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Prevalence of Euthanasia Requests Among Patients with Life-Limiting or Chronic Illnesses in Selected Nigerian Healthcare Settings

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Abstract

There is scant evidence on requests for accelerated death among seriously ill patients in Nigeria. The objective of this study was to determine the prevalence of requests for euthanasia among adults with life-limiting or severe chronic conditions attending selected health care facilities in Nigeria. An analytical cross-sectional study was undertaken in a health facility among 640 consenting persons (≥18 years). The participants were selected utilising a multistage selection process which included primary, secondary and tertiary health care facilities. The data were gathered by means of a standardised questionnaire administered by an interviewer. A euthanasia-related request was defined as an unambiguous request for help to accelerate death or a repeated expression of the will to die because of unbearable suffering during the reference period. Prevalence was calculated using 95% Wilson confidence interval. Among 640 respondents, 223 identified a request connected to euthanasia, with a prevalence of 34.8% (95% CI: 31.2%–38.6%). The remaining 417 respondents (65.2%) did not request euthanasia. More over one in three of the patients surveyed said they had been asked for euthanasia. The conclusion of the study included explicit requests for assistance in hastening death and frequent declarations of a desire to die; therefore the estimate should be taken as an indicator of euthanasia related suffering, rather than proof of access to, attempted or accomplished euthanasia. These findings underscore the need of Nigerian health systems responding to such utterances with rigorous clinical assessment, good symptom management, appropriate palliative care, psychological support and strong ethical protections.

Keywords: *euthanasia request; desire for hastened death; life-limiting illness; palliative care; prevalence; Nigeria.*

INTRODUCTION

Requests for euthanasia and other expressions of a wish for hastened death offer difficult clinical, ethical, psychological, social and public health issues. Such requests may be made when patients are suffering greatly due to an advanced, life-limiting or chronic illness and wish to escape excruciating misery through death. While euthanasia and physician-assisted dying have received considerable scholarly and policy attention in a small number of jurisdictions where assisted dying is legally regulated, there is relatively limited evidence on requests for hastened death in low- and middle-income countries[1]. Euthanasia is not a legal therapeutic treatment in Nigeria and the ethical, religious, cultural and legal environment around deliberate life-ending therapies is very difficult. Thus, the patient may express his want to die sooner in several ways, such as an explicit request to help him die, a plea to relieve excruciating agony, or a recurring yearning to die during the course of a severe illness[2].

The want for accelerated death is a multidimensional phenomena and should not be viewed as a mere consequence of uncontrolled physical anguish. Previous research has indicated that psychological, social, existential and interpersonal aspects may be important contributors to such demands. The patient's perception of the desirability of death is influenced

by factors such as loss of autonomy, perceived loss of dignity, depression, hopelessness, fear of dependence, becoming a burden on family members, social isolation, poor symptom control and poor communication between the patient and health care professionals [3]. In patients with progressive and incurable disorders, decrease of functional capacity and increased dependence on carers may enhance further feelings of hopelessness and loss of control. Individual beliefs, family relationships, cultural expectations and religious ideals can also influence the significance given to disease and death. Sometimes, a request for euthanasia may signify an unfulfilled need for symptom relief, emotional support, better communication, maintenance of dignity or a stronger role in health care decisions, rather than a definite and autonomous wish for death[4].

The therapeutic implications of such demands are especially relevant in places with limited access to comprehensive palliative care. Palliative care attempts to improve the quality of life of patients and their families through the prevention and relief of suffering by means of early detection and impeccable assessment and treatment of pain and other disorders, physical, psychosocial and spiritual. However, access to palliative-care services remains poor in many low- and middle-income countries where patients with terminal illnesses may have a significant symptom load without timely specialised support[5]. The global burden of serious health-related suffering is disproportionately borne by resource-constrained settings that may have shortages of skilled personnel, essential medicines, infrastructure and sustainable financing, therefore limiting the availability of adequate end-of-life care [6]. In such settings, calls for accelerated death may be a crucial marker of unmet palliative and psychosocial needs.

Nigeria is facing an increasing burden of cancer and other chronic progressive diseases which can cause long term illness, disability, reliance and considerable symptom burden. Patients with advanced cancers, severe cardiovascular disease, chronic kidney disease, neurological illnesses, advanced respiratory diseases and other life-limiting conditions may endure significant physical and psychological distress. At the same time, healthcare finance is still a challenge to many Nigerian patients with high reliance on out of pocket expense The expenses of long-term therapy, hospitalisation, drugs, investigations, transportation and care-giving can be a considerable financial burden on patients and their families. Such demands may lead to physical discomfort and feelings of pessimism, perceived burden, or wish for death, particularly when patients feel that their health is worsening despite treatment[7].

There are also unique cultural and ethical issues in the Nigerian setting. Religious views regarding the sacredness and preservation of human life are prevalent in many Nigerian communities and may greatly influence attitudes toward euthanasia and other types of assisted dying[8]. Cultural norms around family responsibility and shared decision-making may also affect the manner in which patients express suffering and the way health-care providers understand pleas for accelerated death. Furthermore, as euthanasia is not a standard therapeutic treatment in Nigeria, requests for death may not be routinely documented or examined. The legal sensitivity of this topic may prevent patients and healthcare professionals from expressing such requests freely. Therefore, the lack of any recorded requests should not be considered as definitive evidence that such experiences do not exist.

The issue may have clinical and public-health importance, however empirical research on the prevalence of euthanasia-related requests among very sick patients in Nigeria is scant. Nationally representative data on the frequency with which patients with life-limiting or severe chronic illnesses want a hastened death are sparse, and data from health care facilities at varying levels of care are even more limited. It is vital to determine how often such requests are made, as this can be an indicator of the amount of severe and potentially treatable suffering among vulnerable patient populations. Prevalence estimates can also inform the development of appropriate clinical screening procedures, strengthening palliative-care services, improving communication between healthcare personnel and patients, and informing ethical recommendations for responding to requests for hastened death [9].

Most importantly, a request for euthanasia should not be confused with actual euthanasia, access to assisted dying or an intention to carry out a life-ending act. Statements like these should instead inspire rigorous evaluation of the patient's physical symptoms, psychological condition, social circumstances, spiritual concerns, understanding of prognosis, treatment preferences and perceived quality of life. A compassionate, multidisciplinary approach can identify reversible causes of discomfort and offer opportunity for appropriate symptom management, psychosocial intervention, palliative care, and shared decision-making[10].

Against this context, this study was designed to determine the prevalence of euthanasia requests among adults with life limiting/chronic illnesses attending selected healthcare facilities in Nigeria. The study specifically aims to meet the first objective of the parent thesis, namely to determine the proportion of patients who reported euthanasia-related requests or repeated declarations of a wish to die when faced with a serious disease. Empirical knowledge on the magnitude of this phenomena may inform improvements in patient-centred care, augment palliative-care responses, and guide future research and ethical discourse on end-of-life care in Nigeria.

MATERIALS AND METHODS

Study Design and Setting

A facility-based analytical cross-sectional study design was employed to determine the prevalence of euthanasia-related requests among adults with life-limiting or advanced chronic illnesses receiving care in selected healthcare facilities in Nigeria. The study was conducted across selected primary, secondary, and tertiary healthcare institutions to capture patients managed at different levels of the Nigerian healthcare system. The parent thesis employed a multistage sampling procedure to accommodate geographical distribution and differences in healthcare delivery across the selected study locations.

Study Population

The study population comprised adults receiving care for clinician-confirmed life-limiting or advanced chronic illnesses. Eligible conditions included advanced cancer, chronic kidney disease, end-stage heart failure, advanced chronic liver disease, severe chronic respiratory disease, progressive neurological disorders, advanced HIV infection with severe complications, and other clinician-confirmed chronic or life-limiting conditions associated with substantial morbidity, functional decline, or prolonged healthcare needs.

Eligibility Criteria

Participants were eligible if they were aged 18 years or older, had a clinician-confirmed life-limiting or advanced chronic illness, were receiving care at one of the selected healthcare facilities, were medically stable at the time of recruitment, were able to communicate effectively in English or an approved translated language, were considered mentally competent to provide informed consent, and voluntarily agreed to participate.

Patients who were critically ill, unconscious, delirious, severely cognitively impaired, unable to communicate adequately, or unable to provide informed consent were excluded. Patients who had participated in the pilot study were also excluded from the main study to prevent duplication and potential contamination of responses.

Sample Size Determination

The sample size for the prevalence objective was determined using Cochran's single-population proportion formula. Because reliable prior estimates of the prevalence of euthanasia-related requests among patients with life-limiting or advanced chronic illnesses in the Nigerian setting were unavailable, an anticipated prevalence of 50% was used. A 95% confidence level and 5% margin of error were applied. Appropriate allowance was subsequently made for the design effect and potential non-response, resulting in a final sample size of 640 participants.

Sampling Procedure

A multistage sampling technique was used to recruit participants. Healthcare facilities were selected across the designated levels of care, including primary, secondary, and tertiary healthcare institutions. The number of participants allocated to each participating facility was determined proportionately according to the estimated number of eligible patients attending the relevant clinics, wards, or service units during the study period.

Within selected facilities, potentially eligible participants were identified from relevant clinics and wards. Systematic sampling was used where an adequate sampling frame of eligible patients was available. Where the number of eligible patients was smaller than the allocated sample for a particular facility or service unit, consecutive sampling was employed until the required allocation was achieved. Participants who met the eligibility criteria and provided informed consent were enrolled in the study.

Data Collection Instrument and Procedure

Data were collected using a structured, interviewer-administered questionnaire developed following a review of relevant literature on euthanasia-related requests, desire for hastened death, palliative care, end-of-life care, healthcare experiences, financial hardship, and factors associated with severe illness-related distress.

The questionnaire obtained information on participants' sociodemographic and clinical characteristics and assessed experiences relating to euthanasia and hastened death. Relevant items addressed explicit requests for assistance in hastening death, repeated expressions of a wish to die, the frequency and timing of such expressions, treatment refusal motivated by suffering, and discussions about hastened death with healthcare professionals or family members.

Trained research assistants administered the questionnaire in a private and appropriate setting within the healthcare facilities. Interviewers were trained on the objectives of the study, administration of the questionnaire, maintenance of confidentiality, and the use of neutral and non-judgmental language when discussing sensitive end-of-life issues.

Validity and Reliability of the Instrument

The questionnaire was subjected to face and content validation by experts with relevant expertise in medical laboratory

science, clinical medicine, public health, research methodology, palliative care, and/or bioethics. Items considered unclear, ambiguous, or inappropriate were reviewed and modified accordingly. The content validity of individual items was assessed, with items having an item-level content validity index below 0.78 reviewed for revision or removal.

A pilot study was conducted among eligible patients outside the selected study facilities to assess the clarity, comprehensibility, acceptability, and administration time of the questionnaire. Participants involved in the pilot study were not included in the main study. The internal consistency of relevant multi-item domains was assessed using Cronbach's alpha, with a coefficient of ≥0.70 considered acceptable.

Definition and Measurement of the Primary Outcome

The primary outcome was the presence of a euthanasia-related request, which was categorized as a binary variable (yes/no). A participant was classified as having a positive outcome if he or she reported either an explicit request for assistance in hastening death or a repeated expression of a desire to die because of unbearable suffering during the questionnaire's specified reference period.

This operational definition was intentionally designed to capture clinically relevant expressions of severe end-of-life distress in a setting where euthanasia is not a routinely available clinical service. It is therefore broader than the definition of a formal, sustained request for legally regulated medical assistance in dying. A positive outcome should consequently be interpreted as evidence of a euthanasia-related expression or distress rather than proof of an attempt to obtain, access to, or completion of euthanasia.

Statistical Analysis

Completed questionnaires were checked for completeness and consistency before data entry and analysis. Categorical variables were summarized using frequencies and percentages. The prevalence of euthanasia-related requests was calculated by dividing the number of participants who met the predefined positive-outcome criteria by the total number of participants included in the analysis and multiplying by 100.

Ethical Considerations

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

Ethical principles governing research involving human participants were observed throughout the study. Participation was entirely voluntary, and written informed consent was obtained from each participant before questionnaire administration. Participants were informed about the purpose and procedures of the study, their right to decline participation, and their right to withdraw from the study without any effect on their healthcare.

Because euthanasia and expressions of a desire for hastened death are legally and emotionally sensitive issues, interviews were conducted using neutral, respectful, and patient-centred language. Privacy was maintained during interviews, and information obtained from participants was treated confidentially. Identifying information was minimized and was not disclosed in reports or publications arising from the study.

RESULTS

Participant characteristics

A total of 640 patients were included. The largest age group was 41–50 years (28.0%), 52.0% were female, 37.0% had tertiary education, 52.0% were married, and 62.0% identified as Christian. According to the sociodemographic table in the thesis, 40.0% were recruited from tertiary hospitals, 35.0% from secondary hospitals, and 25.0% from primary health centres.

Table 1. Sociodemographic characteristics of respondents (N = 640)

Characteristic	Category	n	%
Age (years)	18–30	96	15.0
	31–40	141	22.0
	41–50	179	28.0
	51–60	128	20.0
	61+	96	15.0
Sex	Male	307	48.0
	Female	333	52.0
Education	No formal education	64	10.0
	Primary	115	18.0
	Secondary	224	35.0

	Tertiary	237	37.0
Marital status	Single	128	20.0
	Married	333	52.0
	Widowed	115	18.0
	Divorced	64	10.0
Religion	Christianity	397	62.0
	Islam	192	30.0
	Traditional/other	51	8.0
Facility type	Tertiary hospital	256	40.0
	Secondary hospital	224	35.0
	Primary health centre	160	25.0

Prevalence of euthanasia-related requests

Overall, 223 of 640 respondents reported at least one euthanasia-related request under the study's operational definition. The resulting prevalence was 34.8% (95% CI: 31.2%–38.6%). Thus, approximately one in every three participants reported an explicit request for assistance in hastening death or repeated desire-to-die expression related to unbearable suffering.

Table 2. Prevalence of euthanasia-related requests among respondents

Response	**N**	**%**	**95% CI**
Reported request	223	34.8	31.2–38.6
No reported request	417	65.2	61.4–68.8
Total	640	100.0	—

DISCUSSION

Of persons presenting with life-limiting or severe chronic conditions to specified Nigerian healthcare settings in this study, 34.8% satisfied the study criterion of a euthanasia-related request. This finding shows that expressions regarding hastened death were comparatively common among the surveyed clinical population. But the result should be interpreted with caution, because the outcome of the study comprised both explicit pleas for help to accelerate death and repeated statements of a wish to die because of excruciating agony. Therefore, the observed frequency should not be understood as the prevalence of accomplished euthanasia, access to euthanasia, legal eligibility for assisted dying or as proof of a stable and autonomous choice for death. Rather, it indicates the percentage of participants reporting any type of euthanasia-related distress as defined in the study[11].

The rather high prevalence observed has serious clinical consequences . The want for accelerated death is most often conceptualised as a multifaceted phenomenon that may be the result of a mix of medical, psychological, social, existential and interpersonal reasons. Such manifestations have been linked in previous literature to uncontrolled somatic symptoms, depression, hopelessness, loss of dignity, limited autonomy, dependency on others, dread of being a burden and existential anguish [12]. Patients with advanced chronic illnesses may endure a steady decline in functional status and increased dependence on family members or carers. In these situations, the wish to die may represent not only an evaluation of the sickness itself, but also worries about loss of independence, dignity, financial stability and quality of life[13].

This discovery is especially pertinent in the Nigerian healthcare system where access to comprehensive palliative and supportive care might be patchy. Despite significant symptom burden, access to expert palliative-care services, necessary medicines, psychosocial support and sufficient pain management may be limited for patients with advanced cancer and other life-limiting conditions. In addition, prolonged sickness may place a heavy financial burden on patients and families, especially in settings where health expenditure is mostly borne directly by households. Financial difficulties, treatment expenditures, loss of income, carer burden, and perceived reliance may exacerbate psychological anguish and potentially contribute to statements of a desire for suicide [14] .Thus, some calls for euthanasia may be a desire to have suffering relieved or unmet needs satisfied rather than a fixed desire for a particular life-ending intervention[15]. Therefore, from a clinical standpoint, any manifestations of a wish for accelerated death should be considered carefully but not automatically construed as an irreversible decision. Healthcare professionals should endeavour to understand what the patient means by the request and to ascertain whether the expression is of uncontrolled pain, other physical symptoms, depression, anxiety, hopelessness, demoralisation, fear of dependency, social isolation, family conflict, financial concerns, spiritual distress or dissatisfaction with care. Capacity to make decisions should also be evaluated, especially if serious disease, pharmaceutical effects, delirium, depression, or other factors may interfere with judgement. Where appropriate patients should be offered immediate symptom management, palliative-care consultation, psychological or psychiatric support, social support, and opportunities for open conversation with trusted family members and health care providers [16].

The current prevalence provides a good baseline for assessing the amount of expressions connected to euthanasia among seriously ill patients in selected Nigerian health care settings. But comparisons with studies from other nations should be done cautiously. There is a great deal of variation in the literature about the definition of euthanasia requests. Some researchers limit themselves to formal or repeated requests for assisted dying, while others include passive desire for death, hopelessness or a request to stop treatment. Variations in the kind of sickness, severity of disease, cultural background, access to healthcare, availability of palliative-care, interview methodologies and reference periods might also result in different reported prevalences[17]. The broader operational definition used in this study was designed to improve the sensitivity of the identification of patients with severe distress, but it may also have resulted in a higher prevalence than that achieved with a narrower definition restricted to persistent and explicit requests for medical assistance in dying[18].

The legal and cultural framework of Nigeria is also crucial in interpreting the outcome. Because euthanasia is not a standard therapeutic practice, patients may use indirect or culturally influenced language to express their sorrow. Religious beliefs, family relationships and social expectations, and opinions of the sanctity of life may influence patients' willingness to disclose such thoughts and health care professionals' responses. Thus, the high incidence reported may be a reflection of the combination of severe illness-related suffering and how patients express their experience in the Nigerian sociocultural environment[19].

The finding also has ramifications for future research. Future studies in Nigeria should differentiate between passive wish to die, active wish to die sooner, explicit request for euthanasia and persistent request for euthanasia following appropriate symptom and psychological therapies. Longitudinal research would be especially useful in evaluating whether they are temporary reactions to acute distress or enduring preferences even after symptoms are ameliorated and supportive care is provided. Further qualitative research should address the reasons, meanings, expectations, cultural influences, familial relationships, and healthcare experiences of patients who express a wish for a hastened death. Such evidence would inform culturally relevant clinical guidelines and strengthen end-of-life care in Nigeria.

CONCLUSION

This study operationally defined and reported the requests for euthanasia by 34.8% of surveyed adults with life-limiting or advanced chronic illnesses who were attending selected Nigerian healthcare settings. This study suggests a considerable burden of euthanasia-related distress and emphasises the necessity of recognising expressions of a wish for death as potential markers of unmet physical, psychological, social, spiritual, and palliative-care needs. The incidence should not be taken as indication of accomplished euthanasia, access to assisted dying or a continuing autonomous wish to die.

Healthcare professionals should respond compassionately and with careful clinical assessment to such expressions. This should include clarification of the patient's wishes, assessment of pain and other symptoms, evaluation of psychological well-being and decision-making capacity, and identification of social, family, financial and spiritual pressures. Strengthening of palliative-care services, psychosocial support, effective communication, and ethical protections is needed. More longitudinal and qualitative research is needed to distinguish between transient illness-related distress and persistent requests for accelerated death and to assess the extent to which such demands shift once patients' unmet care needs are adequately fulfilled.

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