



## **Contextualizing Paediatric Euthanasia within the Framework of Children's Right**

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## CONTEXTUALIZING PAEDIATRIC EUTHANASIA WITHIN THE FRAMEWORK OF CHILDREN'S RIGHT

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### Abstract

*Given the universal recognition of the sanctity of human life and the robust protection of fundamental right to life as the most important and foundation of all rights, euthanasia poses considerable legal, moral and ethical challenges. These challenges become more dire and profound with respect to paediatric euthanasia. The article aims at providing insight into the complex legal and ethical challenges which euthanasia especially paediatric euthanasia engenders and explores the import of autonomy rights granted under the rubric of the Child Rights Convention in ameliorating the challenges. This is achieved by examining the meaning and nature of euthanasia, categories and arguments in favour and against euthanasia generally and in particular paediatric euthanasia and the competency of a child in taking end of life decisions. The articles analysis some of the provisions of the Belgian and Netherlands euthanasia laws. The paper believes that given the gravity associated with the decision to request euthanasia and the finality of such a decision, children, especially younger children, should be offered intensive palliative care and be precluded from requesting euthanasia.*

**Keywords:** Euthanasia, child rights, paediatrics euthanasia, autonomy, end-of-life.

### 1. Introduction

The sanctity of human life is universally accepted and protected. The Universal Declaration of Human Rights (UDHR) and other major international and regional treaties on human rights protect human life in one form or the other.<sup>1</sup> Equally, constitutions of various countries and municipal laws secure the inviolability of human life. The robust international and municipal laws protecting right to life is reflective of the great value which is placed on human life. Indeed, the law permits individuals to kill in self-defence. The only condition for deprivation of

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<sup>1</sup> See Universal Declaration of Human Rights (UDHR) art 3 and the International Covenant on Civil and Political Rights (ICCPR) art 6(1).

life within the strictly constitutional exceptions. It is generally accepted that virtually all cultures and societies value human life and protect same within the rubrics of the law.

The question that arises is what is the value of human life? There are three competing views of human life namely vitalism, the sanctity/inviolability of life and quality of life. Vitalism holds the view that human life is an absolute moral value. As a result of the absolute moral worth of the human life, it is wrong or immoral to shorten the life of a patient or fail to make effort to prolong it. This is still so whether that life is the life of extremely disabled new born baby or an elderly patient with advanced cancer illness, vitalism forbids shortening the patient's life and necessitates its prolonging. Notwithstanding the suffering, pain, huge cost of treatment, it must be administered. The vitalist school of thought demands that human life should be preserved at all cost.<sup>2</sup>

The second school of thought with respect to value of human life is that human life is created in the image of God. It necessarily follows that human life is imbued and instilled with an intrinsic dignity which safeguards it from unjustified attack. The idea that human life has an inherent value and dignity is the foundation for the belief that a person must never deliberately or intentionally kill an innocent human being. This is the quintessential essence of the right to life.<sup>3</sup> Accordingly, the theoretical foundation of the right to life is the principle that human beings are instilled with an inherent self-worth because they possess fundamental capacity intrinsic in human nature. This ultimate innate ability has a domino effect in the form of development of rational and logical abilities in the nature of understanding and making of choices.<sup>4</sup> The sanctity or inviolability of the human life as a result of its dignity and self-worth, which prohibits intentional killing, is at the core of the medical ethics and the Hippocratic Oath.<sup>5</sup> The modern reaffirmation of the Hippocratic Oath was made by the World Medical Association in 1948.<sup>6</sup> The right not to be deliberately killed is available to all regardless

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<sup>2</sup> John Keown, *Euthanasia, Ethics and Public Policy* (2<sup>nd</sup> ed, Cambridge University Press, 2018) 37.

<sup>3</sup> Ibid 38.

<sup>4</sup> Ibid 39.

<sup>5</sup> Ibid 39. National Library of Medicine, 'The Hippocratic Oath' <<http://bit.ly/2klqdNb>. [Greek Medicine - The Hippocratic Oath \(nih.gov\)](http://bit.ly/2klqdNb)> last accessed 11 May 2022).

<sup>6</sup> 'I will maintain the utmost respect for human life'. Adopted by the 2<sup>nd</sup> General Assembly of the World Medical Association, Geneva, Switzerland, September 1948.

of inability or disability. The right asserts that ‘human life is not only an *instrumental* good, a fundamental basis of human flourishing. It is ... not merely good as a means but is, like other integral aspects of a flourishing human life such as friendship and knowledge, something worthwhile in itself.’<sup>7</sup> The sick and the dying enjoy this worthwhile good to the degree that they are able to do so. Although human life is a fundamental good, it is not the highest good to which all the other basic goods must be sacrificed in order to ensure its preservation. The idea does not demand the preservation of life at all costs.<sup>8</sup>

The third principle of the value of human life is the Quality of life. This doctrine believes that the value of life is instrumental in ushering a means for a life of sufficient worth. This principle is not only interested in measuring the worthwhileness of the patient’s treatment but also the worthwhileness of the patient’s life. It believes that lives of some patients fall below a minimum quality threshold because of disease, pain, injury or disability. This is the basis for the idea that since some lives are not worth living, it is legitimate to intentionally end such life which can be effected by act or by intentional omission. The act or omission may be at the patient’s request or not.<sup>9</sup> This intentional ending of human life for the benefit of the patient is regarded as euthanasia.

## 2. Conceptual Clarification

There is no generally accepted definition of euthanasia. This may lead to confusion as to the clear meaning of what the term entails. Nevertheless, there are certain features that are common to all of them. There is shared agreement that euthanasia involves a decision that has the consequence of shortening life. Secondly, euthanasia is restricted to the medical environment because it entails a patient’s life being terminated by a doctor and not by a relative or a friend. Thirdly, death which occurs as a result of euthanasia is believed to be of advantage to the patient. It is the third characteristic of euthanasia which differentiates it from the offence of murder.<sup>10</sup>

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The last amendment was by the 68<sup>th</sup> WMA General Assembly, Chicago, United States (October 2017) <<http://bit.ly/2kg9CdI>. [WMA Declaration of Geneva – WMA – The World Medical Association](#)> accessed 11 May 2022.

<sup>7</sup> Keown (n 2) 40.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid 42.

<sup>10</sup> Ibid 10.

The word euthanasia is a derivative from the Greek words *eu-* and *thanatos* which means a good, happy or easy death.<sup>11</sup> It refers to the 'act of painlessly putting to death persons suffering from incurable conditions or diseases, and usually is limited to cases in which the goal is to serve the interests of the victim, with the purpose of death being to end the physical, emotional, or existential pain and suffering of the subject.'<sup>12</sup> Jacob Appel and other scholars emphasize that patients' choice of euthanasia in order to end unrelenting pain and suffering do not apply in all cases. Patients may choose euthanasia not because of unrelenting pain and unbearable suffering but because of fear of loss of autonomy. Other reasons not related to pain and sufferings are the wish of some patients not to constitute unnecessary physical and emotional burden on others as well as not to dissipate family financial resources. Euthanasia is also the intentional killing of a patient which may be by act or omission as part of the patient's medical care. It constitutes one of the weightiest matters confronting the modern world.<sup>13</sup> It could also be defined from the point of view of not prolonging the life of a patient. This was the approach adopted by John Harris when he defined euthanasia as the 'implementation of a decision that a particular individual's life will come to an end before it need do so, a decision that a life will end when it could be prolonged.'<sup>14</sup> Such decision may entail direct interventions or withholding of life-prolonging measures.

Euthanasia 'connotes the active, intentional termination of a patient's life by a doctor who believes that death would benefit the patient.'<sup>15</sup> Intentionality is therefore key to most definitions of euthanasia. The central aim or purpose of the doctor's conduct must be the termination of the life of the patient. However, this definition seems to recognise only active euthanasia and not passive euthanasia and other forms of euthanasia. The definition therefore seems to be too narrow or

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<sup>11</sup> Brianne Donaldson and Ana Baizeli, *Insistent Life: Principles for Bioethics in the Jain Tradition* (Oakland: University of California Press, 2021) 203.

<sup>12</sup> Jacob M Appel 'Paediatric Euthanasia' in Michael J Cholbi (ed) *Euthanasia and Assisted Suicide: Global Views on Choosing to End Life* (Santa Barbara: Praeger, 2017) 351.

<sup>13</sup> John Keown 'Introduction' in John Keown (ed) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press, 1997) 1.

<sup>14</sup> John Harris, 'Euthanasia and the Value of Life', in John Keown (ed) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: Cambridge University Press, 1997) 6.

<sup>15</sup> Keown (n 2) 10.

inadequate. Euthanasia is the ‘deliberate ending, by a third party, of a patient’s life upon his or her explicit request, by the administration of lethal substances.’<sup>16</sup> For a conduct to amount to euthanasia there must be an intentional ending of the patient’s life, a clear unambiguous request by the patient demanding that his or her life be terminated by the use of deadly drugs and the administration of the drugs by a third party such as a doctor or nurse.<sup>17</sup> It is argued that to cause or allow an individual a gentle and easy death for any reason other than the good of the one who dies is not euthanasia.<sup>18</sup>

Under Belgian Euthanasia Act, euthanasia is ‘understood to be the act which intentionally terminates the life of a person at his/her request and which is carried out by an individual other than the person in question.’<sup>19</sup> The issue of assisted suicide marks an important difference between the Belgian Act on euthanasia and that of Dutch and Luxembourg Acts on euthanasia. While the Belgian Act is not applicable to assisted suicide, the Dutch and Luxembourg Acts both apply to assisted suicide and euthanasia.<sup>20</sup> Section 1(b) of the Dutch Act defines assisted suicide as intentionally helping another person to commit suicide or providing him or her with the means to do so while section 1 of the Luxembourg Act defines assisted suicide.<sup>21</sup> The central difference between euthanasia and physician-assisted suicide (PAS) is the role of the physician in both concepts. In voluntary active euthanasia (VAE) the physician intentionally terminates the life of the patient while in PAS, the physician intentionally assists the patient to take his own life. The physician’s assistance may take the method of providing the patient the means to commit the suicide. The physician may provide the patient with lethal drugs or give advice to the patient about methods to adopt to achieve his aim.<sup>22</sup>

Advocates for the legalization of PAS contend that there is a significant moral difference between PAS and euthanasia. They argue

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<sup>16</sup>Mannaerts and Mortier, ‘Minors and Euthanasia,’ 255.  
<<https://biblio.ugent.be/publication/341701/file/6792733.pdf>>

<sup>17</sup>Ibid 255.

<sup>18</sup>Ibid 205.

<sup>19</sup> Section 2 of the Belgian Act on Euthanasia of 28 May 2002.

<sup>20</sup> David Albert Jones and others, *Euthanasia and Assisted Suicide: Lessons from Belgium*, (Cambridge: Cambridge University Press, 2017) 9.

<sup>21</sup> Ibid 9.

<sup>22</sup> Keown (n 2) 6.

that under PAS the patient makes the final decision and performs the fatal act while in VAE it is the physician who decides whether the patient's life should end. PAS, they argue is a decisive expression of the patient's autonomy and the patient remains in control. Conversely, VAE is an application of medical decision-making and the doctor is in control of it. PAS also creates opportunity for the patient to change his mind.<sup>23</sup> Some argue that there is no significant moral difference between PAS and VAE. They argue that the seeming autonomy in PAS is exaggerated. In PAS the patient cannot require the physician's assistance because the physician will not agree to offer assistance to end the patient's life until the physician determines that it is proper to do so. The moral argument for PAS that it protects the autonomy of the patient has been interrogated. If PAS guarantees and respects the autonomy of a suffering patient, why should a similar autonomous request by a patient for a VAE be discountenance? Finally, it has been argued that the physical difference between deliberately ending the patient's life and intentionally helping the patient to end his own life can be insignificant.<sup>24</sup>

### ***2.1 Classification of Euthanasia.***

There are categories of euthanasia. Euthanasia taxonomy is differentiated into two, namely, euthanasia achieved by killing the patient, usually described as active euthanasia. It involves intentional act of a doctor with the aim of shortening the life of the patient. Active euthanasia is used to refer to a direct action that causes a patient's death. Voluntary active euthanasia obliges a doctor to act directly upon a patient who has made a request for the action. It may entail directly administering a lethal dose of medication to a patient who has no intention of living any longer.<sup>25</sup> It is imperative to recognize that euthanasia not only includes deliberate termination of a patient's life by an act of the doctor such as injecting a lethal substance into the patient's body but also incorporates intentional termination of patient's life by an omission. This is accomplished by failing to prolong the patient's life. This type is regarded as passive euthanasia. Passive euthanasia is usually achieved by withdrawing lifesaving treatment from the patient. It denotes an indirect action characterized by the removal or withholding of care instead of a direct action. Voluntary passive euthanasia is when a competent patient decides,

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<sup>23</sup> Ibid 17.

<sup>24</sup> Ibid 18.

<sup>25</sup> Donaldson and Baizeli (n 11) 203

based on informed decision-making ability, to refuse life-supporting treatment. These life sustaining treatments may include food and fluids. The legal and moral import of this type of euthanasia is that it constitutes a patient's act of omission because he refuses or removes further treatment. The natural consequence is that the underlying disease is allowed to take its course usually leading to the death of the patient instead of a direct act of commission which act causes the death of the patient.<sup>26</sup> There are at least two situations where termination of treatment does not amount to passive euthanasia. The first situation is where a patient exercises his right to refuse treatment. It is a general principle of patient's right that a competent adult has the right to refuse treatment, even if that treatment is necessary to prolong the life of the patient.<sup>27</sup> This right can only be overridden in certain special circumstances. One of such circumstances is where the patient has a dependent child. The second situation is where the patient refuses to undergo a treatment. This is because no one can be compelled to administer treatment which the patient have not consented to.

Equally, cutting across the active and passive euthanasia debate are the voluntary euthanasia, which occurs when the patient autonomously requests the termination of life and non-voluntary euthanasia, which is characterized by inability of the patient to competently give consent to termination of life. In the latter type of euthanasia, the person killed is incapable of understanding the choice between life and death. The individuals that fall within this category are gravely deformed or severely retarded infants and the people who have permanently lost the capacity to understand the issue involved.<sup>28</sup>

There is also involuntary euthanasia which is the termination of life of a patient who is competent but his views on the issue are overruled.<sup>29</sup> In this case, the person killed is capable of consenting to his or her own death but does not do so. It could be that he is not asked or he is asked but has chosen to go on living. Killing someone who has not consented to being killed can be considered as euthanasia only when the motive for killing is the need to prevent suffering on the part of the

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<sup>26</sup> Ibid.

<sup>27</sup> *Okonkwo v MDPDT* (1999) 9 NWLR (Pt 617) 1 at 27 para B and 28 para G.

<sup>28</sup> S Uniacke and HJ McCloskey 'Peter Singer and Non-Voluntary 'Euthanasia': Tripping Down the Slippery Slope' (1992) 9 (2) *Journal of Applied Philosophy* 207

<sup>29</sup> E Garrard and S Wilkinson, 'Passive Euthanasia' (2005) 31 (2) *Journal of Medical Ethics* 64.



person killed.<sup>30</sup> Although, the euthanasia taxonomy maybe helpful within the realms of ethics especially in determining euthanasia that may be less morally offensive, it is nevertheless confusing. This paper will be predicated on what may be described as voluntary euthanasia.

## ***2.2 Schools of Thought in Euthanasia***

There are different schools of thought in euthanasia. The first is that active euthanasia and passive euthanasia are not morally significant. Rachels, argues that there is no substantial moral difference between active and passive euthanasia. Accordingly, there is no significant difference between killing and letting to die. He argued that active euthanasia is more humane than passive euthanasia. This is because in passive euthanasia the patient will die in a matter of days with more anguish and suffering before death while active euthanasia will result in quick and painless death. He submitted that active euthanasia is preferable to passive euthanasia because active euthanasia does not prolong a patient's pain and suffering.<sup>31</sup> Passive euthanasia is slow and painful. It entails the patient spending days in agony. Secondly, Rachels claims that the doctrine which prefers passive euthanasia over active euthanasia leads to decisions concerning life and death on irrelevant grounds.<sup>32</sup> The argument that there is a significant moral difference between active and passive euthanasia, he contended, is that people believe that killing a person is morally worse than letting someone die.<sup>33</sup> He concluded that the distinction between active and passive euthanasia is founded on a distinction that has no moral importance. Another scholar has contended that the predicament of prolonged dying or the dilemma of active and passive euthanasia has its foundation in a medical cast of mind that determines success by medicines ability to prolong death, even in the stark reality of inevitability of death.<sup>34</sup>

The second school of thought is that active euthanasia is wrong while passive euthanasia is acceptable. This is in contradistinction with Rachels contention that there is no moral significance between active and passive euthanasia. Will Cartwright argues that a more probable

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<sup>30</sup> Uniacke and McCloskey (n 28) 207.

<sup>31</sup> James Rachels, Active and Passive Euthanasia 2.

<[https://sites.ualberta.ca/~bleier/Rachels\\_Euthanasia.pdf](https://sites.ualberta.ca/~bleier/Rachels_Euthanasia.pdf)> accessed 16 April 2022.

<sup>32</sup> Ibid 2.

<sup>33</sup> Ibid 3.

<sup>34</sup> ML Tina Stevens, *Bioethics in America: Origins and Cultural Politics*, (Baltimore: The John Hopkins University Press, 2000) 79.

explanation of killing and letting die would be that a person kills someone if that person initiates a causal sequence that ends in that other person's death, while one lets someone die if one allows an already existing causal sequence to lead to his death, when one could have prevented this outcome. With respect to euthanasia, he concluded that the distinction is diminished but still important.<sup>35</sup> DeGrazia and Millum also argue that not all the modalities in which a patient's death can be made to occur earlier than it would with full use of life-support measures are morally equivalent. It is widely believed, they pointed out, and that forgoing life support can be morally permissible while active euthanasia is impermissible.<sup>36</sup> In the United States voluntary passive euthanasia is regarded as legally and morally acceptable. The reason is that it is thought to protect patient autonomy and promote patient wellbeing.<sup>37</sup>

The third school of thought is that both active and passive euthanasia are different from the cessation of extraordinary means of treatment to prolong life. Under this scenario, if the condition of the patient, facilities and resources available are considered ordinary, the physician is not only required to continue treatment but also required to commence treatment. For example, providing food and fluids are regarded as ordinary care. However, if the care is regarded as extraordinary in the sense of difficulty to obtain treatment or treatment is expensive, the physician is neither required to start treatment nor is he morally required to continue treatment.<sup>38</sup>

The fourth school of thought is that doctors cannot be agents of harm. The American Medical Association (AMA) believes that permitting physicians to engage in euthanasia would eventually cause more harm than good. AMA's opposition is predicated on the fact that 'Euthanasia is fundamentally incompatible with the physician's role as a healer, would be difficult or impossible to control, and would pose serious societal risks... could readily be extended to incompetent patients

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<sup>35</sup> Will Cartwright, 'Killing and Letting Die: A Defensible Distinction' (1996) 52 (2) *British Medical Bulletin* 354.

<sup>36</sup> David DeGrazia and David Millum, *A Theory of Bioethics* (New York: Cambridge University Press, 2021) 83.

<sup>37</sup> Adam Feltz, 'Everyday Attitudes about Euthanasia and the Slippery Slope Argument' in Michael Cholbi and Jukka Varelius, *New Directions in the Ethics of Assisted Suicide and Euthanasia*, (Springer 2015) 216.

<sup>38</sup> Bernard Gert and others, *Bioethics: A Systematic Approach*, (2<sup>nd</sup> ed, New York: Oxford University Press, 2006) 313.

and other vulnerable populations.<sup>39</sup> This is perhaps flowing from the age long belief that the whole essence of medical practice is to safeguard life and not otherwise. It is equally believed that legalization of euthanasia would result in loss of hope,<sup>40</sup> fear of medical institutions, and likely lead to involuntary euthanasia.<sup>40</sup>

### **2.3 Theoretical Foundation of Euthanasia**

The theoretical foundation of euthanasia is usually anchored on circumstances where people are under intractable pain and unbearable suffering. In situations where there is no hope of recovery as a result of the terminal nature of the illness, coupled with intolerable suffering and pain, it is better to allow the sick to die in dignity than to die a slow and painful undignified death. Nevertheless, it has been argued that most individuals who decide to terminate their own lives are not stirred by physical pain. The commonest reasons offered by people that want to take their lives, according to this view point, are that they are afraid of loss of autonomy and that they do not want to be a burden on others.<sup>41</sup> Some of the reasons for patients requesting euthanasia are, for those of sound mind, their loss of autonomy, decreasing ability to participate in enjoyable activity.

Again, those who request assistance in dying have higher levels of depression, hopelessness and lower level of spirituality than others who are terminally ill but are not requesting euthanasia.<sup>42</sup> It is therefore contended that the suffering which those demanding for euthanasia are undergoing is existential rather than physical pain and suffering and as a result the goal of euthanasia is not to relieve present suffering but to relieve the possibility of future suffering. Such existential concerns will not be pertinent to small children. John Lantes points out that an infant having unbearable suffering can be treated by 'high quality palliative

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<sup>39</sup> American Medical Association, Code of Medical Ethics on Euthanasia. <<https://www.ama-assn.org/delivering-care/ethics/euthanasia>> accessed 16 April 2022.

<sup>40</sup> Uniacke and McCloskey (n 28).

<sup>41</sup> Oregon Health Authority, 'Oregon Death with Dignity Act: Data Summary 2016' <<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithdignityAct/Documents//year19.pdf>>

<sup>42</sup> KA Smith and others, 'Predictors of Pursuit of Physician Assisted Death'(2015) 49 (3) *J. Pain Symptom Manage* 555-561.

care.<sup>43</sup> He further argued that children generally neither fear being a burden on others nor apprehensive about the future loss of autonomy as adults do. Accordingly, different considerations apply in considering euthanasia for children.

Euthanasia weakens the practice of palliative care since euthanasia may essentially amount to killing the patient instead of relieving his pain and the more doctors practice euthanasia the less incentive they have to practice relieving pain. It equally emasculates the demand for palliative care since euthanasia will be regarded as a simpler and cheaper option than palliative care.

Significantly, legalization of euthanasia undercuts our compassion for those suffering and in pain. Some people may indeed tell individuals that are suffering and in pain that ‘Euthanasia is legal, this person did not choose it. If she is refusing euthanasia and is choosing to suffer rather than die, that is her problem. Why should we help her when she is not even helping herself?’<sup>44</sup> The legalization of euthanasia therefore puts enormous pressure on those who are terminally ill and under intolerable pain and unbearable suffering. Accordingly, euthanasia endangers the life of those that are terminally ill particularly those who decided not to kill themselves.<sup>45</sup> Euthanasia is inappropriately described as a means of relieving suffering and pain.

A suffering person who is relieved of suffering is in a position to experience the relief of suffering. But a person who is killed is dead, and so such a person no longer has any bodily experiences. The corpse of a person who has been killed neither feels pain nor the relief of the pain. A corpse feels nothing. Indeed, human beings who are killed no longer exist at all, so euthanasia does not relieve their suffering.<sup>46</sup>

#### **2.4 Child Euthanasia**

Child euthanasia is the causing or hastening the death of a child, under the age of 18 years, who is suffering from an intolerable and painful terminal disease for reasons of mercy, especially to allow the child to die

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<sup>43</sup>Marije Brouwer and others *Quality of Living and Dying: Pediatric Palliative Care and End-of-Life Decisions in the Netherlands*” ( 2018) 27(3) *Cambridge Quarterly of Healthcare Ethics* 376-384.

<sup>44</sup>Ibid 2.

<sup>45</sup>Ibid 2.

<sup>46</sup>Ibid 2.

in dignity.<sup>47</sup> It is the ‘ending of life in a way that, given the unbearable circumstances of a child’s dying can make it gentler, easier, and more humane for both the child and for the parents in whose arms you can help that death to occur’<sup>48</sup> Euthanasia entails a competent patient choosing to die founded on the individual’s evaluation of his life. Opponents of child euthanasia contend that children under the age of 18 lack the capacity of giving informed consent for significant life decisions especially end of life decisions.<sup>49</sup> It is for this reason that we do not permit children to give consent regarding their own sterilization, to vote in elections, to join the military, or to get married. ‘The choice to end one’s own life or to authorize another person to end one’s own life is much more serious than the choice to join the military, to get married, to have sexual intercourse because those decisions can be reversed and do not completely change an individual’s life in every respect.’<sup>50</sup> However, it has been argued that euthanasia should be available to competent and incompetent children who suffer unbearably when there is no other method of relieving their suffering and pain. Euthanasia is sometimes anchored on autonomy or self-determination demonstrated by the voluntary application for euthanasia and in the kindness of doctors to bring to an end unbearable suffering and pain when there are clearly no other options.<sup>51</sup>

### **3. Legal Framework for Child Euthanasia**

Under the Nigerian law, both attempting to commit suicide<sup>52</sup> and aiding suicide<sup>53</sup> are criminal offences. As a result both adult and paediatric euthanasia are criminal offences in Nigeria. The Belgian Euthanasia Law, 2002 was amended in 2014 to legalize euthanasia for minors. The law allows euthanasia for a minor who has the capacity to judge. A minor having a capacity to judge has been interpreted to mean ‘having full ability to judge the situation and the full weight of the request for and the

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<sup>47</sup> Article 6 (1) of the Convention on the Rights of the Child (CRC). CRC was adopted and opened for signature, ratification and accession by the General Assembly resolution 44/25 of 20 November, 1989 and entered into force on 2<sup>nd</sup> September, 1990. Euthanasia is not available in Nigeria for both adults and children. See also Section 3(1) of the Child Rights Act, 2003.

<sup>48</sup> Ibid 3.

<sup>49</sup> Brouwer and others (n 42).

<sup>50</sup> Ibid 2.

<sup>51</sup> Ibid 3.

<sup>52</sup> Section 327 of the Criminal Code Act Cap C28 Laws of the Federation of Nigeria 2004.

<sup>53</sup> Ibid s 326.

consequences of euthanasia.’<sup>54</sup> This paper believes that the test of capacity to judge is similar to the test for determining the competence of a child to be a witness in the Law of Evidence where the child must show that he is rational and understands the questions put to him and can provide rational answers to those questions. In order for a child to consent to euthanasia, he must be conscious at the time of the request and should sign the written request. To determine the ability of the child to request euthanasia, a child psychiatrist or psychologist should assess the child. This is dissimilar to the test in Evidence to determine a child’s ability to give evidence where it is the trial judge that makes the determination. Euthanasia in Belgium is restricted to children with terminal physical diseases and not psychiatric diseases.

There is no lower age limit under the Belgian law unlike in the Netherlands where the lower age limit is 12 years.<sup>55</sup> In the Netherlands only five euthanasia cases were registered between 2002 and 2012. Out of this number, four of the children were between the ages of 16 to 17 years except one child that was 12 years old.<sup>56</sup> In Belgium, between the years 2002-2007 only four patients of less than 20 years were euthanized. In 2002-2003 only one patient was euthanized, in 2004 -2005 only two patients were reported while in 2006-2007 one patient was reported. These four patients between 18 and 19 years represent 0.05 per cent of the total number of 7066 euthanasia cases within that period which shows extreme low prevalence of euthanasia in the age group of below 20 years. In 2012-2013 there were no reported cases of euthanasia of children or a patient under the age of 20 while in 2016 euthanasia of a 17 year old was reported. A 2013 survey showed that a legal framework for paediatric euthanasia existed only in Netherlands and Luxembourg.<sup>57</sup>

An important question to be considered is how a paediatric psychiatrist or psychologist is to objectively assess a child’s capacity to judge. By the amendment to the 2014 Belgian Euthanasia law, the basis for euthanasia was changed from legal capacity to capacity to judge. This is because only adults and not children have the full legal capacity to make determination of issues. As a result of the position of the law, a

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<sup>54</sup> Stefaan Van Gool and Jan De Lepeleire, ‘Euthanasia in Children: Keep Asking the Right Question,’ in David Albert Jones and others, *Euthanasia and Assisted Suicide*, (Cambridge: Cambridge University Press, 2017) 173.

<sup>55</sup> Ibid 173.

<sup>56</sup> Ibid 174.

<sup>57</sup> Ibid 175.

child cannot have the full capacity.<sup>58</sup> It has been suggested that in order to determine a child's capacity to judge, we have to consider the age of the child, type of disease the patient is afflicted with, the patient's level of personal development and the capacity to judge their own situation and requests.<sup>59</sup> A person begins to understand the meaning of death from the age of about seven years and becomes aware of the mortality of all human beings, including himself from the age of 12 years. Assessing a child's capacity to judge should be done individually. There is a broad recognition that children above 14 years can take decisions for themselves in the same manner adults do. This is also accepted for medical decisions. These children that are above 14 years are regarded as mature minors and can take medical decisions like adults.

The Dutch law provides that children aged 12 to 16 are legally permitted to request for euthanasia so long as their parents support the request while children between the age of 16 or 17 are allowed to legally request and receive euthanasia solely on their own determination subject to the fact that their parents must be informed of the child's decision.

#### **4. Ethical Considerations in Child Euthanasia**

There are well founded fears that euthanasia or end of life decisions made by children may easily be susceptible to be manipulated to reflect the concerns of those around them. It may not be out of place for request for euthanasia for a child not be for the child's interest but because of the concerns of the parents. In child euthanasia, as is also in adult euthanasia, hypothetical situations do not determine real-life actions and importantly neurological or psychological concerns mean children cannot be expected to take these decisions themselves without any input from adults.

##### **4.1 Neonatal Euthanasia**

The neonatal euthanasia or euthanasia for new born is euthanasia for severely defective new born babies whose health conditions are hopeless and under intolerable or unbearable suffering. The euthanasia is available under strict and narrow legal circumstances. If a new-born's prospect in life is very grim, then neonatal euthanasia might be permissible in the circumstances.<sup>60</sup> End-of-life decisions have been described as 'medical

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<sup>58</sup> Ibid 177.

<sup>59</sup> Ibid 177.

<sup>60</sup> AAE Verhagen 'The Groningen Protocol for Newborn Euthanasia: Which Way Did the Slippery Slope Tilt?' (2013) 39 *J Med Ethics* 294.

decisions with the effect or the probable effect that death is caused or hastened.’<sup>61</sup> End-of-life decisions with respect to new-born babies include the ‘decision to withhold or withdraw life-sustaining treatment, the decision to administer medication with potentially life-shortening effect to alleviate pain and suffering and the decision to deliberately end the life of physiologically stable new-borns with lethal drugs that otherwise would not have died.’<sup>62</sup> Two national surveys conducted in the Netherlands in 1995 and 2001 showed that 65% of infants less than 12 months of age died because life-sustaining treatment was withheld or withdrawn.<sup>63</sup> The survey revealed that 60% of the neonate euthanasia related to babies with incurable diseases and inevitable death while the remaining decisions were based on quality of life reasons. The survey further revealed that in 1% of all the patients, treatment was administered with the clear intention to accelerate death. The babies that were euthanized were those that had difficult and complicated inoperative congenital malformations. The main issues were spina bifida combined with other complexities.<sup>64</sup>

In order to ensure transparency and to identify conditions in which neonatal euthanasia might be appropriate, the Groningen Protocol was developed in 2002 by Eduard Verhagen and Pieter Sauer.<sup>65</sup> The Protocol was refined, published and ratified in 2005 by the Dutch Paediatric Association.<sup>66</sup> The Groningen Protocol for neonatal euthanasia developed five major criteria for neonatal euthanasia namely ‘(1) diagnosis and prognosis must be certain, (2) hopeless and unbearable suffering must be present, (3) a confirming second opinion by an independent doctor, (4) both parents give informed consent and (5) the procedure must be performed carefully, in accordance with medical standards.’

The Groningen Protocol was criticized for two main reasons. Firstly, it was thought that it will lead to the ‘slippery slope’. According

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<sup>61</sup> Ibid 39.

<sup>62</sup> Ibid 39.

<sup>63</sup> A Van der Heide and others *Medical End-of-life Decisions made for Neonates and Infants in the Netherlands* cited in Verhagen (n 60) 39.

<sup>64</sup> Ibid.

<sup>65</sup> Neil Francis, ‘Neonatal Deaths under Dutch Groningen Protocol Very Rare Despite Misinformation Contagion’ (2016) 1(1)*Journal of Assisted Dying* 7.

<sup>66</sup> E Verhagen and PJJ Sauer ‘The Groningen Protocol - Euthanasia in Severely Ill Newborns’ 352(10) *New England Journal of Medicine* 959-962 cited in Francis, ibid 8.



to this argument the Groningen Protocol is only a first step down a slippery slope which would then lead to a wide use of neonatal euthanasia. This will then lead to erosion of norms in medical practice and in the society. Secondly, it was argued that ending the life of neonatal amounts to a breach of the doctor's obligation to preserve life and will have negative impact on the societal perception of the medical profession.<sup>67</sup> The proponents of the Protocol contend that the Groningen Protocol ensures that doctors are accountable to the society for their decisions. They also believe that the processes required by the Groningen Protocol will reinforce patients' trust in their doctors<sup>68</sup> The Dutch authorities made a Regulation which incorporated a version of the Groningen Protocol which Regulations were latter revised. The revised Regulation pertaining to neonatal euthanasia provides at article 7(a) 'In the event of termination of life of a new-born, the doctor has carefully acted if:

- (a) the doctor is convinced there is enduring and unbearable suffering of the new-born, which among other things means that the discontinuation of medical treatment is justified, that is, prevailing medical opinion has established that intervention is futile and there is no reasonable doubt about the diagnosis and resulting prognosis;
- (b) the doctor fully informed the parents of the diagnosis and the resulting prognosis and that both the doctor and parents believe that there is no reasonable alternative solution to the new-born's situation;
- (c) the parents have agreed to the termination of life;
- (d) the doctor has consulted at least one independent physician who provides a written judgment on the due diligence of the case, or, if an independent physician cannot reasonably be consulted, the doctor consults with the new-born's healthcare team, who provide a written judgment as to the due diligence of the case; and

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<sup>67</sup> Nuffield Council on Bioethics, *Decision making: Ethical Issues. Critical Care Decisions in Fetal and Neonatal Medicine* (London: Nuffield Council on Bioethics, 2006); K Costelo 'Euthanasia in Neonates' 334(7600) *BMJ* 912-13 in Venderhag and Sauer (n 66) 4.

<sup>68</sup>H Lindemann and M Verkerk 'Ending the Life of a Newborn: The Groningen Protocol' *The Hastings Centre Report* (2008) 38(1) 42-51.

(e) the termination of life is conducted with due medical care.<sup>69</sup>

The Dutch Regulation established a Commission known as the Central Expert Commission Late Pregnancy Termination and Termination of Life in New-borns<sup>70</sup> to regulate neonatal euthanasia.<sup>71</sup> In the first nine years of the establishment of the Commission, 2006 to 2014 two cases of neonatal euthanasia were reported to the Commission.<sup>72</sup> This number is at variance with 22 cases of neonatal euthanasia that were reported to local authorities over nine years prior to the making of the Regulation.<sup>73</sup>

Under Nigerian law it is an offence for a physician to withhold medical treatment to a patient and if death occurs as a result of the withholding of such treatment, then the physician may be charged with the offence of murder.<sup>74</sup> It has been held that ‘if a patient refuses to give informed consent, the law is that the medical practitioner will not proceed to administer the medical measure or treatment.’<sup>75</sup> Also ‘an adult of sound mind has a right to choose what medical treatment made available to him to subject himself to and when to refuse. The court should not allow medical opinion of what is best for the patient to override the patient’s right to decide for himself whether he will submit to the treatment offered him.’<sup>76</sup>

#### **4.2 Children, Euthanasia and Autonomy**

The issue which calls for consideration is whether where euthanasia is legally permissible for adults, should children competently and legally request for euthanasia? A fortiori, should age alone be the sole criterion for the validity of a request for euthanasia? Some of the arguments against children euthanasia are similar to the arguments against allowing children take medical decisions affecting their health namely that children are incapable, incompetent or immature to make a euthanasia decision and that children should not be burdened with this kind of

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<sup>69</sup>Netherlands Government Gazette 2016, Regulation of the Minister of Security and Justice and the Minister of Health, Welfare and Sport of 11 December 2015.

<sup>70</sup> Ibid.

<sup>71</sup> Francis (n 65) 9.

<sup>72</sup> Ibid 9.

<sup>73</sup> Ibid 9.

<sup>74</sup> Section 303 of the Criminal Code Act.

<sup>75</sup> *Okonkwo v MDPDT* (n 27) 26 para C.

<sup>76</sup> Ibid 27 para B and 28 para G.

decision. The issue of lack of autonomy or competence is central to the request for euthanasia by adults both in Netherlands and Belgium where euthanasia is legal.

Autonomy simply means self-rule.<sup>77</sup> It also means free will, independence or sovereignty. ‘An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation.’<sup>78</sup> An autonomous individual is that person who is capable of deliberating about his personal goals and taking actions pursuant to such deliberation. Autonomy is essential as a component of a flourishing life and a basis for rights claim.<sup>79</sup> Individuals who are autonomous have some rights that are founded in their autonomy. An autonomous person has the right to determine whether other individuals may do anything to his body or not. He can exercise his right of autonomy by refusing medical treatment. He may exercise that right by doing something which is not for his wellbeing such as giving consent to a medical research that may provide data for other people.

Therefore, autonomy in the sense of personal sovereignty is different from the purpose of promoting a person’s wellbeing. The right of autonomy permits an individual to exercise the right in ways that are detrimental to his wellbeing.<sup>80</sup> This was graphically expressed by Joel Feinberg as follows: ‘There must be a right to err, to be mistaken, to decide foolishly, to take big risks, if there is to be any meaningful self-rule; without it, the whole idea of *de jure* autonomy begins to unravel’<sup>81</sup> Autonomy is important with respect to patient empowerment and helping patients to make informed decisions. The capacity for autonomous action is seen as a total capacity. A person is either competent or not. A middle-aged adult has autonomous rights while a young child does not. This global view of autonomous action has been criticised because it is

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<sup>77</sup> DeGrazia and Millum (n 36) 98.

<sup>78</sup> National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, The Belmont Report (Washington, DC: US Government Printing Office, 1978). <<https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html#xbasic>> accessed 14 May, 2022.

<sup>79</sup> DeGrazia and Millum (n 36) 98.

<sup>80</sup> Ibid 98.

<sup>81</sup> Joel Feinberg, Autonomy, Sovereignty, and Privacy: Moral Ideals in the Constitution,’ (1982) 58*Notre Dame Law Review* 445-429, 461.

contended that autonomous action is either task specific or domain-specific.<sup>82</sup>

The request for euthanasia must originate from a functionally competent person being a person who has the necessary capacities to make such a decision.<sup>83</sup> The fundamental reason for permitting personal choice is the 'principle of respect for persons and their moral worth, acknowledging their capacity for self-determination.'<sup>84</sup> Nonetheless, the right to self-determination is only significant if the individual is properly informed and has at his disposal sufficient information to enable him make the relevant decision; is taking the decision voluntarily and has the capacity to make such a decision. Applying this to euthanasia, the question arises as to whether children, by virtue of their being minors, have the autonomy to make such decisions? Are children capable of making such far reaching decisions the import of which is final?. Can children make serious decisions that have the consequences of life and death?.<sup>85</sup>

It has been argued that some children up from the age of 8 are capable and competent to make difficult decisions regarding their medical treatment.<sup>86</sup> The right of self-determination, it is contended, has no age limit. In Netherlands, the Groningen Protocol provides an option of euthanasia for infants younger than 1 year of age.<sup>87</sup> Under the Groningen Protocol parental agreement is a prerequisite for euthanasia for neonates. This, it is argued, provides for the extension of the notion of self-determination to what is called parental determination.<sup>88</sup> In that regard the parent provides the necessary specific information and perspective on the child's suffering, intimate knowledge of the child and their opinion on the child's quality of life upon which the doctor may exercise his beneficence or kindness in carrying out the act of euthanasia.

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<sup>82</sup> DeGrazia and Millum (n 36) 101.

<sup>83</sup> D Mannaerts and F Mortier 'Minors and Euthanasia' (2006) 257, DOI:[10.1163/EJ.9789004148949.I-337.124](https://doi.org/10.1163/EJ.9789004148949.I-337.124).

<sup>84</sup> Ibid 258.

<sup>85</sup> Ibid 258.

<sup>86</sup> IM Hein and others, 'Key Factors in Children's Competence to Consent to Clinical Research' (2015)16(1) *BMC Med Ethics* 74.

<sup>87</sup> Ministerie van Veiligheid en Justitie en dwe Minister van Volksgezondheid, *Welfare and Sport. Regulation late-term abortion and termination of lives of neonates* (in Dutch). De Staatscourant. 2016; (3145); 1-8.

<sup>88</sup> Ibid Regulation 4.

The idea of parental determination is not without its own legal and moral challenges such as difficulties which may occasion when parents, in exceptional circumstances, prioritize their own needs instead of that of the child.<sup>89</sup> In such circumstances the best interest of the child should be prioritized in accordance with the obligations imposed by the Convention on the Rights of the Child.(CRC) <sup>90</sup>Accordingly, with respect to child euthanasia, the best interest of the child should guide the decision as to whether to euthanize the child or not and the method for such euthanasia.

Consigning paediatric euthanasia to the margins is believed to be reassuring to many because the intentional killing of children and adolescents is more disquieting than the same practices among competent adult patients. Nevertheless, there are at least two circumstances where paediatric euthanasia might be considered to be morally acceptable and might be the basis of legislation regarding paediatric euthanasia. These are where a child is suffering horribly and intolerably from incurable cancer and in that circumstance the child and the parents request lethal injection or administration of drugs to put an end to his pain. Another circumstance is where a new-born with defects that cause severe, unrelenting and chronic pain is to be given an overdose of pain medication or lethal treatment.<sup>91</sup> Generally, children are precluded from taking decisions affecting their lives because they are vulnerable and therefore legally incompetent to exercise their rights based on autonomy or self-determination. The reasoning behind this idea is that children lack the competence which adults possess.<sup>92</sup> It is only in exceptional circumstances such as some emergency situations<sup>93</sup>, specific medical

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<sup>89</sup>Ibid Regulation 4.

<sup>90</sup> Article 3(1) of the Convention. Similar provisions are contained in Article 4 of the African Charter on the Right and Welfare of the Child and Section 1 of the Child Rights Act, 2003.

<sup>91</sup>Ibid 13.

<sup>92</sup>B Ambuel and J Rappaport, 'Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion', (1992) 16 *Law and Human Behavior*, 129–54.

<sup>93</sup>A minor may consent to medical treatment if he will be in serious danger unless health care services are provided(emergency care) – in such circumstances he or she is a 'conditional minor'. This consent to medical treatment is not based on the minor's capacity to consent, but on a theory of *implied consent* by the parents.

situations<sup>94</sup> or when dealing with an emancipated minor<sup>95</sup> are children allowed to make medical treatment decisions otherwise such treatment decisions are made by their parents.<sup>96</sup> Even in those circumstances the exceptions are not granted because the child is believed to possess self-determination and competence but because it is necessary to secure medical care. Nevertheless, recent developments in roles in treatment decision making suggests that children and adolescents should be properly be involved in taking decisions affecting them and that upon acquiring decision making capacity they should indeed be the principal decision makers on issues affecting them. A child who is a patient and is capable of exercising these rights can do so without intervention by parents or guardians. In that regard, a child may give consent to or refuse consent to treatment without parental or guardian consent if it is determined that he is competent to make the decisions.<sup>97</sup>

When the legal competence is in issue, there are two standards that are usually adopted in its determination.<sup>98</sup> They are the presumptive standard and the evidential standard.<sup>99</sup> The presumptive standard stipulates that once a child attains a certain age he is presumed to be competent. An individual is therefore presumed to be functionally competent upon attaining a specific age and the legal competence then

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<sup>94</sup>This condition might relate to certain problem-related medical treatments, for example sexually transmitted diseases, contraception, drug abuse and psychiatric problems.

<sup>95</sup>Emancipated minors refer to those minors who live independently of their parents. They may consent to medical care, and refuse it, as if they were adults. There are various criteria to determine who is an emancipated minor such as marriage, parenthood, financial independence. See H Kunin, 'Ethical Issues in Paediatric Life-Threatening Illness: Dilemmas of Consent, Assent, and Communication' (1997) 7(1) *Ethics and Behavior* 43–57.

<sup>96</sup> SE Zinner, 'The Elusive Goal of Informed Consent by Adolescents' (1995) 16 (4) *Theoretical Medicine* 323–31; TL Kuther, 'Medical Decision-making and Minors: Issues of Consent and Assent', (2003) 38 (150), *Adolescence* 343–58.

<sup>97</sup>Mannaerts and Mortier (n 83) 258.

<sup>98</sup>S Elliston, 'If You Know What's Good for You: Refusal of Consent to Medical Treatment by Children' in S McLean, *Contemporary Issues in Law, Medicine and Ethics* (Aldershot: Dartmouth, 1996).

<sup>99</sup>Ibid.

necessarily attaches to him or her.<sup>100</sup> This presumption of competence, like some presumptions, is subject to be rebutted.

Conversely, despite the fact that a child has not attained the presumed age of competence, yet the child may possess sufficient capacity that amounts to functional competence. This is referred as the evidential standard. The evidential standard is usually referred to as mature minor rule<sup>101</sup> or the Gillick<sup>102</sup> competent child. The Gillick case determined the right of a child under 16 to give consent to medical treatment and the House of Lords held that a child under 16 years of age had the legal competence to consent to medical treatment if the child had sufficient maturity and intelligence to understand the nature and implications of that treatment as well as the risks involved and alternative courses of action. The Gillick competence determination is similar to deciding the competence of a child to give evidence in court. The child's competence is determined by the ability of the child to understand questions put to him and provide rational answers to those questions. Therefore, a distinction between legal competence and functional competence is usually made regarding children who are patients. Accordingly, it is believed that children especially mature minors are capable and competent, unless rebutted, to give consent to medical treatment and indeed take end of life decisions such as terminating life-sustaining treatments. In the case of *Okekearu v Tanko*<sup>103</sup>, the Nigerian Supreme Court held that in the absence of any medical evidence to the contrary, a child of 14 years is competent to give consent for medical treatment and consent to the amputation of one of his fingers. Freyer has opined that there is now agreement among relevant health professionals and lawyers that adolescents of about 14 years of age should be presumed to be functionally competent to take medical decisions including end-of-life decisions.<sup>104</sup> The CRC recognizes the

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<sup>100</sup> For instance, consent to treatment of a 16 year old should be sought in the UK. This consent shall be regarded as valid in law as if he or she is an adult.

<sup>101</sup> The 'mature minor doctrine' is the common-law rule (originated in the USA) that allows an adolescent who is mature to give consent for medical care. See GS Sigman and C O'Connor 'Exploration for Physicians of the Mature Minor Doctrine,' (1991) 119 (4) *Journal of Paediatrics* 520–25.

<sup>102</sup> *Gillick v West Norfolk and Wisbech AHA* (1986) AC

<sup>103</sup> (2002 15 NWLR (Pt 789) 657, 670.

<sup>104</sup> D Freyer, 'Care of the Dying Adolescent: Special Considerations' (2004) 113 (2) *Paediatrics* 381–388.

right of the child to take decisions pertaining to that child.<sup>105</sup> As a result children have the participation right of expressing their views on issues that concerns them and in this regard children can take health decisions affecting them. It equally recognizes the evolving capacity of the child regarding issues concerning the child. Although, there is no equivalent of article 12 in Nigeria's Child Rights Act, 2003<sup>106</sup> nevertheless, that Act recognizes the Nigerian Child's right to privacy under section 8 of the Act.

Mannaerts and Freddy Mortier conclude that some children in certain circumstances may be considered capable of acquiring understanding into their health condition and situation and therefore can be seen as being competent to decide end-of-life matters. They believe that children can exercise the power to determine and request for euthanasia. Paediatric euthanasia should therefore be legitimate especially in those countries where euthanasia has become legally acceptable. If a child is suffering from an incurable and unbearable pain and exhibits sufficient competence then the child can request for euthanasia.

This paper acknowledges the very difficult and traumatic challenges which a child suffering from incurable disease and unbearable pain brings to the child and indeed the entire family. The end-of-life, especially euthanasia, decisions are a specie of medical decisions and has an extraordinary character. It is different from other medical decisions such as consenting to medical examination and treatment. Particularly, the exceptional character of euthanasia stems from the fact that such decisions are final and irreversible. Adult euthanasia is still controversial and as a result it is permitted by extremely few countries. Even in those countries that permit adult euthanasia, there are very strict guidelines that must be followed by the patient and the physician before the request can be acted upon. This is despite the fact that adults are believed to possess self-determination, competence and autonomy. Paediatric euthanasia is even more controversial because of the vulnerability and lack of capacity of children. The paper also believes that the doctrine of mature minor and

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<sup>105</sup> Article 12 of the CRC provides that "State parties assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."

<sup>106</sup> However, an equivalent of Article 12 CRC can be found in Article 12 of the African Charter on the Rights and Welfare of the Child which Nigeria has ratified.



the standard of evidential competence may apply to other aspects of health care decisions especially if the decision is to ensure access to health care for children. This paper also believes that Gillick competence is insufficient for a child to make a determination regarding euthanasia. The Gillick competence principle was developed to enable certain categories of children to access medical treatment and not for the purpose of making end-of-life decisions.

The legalization of euthanasia undoubtedly puts enormous social and psychological pressure on terminally ill persons to end their own lives and relieve the family and care givers from the task of caring for them. A fortiori, permitting child euthanasia will put even more pressure on terminally ill children who are still under the influence of others especially their parents and guardians. The rights of autonomy and rights of participation especially right to express views and other rights such as privacy provided under the CRC are for the purpose of protecting children, secure their wellbeing and protect their best interest. The rights are not for the purpose of imposing severe and arduous responsibilities on children. This paper is of the view that it is bewildering to allow children to determine euthanasia; and to place such a heavy burden and responsibility of such a decision on children, a decision that is extremely difficult and traumatic even for adults, is to stretch insensitivity and lack of empathy to the extreme.

## **5. Conclusion**

Definition of euthanasia has several approaches. Despite that, the essential features of euthanasia are that the act of euthanasia has the consequence of shortening life and is restricted to the medical environment. In euthanasia death which occurs is believed to be of advantage to the patient. There seems to be too much emphasis on unremitting pain and suffering as the reason for demand for euthanasia. However, fear of loss of autonomy and dissipating family financial resources are the main reasons given by those asking for euthanasia

There are significant moral and legal differences between active and passive euthanasia. Indeed, even within the realms of morals carrying out euthanasia has emotional, psychological and traumatic consequences even on the doctors that carry out such acts. Child euthanasia is even more disquieting.

Generally, children are ill-prepared to request for euthanasia as a result of their tender years. However, some minors have the capacity to

take medical decisions including end-of-life decisions. Data has shown that legalization of child euthanasia in some countries has not lead to the slippery slope anticipated. Legalization of child and neonate euthanasia requires extreme care and regulation to restrict it to those circumstances where it is inevitable.