and Directors of Georgetown College,*[36] is a good example of situation where a competent patient was ordered by the court to submit to medical treatment by reason of the interest of the state to protect innocent third parties. The court also considered the fact that the people in general had an interest in the preservation of the life of the woman been a mother of an infant.[37] This point was summarised by the Supreme Court of New Jersey in 1987.[38]

The above represents the justification for judicial intrusion in the event of a patient refusing to accept a particular medical treatment considered the only best option and life-saving on religious grounds. The interest of the infant third party is usually paramount hence the court will always step in to direct that such life-saving treatment be administered on the patient against her belief once such application is brought before it.

Patients Bill of Right in Nigeria

The idea of patient's bill right can be rightly traced to the declaration of the United Nations in 1948.[39] The right to human dignity is properly recognised in this Declaration. This United Nations Declaration of Human Rights recognises the right of everyone, including patients to be treated as equal human being with equal right thereby respecting their right to human dignity. This also implies the recognition of the duty owed the patients by the physicians as well as the state. This bill of rights is a comprehensive guarantee to be enjoyed by everyone receiving medical care. [40]

The patients' bill of rights is an aggregation of all the rights of the patients that exist in many other instruments including the Constitution of Nigeria, 1999, National Health Act 2014, Consumer Protection Act 2004 (now Federal Competition and Consumer Protection Act 2019), Child Rights Act 2003, Freedom of Information Act 2011, and other regulations.[41] This bill was developed by the Consumer Protection Council (CPC) as well as other stakeholders in the health sector, including the Nigerian Federal Ministry of Health for the purpose of ensuring protection of consumers.[42]

There are instances of violation of the rights of Nigerians receiving medical treatment when there is run-down of health facilities staffed by rude health employees. The World Health Organisation (WHO) considered the right of people to health as human rights in 1946 when it defined the right as "the enjoyment of the highest attainable standard of health" that should be available, physically and economically accessible, acceptable by medical ethics standards and of quality to all; regardless of race, religion, political belief, economic or social condition."[43]

The importance of these rights in healthcare cannot be overemphasised as they are in line with international movement towards Universal subject Health Coverage (UHC). The UHC stresses that health services should be available for everyone.[44] The right to health consists of freedoms and

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[35] (1972) 340 F. Supp. 125.
[36] (1964) 377 US 978; 12 L.Ed. 2d 746.
[37] *Ibid*, 1007.
[38] *Matter of Farrel* (1987) 529 A.2d 404, 412; *Holmes v Silver Cross Hospital (no.59)* (1972) 130; *John F. Kennedy Memorial Hospital v Heston* (1971) 58 N.J 576, 279 A.2d 670.
[39] United Nations Declaration of Human Rights 1948, art 1.
[40] Nigeria Health Watch, 'Patients' Bill of Rights: Game Changer or Another Policy Paper?'[2018] <https://nigeriahealthwatch.com/patients--bill-of-rights-game-changer-or-another-policy-paper/> accessed 23 June 2020.
[41] Z Hashim, 'Patients' Bill of Rights: Making Health a Human Right in Nigeria' *Premium Times* (Abuja, 14 April 2019) <https://www.premiumtimesng.com/news/headlines/325291-patients-bill-of-rights-making-health-a-human-right-in-nigeria.html> accessed 23 June 2020.
[42] *Ibid.*
[43] Z Hashim (n41).
[44] *Ibid.*

entitlements. Freedoms to control bodily integrity and the right to be free from non-consensual medical treatment and experiments. Entitlement to the right to a system of health protection, preventive measures, treatments and control of diseases and access to essential medicine. The Right all Nigerians to health is protected in the Patients' Bill of Rights and in the National Health Act 2014 as well as the CFRN 1999. Chapter II of the CFRN1999 make the issue of provision of adequate health and medical facilities for every Nigerian one of the Fundamental Objective and Directive Principles of State Policy to be pursued by the Nigerian State.[45] This is also inferred from the provisions of sections 33 and 34 of the CFRN 1999. This include the right of terminally ill patients to medical self determination and the need for a regulated palliative and hospice care to be in place in the health sector of the country as these class of patients need special treatment and care. Some of the rights recognised in the Patients Bill of Rights (PBoR) are the rights to be treated with respect and the right to decline or refuse or withdraw consent to particular medical procedure. It is submitted that these provisions support the right of a patient, particularly terminally patient to medical self determination and to be treated with special care by making provision for a regulated palliative and hospice care. Therefore, the rights protected in the PBoR are to be protected for proper recognition of the rights of terminally ill patients in Nigeria.

Palliative and Hospice Care in Nigerian Health Sector

Palliative care is the amalgamation of several measures aimed at relieving suffering and improving quality of life for terminally ill patients facing health problems associated with progressive, life-threatening, chronic illness such as cancer, HIV, or chronic obstructive pulmonary disease.[46] The WHO has considered palliative care to be capable of improving the quality of life of terminally ill patients facing health problems associated with life-threatening illness through the prevention and relief of their suffering through means of early identification and perfect assessment and treatment of the pain as well as other problems, which may be physical, psychosocial and even spiritual.[47]

This type of care is offered from the point of the diagnosis of the illness and until death of the patient, and even continues through bereavement, by rendering help to the families to cope with their loss. Since the needs of terminally ill patients with life-threatening disease change over time, palliative care are usually based on the principle of client as well as family centered care. Clinical and lay client assessment centers on the determination of the needs of the clients/terminally ill patients. That is, whether physical, emotional, social, or spiritual and develop a plan with the clients/terminally ill patients and their families on how to address the identified problems. Given this holistic approach, services offered through palliative care may include treatment of pain, treatment of symptoms of the illness, counseling as well as treatment as a way to addressing the problems, support in coping with the stigma as well as discrimination and rejection from family members.[48]

There are numerous benefits of palliative care to terminally ill patients, their families, and the society. It improves the quality of life of the patients. It addresses emotional, physical, social, and spiritual needs, and by rendering support to the patients to achieve a sense of life meaning and peace, there be can be prevention of end-of-life suffering and despair.[49] This type of care has demonstrated some improvements in quality of life of terminally ill patients through a variety of services offered in different settings in a country.[50]

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[45] (n26), s 17(3)(d).

[46] Family Health International, 'Palliative Care Strategy for HIV and Other Diseases' [2009] <https://www.fhi360.org/sites/default/files/media/documents/FHI%20Strategy%20for%20Palliative%20Care%20for% 20HIV%20 and%20Other%20Diseases.pdf> accessed 23 June 2020; M J Wright and Others, 'Mapping Levels of Palliative Care Development: A Global View' [2008] (35) (5) *Journal of Pain and Symptom Management*;469.

[47] World Health Organisation, 'Definition of Palliative Care' [2002] <www.who.int/cancer/palliative/definition/ en> accessed 23 June 2020.

[48] C Saunders, 'The Evolution of Palliative Care' [2001] (94) *Journal of the Royal Society of Medicine*;430.

[49] R Farinpour and Others, 'Psychosocial Risk Factors of HIV Morbidity and Mortality: Findings from the Multicenter AIDS Cohort Study (MACS)' [2003] (25) (5) *Journal of Clinical Experimental Neuropsychology*;654; S C Kalichman and Others, 'Prospective Study of Emotional Reactions to Changes in HIV Viral Load' [2002] (16) (3) *AIDS Patient Care STDS*;113; J Leserman and Others, 'Progression to AIDS, A Clinical AIDS Condition and Mortality: Psychosocial and Physiological Predictors' [2002] (32) (6) *Psychology Medicine*;1059.

[50] P J Armes and I J Higginson, 'What Constitutes High-Quality HIV/AIDS Palliative Care?' [1999] (15) (4) *Journal of Palliative Care*;5.

Modern hospice and palliative care is traceable to England as far back as the 1960s and was mainly for cancer patients and Human Immunodeficiency Virus (HIV) epidemic with focused attention on the need for palliative care.[51] The pioneering work of Merriman working in Uganda in the year 1993 led to the agitation of the hospice and palliative care carried to University College Ibadan by one Professor Soyanwo and her co workers across some centres in Nigeria.[52]

Every effort in this regard by way of advocacy and sensitisation to the then Government proved abortive. This made Merriman to move to Kenya and later Uganda.[53] Merriman facilitated the actual inauguration of the Hospice and Palliative Care Association of Nigeria (HPCAN) in 2007.[54] Despite the prescriptions of the WHO in 2002 and emphasis on the practice at the 2004 WHO General Assembly that this should be integrated into every nation's health care system,[55] Nigeria is yet to approve it as a working policy. Although, the government of Nigeria set-up a Consultative Committee on Cancer and HIV/AIDS Policy draft in 2006.[56] Regrettably, more than ten years after the white paper approving the policy is yet to be implemented. This contributes to the slow level of palliative and hospice care development in the country.

Classification of Terminal Ailments under Emergency Care

Health policy across the globe emphasised on several vertically oriented programmes that focus on the treatment of various ailments and control of communicable ones. Sometimes, this result in most public health agencies concentrating on supporting selective programmes that address ailments and activities considered priority.[57] Unfortunately, programmes of this nature do not encourage the development of efficient and strong health care delivery systems.[58] The weakness of this approach in the health sector is most visible during crises, such as medical emergencies or other incidents that involve many casualties. Consequently, experts in the international health are beginning to review the health sector in a comprehensive manner as well as the provision of emergency medical care. Thus, Nigeria should not be an exception to this global reformation so as to give consideration to terminally ill patients through a classification of such patients under emergency care. The need for this classification cannot be overemphasised as the emergency unit in Nigeria is general in nature taking care of every patient in need of such care depending on the severity of ailments. With the recent available legal framework encouraging emergency medical treatment this classification is possible.[59] The principle of emergency medical care is centered on the stabilisation of patients suffering from a limb-threatening or life-threatening injury or illness. This type of medical care centers on the provision of urgent medical interventions. It includes actions necessary for the prevention of needless death irrespective of the age of the patients.[60]

Lesson from Canada

The issue of legalisation of medical assistance in dying in Canada generated a lot of controversies for decades and many individuals argued for and against it. Many terminally ill patients suffered in excruciating pains and lost their lives at the end of the day as a result of the prohibition of physician-assisted dying or medical assistance in dying in Canada. There was a different turn of event after the decision of the Supreme Court of British Columbia in the *case of Carter V Attorney General of Canada* was delivered in 2015 leading to the legalisation of medical assistance in dying in Canada.

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[51] A Merriman, *Palliative Medicine: Pain and Symptom Control in the Cancer and/or AIDS Patient in Uganda and Other African Countries* (4th edn, Marianum Press 2006) 28.

[52] I. H. Shambe, 'Review of Article Palliative Care in Nigeria: Challenges and Prospects' [2016] (8) (3) *Jos Journal of Medicine*;54.

[53] F O Oyebola, 'Palliative Care Trends and Challenges in Nigeria: The Journey So Far' [2017] 1 (2) *Journal of Emergency and Internal Medicine*;1<https://www.imedpub.com/articles/palliative-care-trends-and-challenges-in-nigeria--the-journey-so-far.pdf> accessed 23 June 2020.

[54] *Ibid.*

[55] *Ibid.*

[56] *Ibid.*

[57] J A Razzak and A L Kellermann, 'Emergency Medical Care in Developing Countries: Is it Worthwhile?'[2002] (80) (11) *Bulletin of the World Health Organisation*;900.

[58] *Ibid.*

[59] National Health Act 2014, s 20.

[60] J A Razzak and A L Kellermann (n57) 901.

There was enactment of a federal legislation on medical assistance in dying on 17/6/2016.[61] This came up after heated debate between Canadian House of Commons and the Senate over Bill C-14 for An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying which later receive royal assent and subsequently came into force amending the Criminal Code of Canada and establishes the procedures and conditions under which a terminally ill patient can receive and enjoy medical assistance in dying services in the country.[62] In order to ensure effective implementation of the new law, the governments of Canada have been working tirelessly and together to give support for proper integration as well as implementation of the new regime of medical assistance in dying in the country within the health care system. Some inter-professional care teams or coordination systems have been put in place by territories and provinces as ways of helping individuals who are in need of information on how to assess medically or physician-assisted dying. Some legislative as well as system level policy changes have been put in place for the furtherance of integration of assisted dying as an integral part of the extent of available end-of-life services in Canada. This is not only left in the hands of provinces and territories but the federal government of Canada has also contributed to this by making necessary current information relating to medical assistance in dying available to every Canadian through its directory on website designed for such purpose.

With the current regime of medical assistance in dying in Canada, the Minister of Health is expected to make regulations as a way of supporting data collection, reporting on request for, and endure medical assistance in dying. Such regulations were expected to be in place before the end of 2018. This remains an important aspect of the practice of physician-assisted dying in every country that practices it. Public reporting is a way of fostering public trust and provision of transparency in the application of relevant law for such practice. The need for such reporting reflects the serious nature of medical assistance in dying being an exceptional aspect of the criminal laws which prohibit intentional killing of persons.[63] Therefore, federal, provincial, including territorial governments were working in synergy in order to produce interim updates with the use of available data. This is to be done until the federal government puts a permanent system in place. In fact, the first update on this was released on 26/4/2017 containing information on the first six (6) months of the practices. It covered the period of 17th June to 31 December 2016 of the practice of medical assistance in dying in Canadian federal legislation, while the second report covered the period of 1st January to 30th June 2017 and released on 6/10/2017 and made provision for insight into the proper implementation of the practice in the first year of its recognition. The report contained data covering from the 1st of July to 31st of December 2017 which borders on the most comprehensive profile of the practice in Canada till date.[64]

Federal legislation sets out framework for the accessibility of medical assistance in dying to every Canadian, it is the responsibility of the provincial as well as territorial governments to manage and deliver health care services and ensure law enforcement in general. Jurisdictions ensure continuous implementation of legislative policies or changes relating to the delivery as well as oversight of the practice of medical assistance in dying all over the country. As a way of increasing awareness among medical health practitioners and improvement of service delivery many jurisdictions are offering training programmes and education on medical assistance in dying for medical/health practitioners.[65]

Provinces and territories are empowered to make legislation and regulation on physician-assisted suicide as well as euthanasia, provided they do not conflict with the federal legislation. Many provinces and territories have adopted various policies and guidelines relating to medical assistance in dying but Quebec has been noted as the only province to have adopted a legislation governing/regulating medical assistance in dying. In fact, it is on record that the province was even the first jurisdiction to have legislated on this issue in Canada before the decision of the Supreme Court of British Columbia in *Carter v Attorney General of Canada.* Quebec adopted its legislation titled "Act Respecting End-of-Life Care" in the month of June 2014. Since the adoption of the law

[61]R Levush, 'Legalisation of Medical Assistance in Dying in Canada' [2016] <https://blogs.loc.gov/law/2016/07/ legalization-of-medical-assistance-in-dying-in-canada/> accessed 25 January 2020.
[62] *Ibid.*
[63] R Levush (n61).
[64] *Ibid.*
[65] R Levush (n61).

was before the decision of court in the *Carter's* case, and invalidation of sections 7 and 14 of the Canadian Criminal Code, its provisions relating to euthanasia were first declared to be of no effect but with the delivering of the decision in the case of *Carter v Attorney of British Columbia*, the law became effective in the province of Quebec on 10/12/2015 and declared constitutional in the same year. Contrary to the provisions of the federal law on the practice of euthanasia, the Quebec's Act only permits the practice of euthanasia for a terminally patient. Therefore, while the federal law provides for the requirement of "reasonably foreseeable" as condition for the application of medical assistance in dying, the Quebec Act allows terminally ill patients to request for euthanasia without such condition.[66]

Applying Lessons from Canada to Nigeria

Going through our laws, it does appear that there is no right of patients to medical self determination that can justify physician assistance in dying. But how can Nigeria benefit from the practices in the selected jurisdiction of Canada as discussed in this article, appreciative of the country's legal system, cultural relativism, level of ignorance and poverty of the mind arising from depression.

However, from the several existing constitutional provisions, and judicial pronouncement justification could be seen. The apex court in Nigeria has demonstrated their belief in the autonomous right of a patient to refuse treatment even if the refusal will lead to lethal consequences. This was so illustrated in the case of *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*,[67] Ayoola JSC (as he then was).

In the mindful construction of the Criminal Code, any person who: "(i). procures another to kill himself; or (2) counsels another to kill himself and thereby induces him to do so; or (iii) aids another in killing himself, is guilty of felony and is liable to imprisonment for life".[68]

In the same vein, section 311[69] which provides for acceleration of death, states that:

> A person who does any act or makes any omission which hastens the death of another, who, when the act is done or the omission is made is laboring under some disorder or disease arising from another cause is deemed to have killed that person.

Section 241(b) of the Canadian Criminal Code is almost similar when juxtaposed with the Nigerian Criminal Code provision on assisted suicide. This section provides "that everyone who aids or abets a person to commit suicide whether suicides ensues or not, is guilty of an indictable offence and is liable to imprisonment for a term not exceeding 14 years".

In *Carter v Attorney General of Canada*[70]which led to the suggestion that Nigeria should adopt Canadian model of physician assistance in dying, the court held that: "section 241(b) of the Canadian Criminal Code infringed the plaintiffs' right to life, liberty and security of person. That section 241(b) also infringed section 15 of the Charter which provides for the plaintiffs right to equal protection under the law."

Section 306 of the Nigerian Criminal Code states that: "it is unlawful to kill any person unless such killing is authorised or justified or excused by law". What circumstances can really authorise or justify killing based on the principle of sanctity of human life?` There are already established conditions in which killing can be lawful and the sanctity of life is suspended. This accounts why the opponent of medical or physician assistance in dying cannot successfully rely on sanctity of human life to defeat the campaign for legal recognition of medical or physician assistance in dying in deserving circumstances.

But in *OLGA Telli*'s case[71] the Indian Supreme Court held that "the right to life includes the right to livelihood". The court authoritatively posited that "no person can live without the means of livelihood… Deprive a person of his right to livelihood and you shall have deprived him of his life". The right to life without the basic component of the means of livelihood is meaningless and worthless. In the absence of good health care, palliative care, means of livelihood, prevention of the terminally ill

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[66] *Ibid.*
[67] (n3).
[68] Criminal Code Act, Cap C39 Laws of the Federation of Nigeria, 2004, s 326.
[69] CCA.
[70] *Carter v Attorney General of Canada* (2015) SCC 5; (2015) 1 SCR 30.
[71] (2007) CHR 236.

under intractable pain, agony, suffering and with no hope of survival from following the path of honour to end his life of misery and emptiness is callous and intransigence.

The point intended to score here is that if these practices are allowed by the Constitution, it means, following the case of *Kalu v State*,[72] "the right to life is not absolute". Indeed, if the "right to life is not sacrosanct or absolute, then it is apposite to explore other provisions of the Constitution in support of argument for the "right to die". According to the provision of section 34(1) of the 1999 Constitution, "every individual is entitled to respect for the dignity of his person and accordingly; (a) no person shall be subjected to torture or to inhuman or degrading treatment".

The above exciting provision raises possible interpretation which may provide to serve as support for "right to die" . It could be contended that a refusal to terminate life of a suffering patient in irretrievably excruciating condition may constitute "violation of the right not to be subjected to torture or undignifying treatment".[73] This position was emphasised by the Supreme Court of Nigeria in the case of *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*.

In summary, it is submitted that patients right to medical self determination particularly right to reject treatment, hospice/palliative care could be practiced in Nigeria. Right of terminally ill patients to physician assisted dying could also be legally recognised in Nigeria by relevant amendment to our constitution with medical safeguards as suggested in the recommendation.

CONCLUSION

There is no statute for the recognition and protection of the right of patients, particularly the terminally ill patients to medical self-determination in Nigeria. Therefore, there is absence of any positive right of a terminally ill patient to end his or her life through the assistance of physician or medical staff. This contributes to the unending pain of a patient suffering from a life-threatening ailment associated with pain hence, making such patient to depend on family members and friends for the performance of his or her daily activities. The problem is that the life of such patient is prolonged through a life saving/sustaining medical technology while such patient will still die. One of the reasons for the prevention of medical assistance in dying or euthanasia in general is the doctrine of sanctity of human life. Another problem is that Nigeria is one of the countries retaining death penalty in her criminal legislation. The Supreme Court of Nigeria recognised the right of a patient to refuse or withhold medical treatment in Nigeria. But in spite of this decision of the apex court, there is still absence of a legislation for the recognition and protection of the right of patients in general and terminally ill patients in particular to Medical Self Determination in the country whereas the decision of the Supreme Court of British Columbia in the case of *Carter v Attorney General of Canada* led to the legalisation of medical assistance in dying in Canada.

RECOMMENDATIONS

The following recommendations are made in this article as way of ensuring the legalisation of the right of a patient to medical self-determination in Nigeria, particularly the terminally ill patients.

1. The National Assembly of Nigeria should set up a legal framework like the Canadian model for the accessibility of a medical assistance in dying to deserving patient(s), particularly the terminally ill patients. Observing the strict medical procedures/conditions for eligibility thus:
    a. the physician or medical practitioner must make sure that the request by patients for medical assistance in dying must be in writing, dated, clearly signed by such patient and in the presence of at least two witnesses;
    b. the medical condition of the patient must be grievous, irremediable and death reasonable foreseeable;
    c. the patient's request must be voluntary and flexible,;
    d. the patient must be properly informed of his/her situation and possible alternative;
    e. the patient must be competent and capable of making decisions;
    f. there must be evidence of absence of any alternative means of improving his condition;

[72] *Kalu v State* (1998)13 NWLR (pt 583) 531; (1998) 12 SCNJ; (1998) 3 NWLR (pt 581) 604.
[73] E Owusu-Dappa, 'Euthanasia, Assisted Dying and the Right to Die in Ghana' [2013] (4) *Social Legal Analysis Med. Law*;15-16.

g. there must be presence of mental and physical suffering that is unbearable;
h. the voluntariness of the consent of the patient must be ascertained by the doctor in the presence of two other medical practitioners, and finally the physician confirmed by a psychiatric and a psychologist to ensure that the patient's decision is not out of ignorance or depression;
i. the name of the physician or team of physicians or caregiver, name of patient, hospital and date of the exercise must be documented;
j. the patient must be 18 years of age and above;
k. the physician will file the document with appropriate health organisation, to wit; the Nigerian Medical Association, Medical and Dental Council of Nigeria.

2. A law for the recognition and protection of the right of patient should be enacted in Nigeria in the form of a Medical Self Determination Act.
3. The Constitution of the Federal Republic of Nigeria 1999 should be amended with the insertion of a direct provision for the recognition of the rights of patient, particularly a terminally ill patient to refuse or withhold medical treatment and medical self-determination.
4. Physician should always inform the patient about a particular medical procedure or diagnosis before administering it if allowed by the patient. The will/wish of the patient should be respected by every physician.
5. The derogation to right to life as contained in the Constitution should be enlarged to include a justification of physician-assisted dying in Nigeria. This right should be made exercisable by a terminally ill patient suffering from excruciating pain and living a life dependent on others if he or she indicates interest to end the pain and agony by ending his life.
6. State intervention in the exercise of the right of a patient to refuse treatment through judicial intrusion should not be permitted in every circumstance.
7. It is recommended that that every health care giver treating terminal ill patients should apply the principles of palliative and hospice care in caring for them.
8. Patients suffering from terminal ailments should be classified under emergency care for prompt treatment and care.