

Euthanasia: Socio-Medical and Legal Perspective

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Abstract

Globally, the controversy on euthanasia traverses public opinion, decisions of courts, socio-medical and even legal discourse. In view of this, this paper considers, not only the general conceptual and ethical issues involved in euthanasia, but it also examines the subject from socio-medical and legal perspectives. The paper concludes that killing under the guise of compassion is potentially dangerous, morally reprehensible and ethically flawed. This paper however concedes that different countries should adopt alternatives suitable to their values and ways of life.

Keywords: Euthanasia, Assisted suicide, Life, Rights, Sanctity, Murder

1.0 Introduction

“A long illness between life and death makes death a comfort both to those who die and to those who remain” – Jean de La Bruyere (1645-1696)

“On no subject are our ideas more warped and pitiable than on death ... Let children walk with nature... and they will learn that death is stingless indeed, and as beautiful as life, and that the grave has no victory, for it never fights. All is divine harmony” – John Muir.(1838-1914)

Euthanasia is a controversial subject. It is an issue that provokes arguments among lawyers, medical practitioners, moral philosophers and theologians. The central questions raised by those arguments are: to what extent can the sanctity of life be justified? Can the sanctity of life be violated in certain circumstances where it becomes intolerable for a person to continue to live?

It is universally accepted that every person has a right to live. A number of municipal laws, national constitutions, court decisions and a host of international human rights instruments reinforce the right to life. For example, the Universal Declaration of Human Rights (1948) provides that every person has the right to life, liberty and security of persons (Article III). Besides, the African Charter of Human and People’s Rights (1981) also declares that human beings are inviolable; thus, every man shall be entitled to respect for his life (Article IV). Some other instruments that made such provisions as these include the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950) and the American Convention on Human Rights (1969).

Principally, the foregoing instruments presuppose the sanctity of human life.

Since euthanasia involves the taking of human life by another, or with the assistance of another with a motive supposedly humane, it immediately confronts us with two fundamental questions: can euthanasia be condemned as unlawful and immoral? Can the consent of the victim and the apparently sympathetic and humane motive of the person taking the life exculpate the latter from legal sanction and moral blame? The attention of the writer in this paper is focused on resolving these questions, among others.

2.0 Historical Overview

The world’s first Euthanasia Society was established in London, England in 1935, and by 1938 the Euthanasia Society of America was founded. Since then, in a manner unprecedented, euthanasia has been on the front burner of public discourse (Iyaniwura, 2003).

However, the most recent case of euthanasia which got a great deal of publicity- chiefly due to the advancement in information and communications technology- was the case of Terri Schiavo. An article by Quill, T. E. in the 2013 edition of *The New Journal of Medicine* clearly set out the facts of this case; and an extract of this is reproduced hereunder.

“On February 25, 1990, Terri Schiavo had a cardiac arrest, triggered by extreme hypokalemia brought on by an eating disorder. As a result, severe hypoxic-ischemic encephalopathy developed, and during the subsequent months, she exhibited no evidence of higher cortical function. Computed tomographic scans of her brain eventually showed severe atrophy of her cerebral hemispheres, and her electroencephalograms were flat, indicating no functional activity of the cerebral cortex. Her neurologic examinations were indicative of a persistent vegetative state, which includes periods of wakefulness alternating with sleep, some reflexive responses to light and noise, and some basic gag and swallowing responses, but no signs of emotion, willful activity, or cognition”

The Journal continues further: “...there is no evidence that Ms. Schiavo was suffering, since the usual definition of this term requires conscious awareness that is impossible in the absence of cortical activity. There have been only a few reported cases in which minimal cognitive and motor functions were restored three months or more after the diagnosis of a persistent vegetative state due to hypoxic-ischemic encephalopathy; in none of these cases was there the sort of objective evidence of severe cortical damage that was present in this case, nor was the period of disability so long.

In 2002, the Florida trial court judge conducted days of evidentiary hearings on Ms. Schiavo’s condition, including evaluations by four neurologists, one radiologist, and her attending physician. The two neurologists selected by Michael Schiavo, a court-appointed “neutral” neurologist, and Ms. Schiavo’s attending physician all agreed that her condition met the criteria for a persistent vegetative state. The neurologist and the radiologist chosen by the patient’s parents and siblings, the Schindler family, disagreed and suggested that Ms. Schiavo’s condition might improve with unproven therapies such as hyperbaric oxygen or vasodilators - but had no objective data to support their assertions. The trial court judge ruled that the diagnosis of a persistent vegetative state met the legal standard of “clear and convincing” evidence, and this decision was reviewed and upheld by the Florida Second District Court of Appeal. Subsequent appeals to the Florida Supreme Court and the U.S. Supreme Court were denied a hearing.”

The Article at this point went further to consider the relevant statute upon which the dispute in Schiavo’s case rested by stating that “The relevant Florida statute requires “clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent or, if there is no indication of what the patient would have chosen that the decision is in the patient’s best interest. Since there is no societal consensus about whether a feeding tube is in the “best interest” of a patient in a persistent vegetative state, the main legal question to be addressed was that of Terri Schiavo’s wishes. In 2001, the trial court judge ruled that clear and convincing evidence showed that Ms. Schiavo would have chosen not to receive life-prolonging treatment under the circumstances that then applied. This ruling was also affirmed by the Florida appeals court and denied a hearing by the Florida Supreme Court. When Terri Schiavo’s feeding tube was removed for the second time, in 2003, the Florida legislature created “Terri’s Law” to override the court decision, and the tube was again reinserted. This law was subsequently ruled an unconstitutional violation of the separation of powers.”

Having narrated the essential facts of this case the Article concludes “On March 18, 2005, Ms. Schiavo’s feeding tube was removed for a third time. The U.S. Congress then passed an “emergency measure” that was signed by the President in an effort both to force federal courts to review Ms. Schiavo’s case and to create a legal mandate to have her feeding tube reinserted yet again. The U.S. District Court in Florida denied the emergency request to reinsert the feeding tube, and this decision was upheld on appeal. Multiple subsequent legal appeals were denied, and Ms. Schiavo died on March 31, 2005, 13 days after the feeding tube was removed” (*Terri Schiavo: A Tragedy Compounded*, 2013).

3.0 Definition of Euthanasia

Euthanasia could simply be described as an addendum to final exit. More concisely, the expression “euthanasia” is an amalgam of two Greek words: “eu” which means good and “thanatos” which means death (Oduwole and Olaolu, 2011); thus, Euthanasia can be called “good death”.

3.1 Classification of Euthanasia

Euthanasia can be classified into the following categories:-

- (a) Voluntary Euthanasia: In this case, the patient must have made an explicit request that his life be terminated, either because the patient is suffering unbearable pain or is terminally ill. To qualify as voluntary euthanasia, the request must not emanate from the patient's relations or carers (Iyaniwura, 2003).
- (b) Involuntary Euthanasia: Here, the person who is to die does not take the decision about death. The decision is taken by this family, friends or even the physician treating him. Such cases, according to Unduigwomen (2003) occur where the patient suffers from brain damage or serious brain hemorrhage and there is no hope of recovery. Another person makes an informed consent on his behalf.
- (c) Active Euthanasia: This refers to causing death of a patient by a direct and positive response to the request of the suffering individual. Robinson (2000) illustrated this with the mercy killing, in 1998, of a patient suffering from ALS (Lon Gellin's Disease) by Dr. Jack Kervokian, a Michigan physician. Dr. Kerrokian injected lethal substance into the patient who was scared of the prospect of an agonizing death and desired a painless exit. Dr. Kervokian was later convicted of second degree murder, and sentenced to a term of imprisonment.
- (d) Passive Euthanasia: Gifford (1993) describes passive euthanasia as "allowing a patient to die by removing (him) from artificial life support systems such as respirators and feeding tubes or simply discontinuing medical treatments necessary to sustain life". A good example is the case of Terri Schiavo mentioned earlier.
- (e) Physician Assisted Suicide: This occurs where a physician supplies information and /or dose of sleeping pills or carbon monoxide gas. It is then left to the patient to administer it on himself. Robinson (2000) referred to this as voluntary passive euthanasia.

4.0 Trends in Euthanasia in Some Countries

Generally, Scandinavian countries have been at forefront of advocacy for legislation and recognition of euthanasia. The reason adduced has been that people now live longer than in the past, and as they age, they face painful, debilitating and eventually fatal conditions and therefore may well choose physician assisted euthanasia- a quick, dignified, safe and painless end of life (Iyaniwura, 2003).

It is pertinent to consider the position of law in a few countries to explain the development on this subject over the years.

i) Netherlands

This country had been ahead of others in advocating for a libertarian position on gay and abortion rights. (Iyaniwura, 2003). It is therefore not surprising that it was the first country to legalise euthanasia upon confirmation by the Upper House of Parliament on April 10, 2001. In this context, euthanasia refers to voluntary euthanasia, because where it is not voluntary, it is deemed unlawful. Voluntary euthanasia is described as the termination of life by a physician upon the express wish of the patient with the request having been carefully considered, and also that the condition of the patient has become intolerable with no possibility of improvement (Bamgbose, 2004)

ii) Belgium

This was the second country to legalise euthanasia, precisely in May, 2002. The decision was reached on the ground of public policy; in view of the results of a government sponsored research which showed that in countries where no law exist to regulate euthanasia, little or no attention is paid to a careful end of life decision making, thus putting the vulnerable at risk (Bamgbose, 2004).

iii) United Kingdom

In the United Kingdom, both suicide and attempted suicide are no longer criminal offences (Suicide Act, 1961). Nevertheless, it is still debatable whether this impliedly legalise terminating one's life. However, though, it is obvious that counseling or assisting a suicide are still criminal offences, the impersonal distribution of advice or information is not likely to attract penal sanction (A-G V Abel (1984) Q. B. 795).

Besides, evidence suggests that annually, a high number of euthanasia do occur as doctors, patients, and relations, out of sympathy, continue to help ease the suffering of terminally ill patients (Bamgbose, 2004).

iv) United States

As in other certain legal (constitutional) and political matters, the question regarding lawful recognition of euthanasia is left for each state to decide. One of the chief reasons being that the matter touches on the whole level of Medical Ethics and the position of the American Medical Association (www.exitinternational.net/page.USA 2014).

As a result, most States in the United States of America have not legalised euthanasia. For instance in 1999 one Dr. Jack Kervorkian (alias Dr Death) was convicted in Michigan for second degree murder of Thomas York after showing a video of death by injection on national television (Bamigbose 2004). He was sentenced to 10-25 years imprisonment.

However, the State of Oregon, by virtue of Death with ‘Dignity’ Act of 1977, recognises physician assisted suicide, administered on a patient in pain difficult to alleviate. In this context, a physician could, upon the request of the patient, prescribe drugs to terminate life, but the patient must administer the drugs on himself (www.exitinternational.net/page.USA. 2014) However, the use of lethal injection and voluntary euthanasia are crimes (Bamgbose, 2004).

From this overview of global trends in euthanasia, many countries still consider euthanasia a crime, or at best unconventional.

5.0 Arguments for and Against Euthanasia**i. Argument for Euthanasia**

The first reason adduced by supporters of euthanasia is that where an advanced terminal illness becomes intolerable and causes intractable pain to the individual, euthanasia lends a way out by providing quick, safe and painless death; thus compassion for the suffering is the main pillar, upon which this argument stands (Ekeke and Ikegbu, October, 2010.)

Another argument is that euthanasia permits a terminally ill person to make a dignified exit out of life. According to proponents of this argument, watching a person suffering excruciating pain, or who is in a persistent vegetative state offends the sensibilities of his relations, friends, associate and anyone who knew the individual while active; therefore allowing the individual to remain in such a sub-human condition is incompatible with human dignity (Pojman, 1992).

Again, it has been asserted that each person has the right to die, considering the fact that every person has the right to control his or her life. As such, every person has the right to determine issues that are related to his life and death. This is premised on the idea that human beings are free moral agents and are independent biological entities possessing the right to arrive at, and execute decisions about themselves. Advocates of this position share no belief in life after death. They consider death as the permanent, absolute and irreversible end of all things (Pojman, 1992).

ii. Argument against Euthanasia

The first argument against euthanasia stemmed from religious point of view. Adherents of two world’s major religious (Christianity and Islam) posit that euthanasia amounts to human invasion of the authority and sovereignty of God-the creator of all things (Iyaniwura 2003); thus, voluntary euthanasia is seen as “playing God” and violates the idea of sanctity of life.

Another argument employed to rebut the compassionate and dignity rationale behind euthanasia relied on by advocates of euthanasia is that, a suffering person retains innate dignity even while he or she takes advantages of all available options for relief of pain and other forms of suffering. The issue of dying with dignity is a reason for the provision of good quality holistic palliative care which is responsive and respectful of patients and their families’ needs and desires. It is not a reason to legalise euthanasia or assisted suicide (Iyaniwura, 2003)

Furthermore, it is contended that issues surrounding decision making regarding termination of life of a suffering or terminally ill person are complex and difficult to contemplate. Evidently, a competent person cannot be treated without his or her consent.

However, difficulties arise when life ending decision has to be made for an incompetent person – for example, a patient in a permanent vegetative state or a patient who has slipped into an interminable coma. In such cases, decision is made by relatives or guardians. It is assumed that such relations have the best interest of the patient at heart. This is seriously doubtful. The primary role of physicians is to heal, or better still treat a patient with a medically precarious condition. This alone should be the physician's priority and this has often served the society well (Bob Thomas, 1995)

The practice of hastening the death of a patient runs contrary to the societal expectations and basic ethics of the medical profession (Bob Thomas, 1995)

Another argument proffered to challenge the pro-euthanasia advocates on the right of every man to die is that whatever right a person has is undoubtedly limited by his obligations. The decision to die by euthanasia invariably affects other people, such as family, friends, health care professional and the society at large. Therefore, the exercise of a person's right to die through euthanasia, or assisted suicide should be balanced against the consequences for those who would be affected by the exercise of that right (Ekeke and Ikegbu, October 2010). The intolerable guilt, excruciating pain and gross emotional trauma (guilt, grief and anger) that would be visited on the survivors and the society at large clearly outweigh whatever value or benefit euthanasia has for the deceased.

5.1 Euthanasia: The Nigerian Position and the Author's View

In Nigeria, the Penal Laws are governed by statutes (called Penal Code for the North, Criminal Code for the south).

Generally, under these statutes, consent of a person for an act causing his death is not a defence.

Although the statutes do not specifically mention the expression "euthanasia", it is submitted that shorn of all forms of linguistic adornments, the practice of euthanasia in any of its aforesaid categories fall within the scope of homicide, a term which, for example in Southern Nigeria, covers the criminal offence of murder, among others (Sections 306,308,326 and 327 Criminal Code Act, 2004)

Under the statute referred to above, the killing of a human being by another is a crime under homicide which could mean murder or manslaughter, depending on the intent with which the killing was carried out.

It is safe to conclude that euthanasia, under whatever form, would, in the context of Nigerian statutes on crime, be considered either murder, attempted suicide or aiding suicide, all of which are criminal offences and punishable under the law (Criminal Code Act, 2004).

Besides, the Nigerian Constitution expressly provides for every person's right to life and sets out circumstances under which a man's life can be taken. Clearly, these do not include euthanasia or mercy killing (Section 31(1) & (2) Nigerian Constitution, 1999).

Although, Nigeria is a multi-ethnic nation with a diverse culture, yet attitudes about life and death are essentially coterminous. There is the general belief that God is the giver of life and death, thus, understandably, suicide is considered an aberration and euthanasia an anathema. As a result, even when an individual or patient is faced with the prospect of death, fervent hope of recovery is still entertained by his loved ones by performing rituals to appease the gods. To underscore this fact, for example among the Yorubas on the western part of Nigeria, there is a saying that "*ebo die, oogun die lo ngbaalaare la*" meaning "*a little medicine and a little ritual (sacrifice) to appease the gods eventually heal the sick*".

It is against the norm to give up on life. Life should be preserved by all means, but where death eventually occurs, in the absence of connection with sorcery or witchcraft, it is regarded as God sent (Iyaniwura, 2003)

6.0 Conclusion and Recommendations

Without any doubt, the polemic on euthanasia can hardly be laid to rest; given the direct relationship it has with our actual existence as humans- our self-worth, dignity and right to life. Central to the controversy is the age long debate on the measure of right and control a man, has over his life as an individual member of the human community, and the propriety of imposing checks on the exercise of that right for the collective good.

For one, euthanasia is a rather sensitive concept which runs contrary to the attitudes, world view and values of many people in the world, regardless of modernity or whatever might have formed the bases of such attitudes and values. It is therefore reasonable to suggest that any attempt to make it legal in those communities where it is unacceptable, would result into social upheavals and ultimate destruction of social cohesion. It is also plausible to argue that if euthanasia were legalised in poor countries (which form a sizeable fraction of the world) the poor people in such countries would definitely become victims of “killings” occasioned, not on account of incurable or terminal illnesses, but by inability to afford sufficient care due to their impoverishment caused by the profligacy of their leaders, which had made the poor people vulnerable and marginalized. Adding euthanasia to their headache simply compounds their hardships.

Lastly, it is reasoned that it is difficult in practice to enforce the condition that euthanasia must at all times be administered with only good intentions. This could hardly be so in view of the decline in moral values and community building ethos in the modern world. Accordingly, it is not impossible for relations or family of a terminally ill or suffering patient to deliberately induce euthanasia on the suffering person solely for the reason of inheriting his property. Therefore, it is humbly submitted that euthanasia is an ideological point of view which will always create a furore, both socially and legally, and whatever judgment or law a country decides to make will always create legal and social dilemma. In order to clear the dilemma, the paper recommends as follows:

- Efforts should be made to give credence, by legislation and moral suasion, to those practices that elevate collective good above individual good. In this context, euthanasia represents individual good. It should not supersede the collective good.
- The provision of compassionate and humane care of the terminally ill and dying persons can be achieved without having to kill them or induce them to commit suicide (Baird and Rosenbaum, 1989). In recent times the concept of palliative care has been devised. Palliative care is often carried out by a multi-disciplinary team upon the holistic model of care (Megan-Jane, 1996)
- Without removing the prospect of death, patients can be encouraged to face death with a realistic attitude, and at the same time strengthen their sense of dignity and self – worth. Besides, more often than not, strong belief in some forms of religious tenets tends to downplay the grim prospect of death, and further provides, in certain cases, hope beyond the grave; thus steadying the resolve of the patient not to give in to suicide.

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