The Research Journal of Medical Sciences
[E-ISSN: 3078-2481| P-ISSN: 3078-2473]
Available on: https://rjmsonline.com/
Volume: 08 | Issue: 02, 2026
DOI: 10.5281/zenodo.22768280

Research Article *Open Access*

Initiators, Timing, and Stated Reasons for Euthanasia Requests Among Patients with Life-Limiting Illnesses in Nigeria

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Source of support: Nil.
Conflict of interest: None

Received: 06-08-2026
Accepted: 03-09-2026
Available online: 15-09-2026

Abstract

There is scant empirical research on the expression of requests for euthanasia when faced with a critical disease in Nigeria. This study described who made such requests, at what point in the illness trajectory they happened and the main reasons provided for making the requests. This descriptive analysis was based on a facility-based analytical cross-sectional survey of 2,500 persons with life-limiting or advanced chronic illnesses getting care in specified healthcare settings in Nigeria. Patterns were examined among 949 participants who satisfied the composite definition of having made a euthanasia-related request in the parent research. Data were obtained using a standardised interviewer delivered questionnaire . Data were summarised using frequencies, percentages and 95% Wilson confidence intervals. Initiation of euthanasia requests was by patients alone in 54.2% of the cases, by family members alone in 32.0%, and jointly by patients and family members in 13.8%. Requests were most common at the terminal period of disease (48.5%), followed by mid-illness (35.8%) and diagnosis (15.7%). The most common reasons cited were terrible physical pain (32.1%), poor quality of life/loss of dignity (27.9%), financial burden on the family (18.0%), mental exhaustion/depression (11.4%), and fear of future suffering (10.5%).Euthanasia requests in this clinical sample were mostly patient-initiated and most often occurred in the mid-to-terminal phases of disease. The most commonly cited reasons were unbearable pain, poor quality of life or loss of dignity, and financial strain. Such requests should trigger immediate explanation of the patient's concerns, full assessment of physical and mental health symptoms, consideration of palliative care needs, and adequate precautions against family pressure, financial coercion, and other potentially modifiable sources of distress.

Keywords: *euthanasia-related request; desire for hastened death; end-of-life care; pain; dignity; financial burden; Nigeria.*

INTRODUCTION

Requests for euthanasia or for a hastened death are complex and emotionally fraught messages, which may arise when faced with a serious, life limiting illness. Such requests do not necessarily reflect a singular, fixed desire to die but may express physical suffering, psychological distress, loss of autonomy, reduced quality of life, threats to personal dignity, fear of future suffering, or concern about the effect of illness on family members[1]. In rare situations, a request may also be an indirect plea for relief of symptoms or distress perceived by the patient as unacceptable. Therefore the understanding of euthanasia-related requests involves paying attention not only to whether they occur, but also to who initiates them, when they occur in the trajectory of the sickness and what reasons are stated for making them[2]. The want for a hastened death has garnered much interest in palliative and end-of-life care research. Patients with severe illness commonly have several and overlapping sources of suffering, including uncontrolled pain, exhaustion, functional decline, despair, hopelessness, social isolation, loss of independence, and existential discomfort. It has been stressed that the wish for death in patients with terminal illness may be motivated by psychological, social, physical and existential issues, and not only by medical symptoms[3]. Similarly, studies have shown that demands for hastening death can be

dynamic, and may be impacted by symptom burden, psychological well-being, interpersonal relationships, and quality of communication and supportive care received [4]. Thus, a desire for euthanasia can be an essential clinical signal of unmet needs that must be carefully assessed, rather than an initial assumption that the patient is requesting an irreversible action. The person making a request connected to euthanasia is of particular interest for the ethical and clinical context of communication concerning euthanasia. A request made directly by the patient may be an autonomous expression of suffering, of preferences or of concern about the future. By contrast, a family members' request may be based on authentic concern about the patient's suffering, but can also evoke issues of carer load, financial difficulties, family expectations, or coercion. Jointly initiated requests could suggest joint decision-making or the role of family relationships in end-of-life wishes. These differences are particularly important where healthcare decisions are highly affected by the family. Therefore, identifying who first raises the issue can help health providers distinguish patient-centred expressions of concern from demands that are primarily driven by relatives or environmental pressures[5]. Another key dimension is the time of a request in the sickness trajectory. Euthanasia-related issues might arise at the time of diagnosis, throughout disease progression, after a decline in functional status or during the terminal phase of illness. A request made soon after diagnosis may reflect shock, fear, uncertainty, or an acute psychological response to the diagnosis, whereas one made later may be associated with persistent symptoms, progressive disability, treatment fatigue, loss of independence, or increasing dependence on carers. Requests at the end of life may be indicative of significant symptom burden or accumulated physical, psychological, social and existential anguish. Thus, analysis of timing might reveal periods in the disease trajectory at which greater communication, psychosocial support, advance-care planning, and palliative-care interventions may be especially relevant [6].

The grounds given for requests for euthanasia are as crucial as many of the underlying issues are possibly treatable. Requests to accelerate death are often linked to unbearable pain, but suffering can involve more than physical symptoms. Loss of dignity, quality of life, despair, hopelessness, fear of further deterioration, loss of autonomy and perceived burden on family members may also influence end-of-life preferences [7]. Financial factors may be especially pertinent in low- and middle-income countries, as patients and families often bear substantial direct expenditures of health care. Thus, a request for euthanasia may sometimes signify not simply an individual's response to disease but also a response to the wider social and economic circumstances surrounding that illness[8].

Such issues are particularly pertinent in Nigeria because euthanasia is not an available normal clinical service under the law. End-of-life care is delivered in a health care system in which family plays a significant role in medical decision-making, where access to specialist palliative-care services is inconsistent, where there are limitations in opioid availability and pain-management resources, and where health care expenditure is largely out of pocket [9]. Cultural norms related to family obligation, caregiving, dignity, pain, and death may also influence how patients express their wishes and how family members understand or react to them. In such circumstances, a statement of a wish to die may have meanings that go beyond a literal call for euthanasia and may instead reflect untreated illness, psychological anguish, carer concerns, financial difficulties or a perceived loss of dignity[10].

Although these questions are ethically relevant, there is a lack of empirical research documenting the features and pattern of euthanasia-related requests among patients with life-limiting illness in Nigeria. In particular, we have no evidence of who makes such requests, at what stage of sickness they are made and the main reasons patients or families offer for making them. The generation of evidence in these domains is key to strengthening clinical assessment, improving communication among patients, families, and health professionals, and identifying potentially reversible sources of suffering. It may also assist in the establishment of culturally fitting safeguards against coercion, while preserving patient autonomy and dignity within the Nigerian healthcare context.

This study consequently focuses on the initiators, timing and the reported reasons for euthanasia requests in patients with life-limiting or severe chronic conditions in selected Nigerian health care settings. The study aims to provide insight into how requests related to euthanasia are expressed in clinical practice and where there might be opportunities for timely symptom management, psychosocial support, palliative-care intervention and protection of vulnerable patients from inappropriate family or financial influence, considering these three dimensions together.

MATERIALS AND METHODS

Study Design and Setting

This study was a descriptive secondary analysis of data generated from a facility-based analytical cross-sectional study conducted among adults receiving care for life-limiting or advanced chronic illnesses in selected primary, secondary, and tertiary healthcare facilities in Nigeria. The parent study was designed to investigate experiences and perceptions related to end-of-life care among adults living with serious chronic or life-limiting conditions. The present analysis focused specifically on the pattern of euthanasia-related requests, including the person who initiated the request, the stage of illness at which the request occurred, and the principal reason stated for the request.

Study Population and Eligibility Criteria
The parent study recruited **2,500 adults aged ≥18 years** with clinician-confirmed life-limiting or advanced chronic illnesses. Eligible participants were adults who were receiving care at the selected healthcare facilities, were medically stable at the time of recruitment, were able to communicate in English or an approved translated language, possessed the cognitive capacity to provide informed consent, and voluntarily agreed to participate.

Patients who were critically ill or unable to participate meaningfully in an interview were excluded. Specifically, individuals who were unconscious, delirious, had severe cognitive impairment, or were otherwise unable to provide informed consent were excluded from participation. These criteria were applied to minimize the risk of obtaining unreliable responses and to protect patients who might have been particularly vulnerable during the data-collection process.

For the present secondary analysis, only participants who had been classified in the parent study as having reported an euthanasia-related request were included. Thus, the analytical sample comprised 949 participants.

Sampling Procedure
A multistage sampling technique was employed in the parent study. Sampling proceeded through the selection of healthcare settings, healthcare facilities, relevant clinical units, and eligible patients. The allocation of participants across selected facilities was proportional to eligible patient attendance, thereby ensuring that facilities with larger numbers of eligible patients contributed proportionately more participants to the study sample.

Within the selected clinical settings, participants who met the eligibility criteria were approached and recruited following informed consent. The sampling procedure resulted in a total parent-study sample of 2,500 participants, from which the 949 participants included in the present analysis were identified according to the predefined euthanasia-related request criterion.

Data Collection Instrument and Procedure
Data were collected using a structured interviewer-administered questionnaire developed from a review of relevant literature on euthanasia-related requests, desire for hastened death, palliative care, end-of-life care, financial hardship, psychological distress, and healthcare experiences. The questionnaire was administered by trained research assistants who received orientation on the study objectives, ethical requirements, confidentiality, and the use of neutral and non-judgmental language when discussing sensitive end-of-life issues.

The questionnaire contained a module specifically designed to characterize euthanasia-related requests. The module assessed three principal domains: initiator of the request, timing of the request within the illness trajectory, and principal stated reason for the request.

The initiator was categorized as patient alone, family member alone, or patient and family jointly. Timing was categorized as occurring at diagnosis, during the mid-illness phase, or during the terminal phase. For the principal stated reason, responses were classified into the predefined categories used in the parent study, with each participant assigned one principal reason for purposes of the present descriptive analysis.

Validity and Reliability of the Instrument
The questionnaire underwent expert review to assess face and content validity. The instrument was also pilot-tested among participants outside the selected study facilities before commencement of the main data collection. Feedback obtained during the pilot phase was used to improve the clarity, comprehensibility, sequencing, and appropriateness of questionnaire items.

Operational Definition of Euthanasia-Related Request
For the parent study, a euthanasia-related request was operationally defined using a composite criterion comprising either an explicit request for assistance to hasten death or a repeated expression of a desire to die because of unbearable suffering within the specified study reference period.

This operational definition was developed for research classification and should not be interpreted as equivalent to a formally assessed, persistent request for legally regulated medical assistance in dying. In particular, the term *euthanasia-related request* in this study refers to the participants' reported expressions or requests within the study context and does not imply that euthanasia was offered, medically authorized, or legally available in the participating Nigerian healthcare settings.

Study Variables

The primary variables examined in this secondary analysis were:

1. Initiator of the request: patient alone, family member alone, or patient and family jointly.
2. Timing of the request: at diagnosis, mid-illness, or terminal phase.
3. Principal stated reason: the main reason reported by the participant for the euthanasia-related request.

The categories were treated as mutually exclusive for analytical purposes. Where more than one concern was expressed, the principal reason recorded in accordance with the parent study's classification procedure was used for the present analysis.

Statistical Analysis

Data analysis was descriptive and restricted to the 949 participants classified as having made an euthanasia-related request. Categorical variables were summarized using frequencies and percentages. The distribution of request initiators, timing across the illness trajectory, and principal stated reasons was reported using the corresponding denominators.

Ethical Considerations

Ethical approval for the parent study was obtained from Research Ethics Committee of Health Science, Imo State University Owerri, before commencement of data collection.

Ethical principles governing the parent study were applied throughout the research process. Participation was voluntary, and written informed consent was obtained from all participants before enrolment. Participants were informed of the purpose and procedures of the study and their right to decline participation or withdraw without any effect on the care they received.

Because discussions concerning death, suffering, and euthanasia may evoke emotional distress, interviews were conducted using neutral, respectful, and patient-centred language. Privacy and confidentiality were maintained during data collection, and information obtained from participants was handled. Participants who exhibited significant distress during the interview were to receive appropriate support and referral in accordance with the study protocol.

RESULTS

Analytic subset

Of 2,500 respondents in the parent study, 949 were classified as having made a euthanasia-related request and constituted the pattern-analysis subset. The proportion 949/2,500 (38.0%) is reported only to define the subset; it should not be combined with the separate 640-participant prevalence sample used for Objective One.

Initiator of the request

More than half of the requests were initiated by patients alone (54.2%). Family members initiated almost one-third (32.0%), while 13.8% were reported as jointly initiated by the patient and family. Thus, family members participated in 45.8% of requests either independently or jointly.

Table 1. Initiator of euthanasia-related requests (N = 949)

Initiator	n	%	95% CI
Patient	514	54.2	51.0–57.3
Family member	304	32.0	29.1–35.1
Patient and family jointly	131	13.8	11.8–16.1
Total	949	100.0	—

Timing in the illness trajectory

Requests clustered later in the illness trajectory. Almost half occurred during the terminal phase (48.5%), more than one-third during mid-illness (35.8%), and 15.7% at diagnosis. In combination, 84.3% occurred after the diagnostic stage.

Table 2. Timing of euthanasia-related requests (N = 949)

Timing	n	%	95% CI
At diagnosis	149	15.7	13.5–18.2
Mid-illness	340	35.8	32.8–38.9
Terminal phase	460	48.5	45.3–51.7
Total	949	100.0	—

Commonly stated reasons

Unbearable physical pain was the most frequently stated principal reason (32.1%), followed by poor quality of life or loss of dignity (27.9%). Together, these accounted for 60.0% of the reported principal reasons. Financial burden on the family accounted for 18.0%, while emotional exhaustion or depression (11.4%) and fear of future suffering (10.5%) were less

frequent.

Table 3. Principal stated reason for euthanasia-related requests (N = 949)

Principal stated reason	n	%	95% CI
Unbearable physical pain	305	32.1	29.2–35.2
Poor quality of life/loss of dignity	265	27.9	25.2–30.9
Financial burden on family	171	18.0	15.7–20.6
Emotional exhaustion/depression	108	11.4	9.5–13.6
Fear of future suffering	100	10.5	8.7–12.7
Total	949	100.0	—

Note. Categories are presented as mutually exclusive principal reasons because their frequencies sum to 949.

DISCUSSION

The study examined three key dimensions of euthanasia-related requests among patients with life-limiting or advanced chronic illnesses in selected Nigerian health care settings: who made the requests, when they occurred in the illness trajectory and the primary reasons provided for making them. Three main patterns were found. Firstly, the majority of requests were made by the patients themselves, although family involvement was high. Secondly, requests clustered in the mid-illness and final periods. Third, the chief claimed reasons were extreme physical discomfort and poor quality of life or loss of dignity. The combined findings show that requests for euthanasia may be complex representations of suffering that require extensive clinical, psychological, family and ethical assessment[11].

That 54.2% of requests were made by patients themselves is consistent with the role of personal agency in decision-making about serious illness and end of life care. However, patient initiation should not be taken as automatic proof of voluntariness, informed decision-making, durability of the choice, or intact decision-making competence. A patient can bring this problem to himself/herself with uncontrolled symptoms, depression, worry, financial difficulties or feeling pressure due to dependence on family members. The high proportion of requests originated by family members alone or jointly with patients (45.8%) further emphasises the role of the family within the Nigerian health care setting. Family engagement can offer emotional support and promote collaborative decision-making, but it can also be a source of overt or covert coercion, particularly when the burdens of caregiving and financial responsibilities are heavy. Healthcare personnel must, however, distinguish between the presence of supportive family participation and those cases where the patient's preferences are being affected or substituted by those of relatives[12].

The concentration of requests in the mid-illness (35.8%) and final periods (48.5%) is also therapeutically relevant. As serious illnesses advance, patients may face growing symptom burden, loss of functional abilities, dependency on carers, recurrent hospitalisations or treatments, worry about the future, and loss of previously important roles and activities. If prolonged, these changes may lead to despondency and a feeling that life is mostly related to suffering[13]. The prevalence of requests in the terminal phase therefore emphasises the necessity of palliative-care assessment well before significant deterioration. Discussions about prognosis, symptom control, goals of treatment, advance-care planning, psychological support and patient preferences early and frequently may provide chances to address discomfort before it becomes overwhelming. Importantly, the cross-sectional aspect of this study does not prove that progression of sickness led to the requests, but rather shows that requests were recorded most commonly at these stages[14]. The most common major cause was unbearable physical discomfort (32.1%), with poor quality of life or loss of dignity cited by a further 27.9%. These two issues represented 60.0% of the primary reasons mentioned. This finding is consistent with the multimodal perspective of the desire for hastened death articulated in prior studies, where physical suffering interacts with psychological, social, existential and dignity-related concerns [15]. Requests for pain-related should consequently prompt a timely assessment of the level of pain, adequacy of analgesia, treatment adherence, adverse effects, availability of appropriate analgesics and adjuvants and access to expert palliative care services. Inadequately regulated pain should be considered as a potentially adjustable source of suffering, rather than a simple manifestation of an irreversible wish for death[16].

Poor quality of life and loss of dignity feature just as prominently. Advanced disease can jeopardise independence, privacy, control of one's body, social identity, and the ability to engage in activities that formerly offered meaning and self-worth. Thus, responses need to go beyond medication symptom control. Respectful communication, protection of privacy, involvement of the patient in the decision about their care, assistance with activities of daily living, rehabilitation where appropriate, psychosocial support and attention to spiritual or existential concerns may help to reduce distress associated with loss of dignity. These techniques are especially relevant when a request is made out of a wish to escape from dependence or loss of personal identity, rather than just a wish to die[17].

The most noteworthy conclusion from a Nigerian perspective was that financial stress was the major factor in 18.0% of requesters. In a healthcare setting where patients and families may face significant out-of-pocket costs, extended serious

sickness can be a significant financial burden on household budgets. This may cause patients to worry being a financial burden to relatives or viewing continuation of therapy as monetarily unsustainable[18]. In this case, a request creates a substantial ethical issue, since the visible option may be hampered by poverty, inadequate insurance coverage or limited access to cheap therapy. Thus, interventions should include social-work referral, health-insurance navigation, cost-conscious treatment planning, linkage with accessible welfare or charitable resources, and assessment for economic coercion . Financial strain should be seen as part of the patient's clinical and social suffering, not as a separate reason for hastening death[19].

Less often but clinically essential were emotional tiredness or depression (11.4%) and fear of future suffering (10.5%) as key explanations. Physical pain, functional decline, financial hardship and loss of dignity may be accompanied by psychological misery. Depression, anxiety, demoralisation, delirium and suicidal thinking must be properly differentiated by adequate clinical examination. Every request for euthanasia should be met by a calm, non-judgmental discussion with the health practitioner to establish what the patient intends, why the request has been made, how persistent it is and whether any safety issues are immediate. Assessment should include symptom burden, mental health, decision making competence, familial relationships, social support, financial conditions, spiritual anguish and probable coercion[20].

CONCLUSION

Of the 949 respondents who were classed as having made a euthanasia-related request, the majority of requests were initiated by patients, but family members were involved in over half of the cases. Requests most often occurred in the mid-illness and final phases and extreme physical discomfort, poor quality of life or loss of dignity, and financial strain were identified as the main cited reasons. These results indicate that calls for euthanasia are often reflections of considerable and perhaps remediable bodily, psychological, social and existential pain.

Hence, Nigerian health care services should take an organised and empathetic approach to such requests. This needs to include clarification of the meaning and persistence of the request, comprehensive assessment and treatment of physical symptoms, assessment of mental health and decision-making capacity, assessment of family influence and possible coercion, early and ongoing palliative-care involvement, and appropriate psychosocial, spiritual and financial support. Patients whose requests are based on uncontrollable suffering, loss of dignity, or fears of being a financial or caregiving burden to their families deserve special attention. This strategy can improve patient-centred end-of-life care by protecting vulnerable patients and ensuring that wishes for accelerated death are carefully addressed in their wider clinical and social context.

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