

## COMPARATIVE PERSPECTIVES ON EUTHANASIA IN NIGERIA AND ETHIOPIA

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### Abstract

Discussions on euthanasia usually revolve around medical, legal and moral issues geared at determining the extent to which a physician may feel obliged to accede to the request of the terminally ill patient to bring to a graceful end his or her pain and suffering by assisting the patient to die. In some jurisdictions, physicians are statutorily conceded such rights in spite of the Hippocratic Oath. But the conservatively religious would have none of such as life is seen as sacred which only the Creator could terminate at the chosen time. This paper examines various views on euthanasia, zeroing in on criminal law regimes of two countries in Africa, namely Nigeria and Ethiopia. It is discovered that while the statutes and judicial decisions in these countries (especially in Nigeria) appear favourably disposed to the idea of passive euthanasia, active euthanasia is still criminalised whatever may be the intention of the doctor, and even at the request of the patient. A strong case is made for the need for these countries to borrow a leaf from some European countries, such as the Netherlands and Belgium, which have legalised euthanasia as a mark of respect to the right of the terminally ill to choose the most honourable way of passage to the Creator while putting an end to unceasing pain and suffering associated with the ailment.

### I. INTRODUCTION

The concept of euthanasia has continued to attract sound debate in the intellectual circle often laced with moral and medico-legal issues. This is an area of legal development in which moral concept has so much intruded into the realms of law that it has become increasingly difficult to adopt a rational view of the events

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without the risk of being adjudged an unbeliever. It must, however, not be denied that even if law and morals are distinguishable, it remains true that morality is in some way an integral part of law or legal development, and as stated by Freeman<sup>1</sup> 'morality is "secreted in the interstices" of the legal system, and to that extent is inseparable from it'. This explains why the legal development is usually stalled when projected above or against the society's established moral or cultural ethos. The concept of euthanasia, as shall be seen shortly, is a clear victim of the interactions between law and morality. The moralists founded their argument on the sanctity of human life, which advocates the preservation of life at all cost and not destruction of the same. Physicians base their argument on ethics enshrined in the time-honoured Hippocratic Oath, which states in part: 'to please no one will I prescribe a deadly drug, nor give advice, which may cause his death'. Legal practitioners do not lose sight of various constitutional provisions and international instruments and covenants urging the preservation of human life. Rarely is a thought given to the value, essence and expense involved in the preservation of such life.

What is the value of life when the person is permanently incapacitated mentally and physically and is only sustained medically through artificial means and under great pain and suffering, not just to the person, but also the relatives who must now shoulder the unenviable responsibility of sustaining the person at great expense even when the hope of recovery is entirely lost. Will it not be more convenient and sensible to allow such a person easy and less painful passage to the great beyond than indulging in the futile medical exercise of sustaining such life for whatever length of time?

The response to these questions is certainly not expected to attract a consensus or be an easy one having regard to the passion or compassion that any discourse pertaining to human life often attracts. This is apparent in the statement of Ronald Dorkin where he equated abortion with euthanasia as follows:

Abortion is a waste of the start of human life. Death intervenes before life in earnest has even begun. Now we turn to decisions that people must make about death at the other end of life after life in earnest has ended. We shall find that the same issues recur. That the moral questions we ask about the two edges of life have much in common.<sup>2</sup>

Notwithstanding the moralist standpoint, it may just be conceded that at a certain stage in human life when death has become inevitable, the dying might as well be assisted to end it all and for good rather than continuously protracting that which cannot be prevented. Considering such concession, however, raises further issues as to what stage in human life should the concession be made, who determines that stage and what should be the criteria? How is this assistance, which leads to death, to be rendered; is it by positively terminating the person's

1 M. D. A. Freeman, *Lloyd's Introduction to Jurisprudence*, 6<sup>th</sup> edn, Sweet & Maxwell (1994), p. 58.

2 R. Dworkin, *Life's Dominion*, HarperCollins, London (1993), p. 179.

life or passively allowing the terminally ill to die? These are some of the issues raised by the concept of euthanasia, which form the focal points of this paper.

## II. WHAT IS EUTHANASIA

An acceptable definition of the term ‘euthanasia’ is beclouded by the moral cum medico-legal debate on the acceptability or otherwise of termination of human life in whatever guise. Davies proffers what may be described as a compromise stand where he asserts that the term may best be described as an umbrella term connoting decisions made in relation to the ending of the life of the patient.<sup>3</sup>

A close appraisal of this definition would immediately reveal such terms as activity, passivity and voluntariness on the part of the physician, which leads to the death of the patient. Some of these conducts are obviously abhorred by those who oppose euthanasia. An unequivocal rejection of a positive act leading to death as euthanasia can be found in the statement of Bingham, MR in the leading case of *Airedale NHS Trust v Bland*,<sup>4</sup> which deals with the issue of removal of life support from a patient in a persistent or permanent vegetative state. His Lordship considered that such practice,

is not about euthanasia, if by that is meant the taking of *positive action* to cause death. It is not about putting down the old and infirm, the mentally defective or the physically imperfect. It has nothing to do with the eugenic practices associated with fascist Germany.

This denial of a positive act which causes death as euthanasia has also found acceptance in the United States of America as evidenced in the case of *Vacco v Quill*,<sup>5</sup> where the court emphasised that ‘the distinction between assisting suicide and withdrawing life sustaining treatment in hopeless case is logical, widely recognised and endorsed by the medical profession and by legal tradition’.

Implicit in this judicial approach is that merely assisting a terminally ill patient to die by withholding life support facility (a passive act) amounts to euthanasia, whereas administering a lethal therapy to hasten the death of the patient is not euthanasia and is unacceptable. This may rightly be referred to as a distinction without a difference as the ultimate goal in both cases is to hasten or facilitate the death of the terminally ill patient. There is indeed no logical difference or distinction between the conduct of a physician who responds to a request to disconnect the ventilator in a case of progressive neurological disease and that of another physician who administers a lethal therapy on the patient at the patient’s request. Both acts are aimed at achieving the same goal, which is the death of the patient. It is in the light of this that euthanasia has been defined in some circles as encompassing both positive and passive acts that lead to the death of the patient.

<sup>3</sup> M. Davies, *Textbook on Medical Law*, 2<sup>nd</sup> edn, Blackstone Press Ltd, Great Britain (1998), p. 344.

<sup>4</sup> [1993] A.C 808, [1993] 1 All ER 821. Emphasis mine.

<sup>5</sup> 117 Ct 2293(1997).

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Proponents of euthanasia would lightly define the same as providing a 'good' death or easing the passing.<sup>6</sup> A quiet, painless death, the intentional putting to death by artificial means of persons with incurable or painful disease.<sup>7</sup> This is seen as such because the primary aim is to ease the pain and suffering of the patient who is faced with an imminent death without any foreseeable medical solution. The definition in Black's *Law Dictionary* buttresses this primary aim of euthanasia where the term is defined as 'the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an *act of mercy*'.<sup>8</sup>

This definition unequivocally reveals that it is in the interest of the suffering and pain-stricken patient that death be facilitated. The manner in which it is administered, whether passively or actively, is certainly secondary and does not solely by that means preclude the conduct from properly being referred to by what it is, which is euthanasia.

Thus, some writers have deduced various classifications of euthanasia, instead of outrightly denying that fact. Euthanasia has been classified as active, passive, voluntary, involuntary, non-voluntary euthanasia and physician-assisted suicide. This should command greater acceptability than drawing a distinction where none obviously exists.<sup>9</sup>

The common factor in all these categories of euthanasia is death, which often results not so much out of the physician's desire to kill the patient, as to the desire to ease the patient's pain, suffering, disdain, odium or embarrassment attendant upon such a worthless life. In other words, the best interest of such a patient is objectively considered to be the death of the patient, and whichever way or manner death is brought about is rather of little significance. Euthanasia may thus be looked upon as the act of bringing about the death of a patient by a physician, by whatever means so attained, in the interest of the patient.

### III. SANCTITY OF HUMAN LIFE THEORY

The debate on legal recognition of the concept of euthanasia is often beclouded by the general belief in the sanctity of human life. Life, it is argued, is a gift from God which people are mere stewards employed by God to polish and nourish.

6 J. K. Mason and M. Smith, *Law and Medical Ethics*, 4<sup>th</sup> edn, Butterworths, London (1994), p. 413.

7 *Id.* p. 316. Other definitions are mercy killing, the good death, being put down, put to sleep, put out of one's misery, going to sleep permanently, ending your life, available at <http://searchwarp.com/swa459258-Euthanasia.htm>.

8 H. C. Black, *Black's Law Dictionary*, 16<sup>th</sup> edn, St Paul Minn-West Publishing Co (1991), p. 554. Emphasis mine.

9 For instance, Nead has defined euthanasia as 'the intentional premature termination of another person's life either by direct intervention also known as active euthanasia or passive euthanasia by withholding life-prolonging measures and resources, either at the express or implied request of that person'. N. Nead *Euthanasia the right to die* (2009), available at <http://searchwarp.com/swa459258-Euthanasia.htm>. See also A. O. Nwafor, 'Euthanasia – Religion, Medical Ethics and the Law', 1 *Ife Juridical Review* (2004): 246, where a number of these classifications are discussed.

No one shall therefore under any guise terminate that which he or she cannot bring into being. A close scrutiny of the various standpoints of the religious reveals some moderation in the argument of the more liberal contemporary Pentecostal adherents when compared with the hyper-conservative views of the Orthodoxy.

The Orthodox theory spearheaded by the Roman Catholic Institution is encapsulated in the writings of Saint Thomas Aquinas (c. 1225–74 CE) wherein he condemned all forms of suicide whether assisted or not, because:

- It violates one's natural desire to live.
- It harms other people.
- Life is a gift from God and is to be taken only by God.<sup>10</sup>

The erstwhile Catholic Pontiff, John Paul II, in lending credence to the views of Saint Thomas Aquinas, denounced unequivocally the concept of abortion and euthanasia, which he described as crimes that no human law can claim to legitimise. He urged the religious not to obey such laws, but to abide by their grave and clear obligation to oppose them by conscientious obligation. 'In the case of an intrinsically unjust law such as a law permitting abortion or euthanasia, it is therefore never licit to obey it or to take part in a propaganda campaign in favour of such a law or vote for it'.<sup>11</sup>

It is of interest that what Pope John Paul II regarded as 'intrinsically unjust law' are laws that are contrary to the conservative doctrines of Catholicism.<sup>12</sup> Disobedience to such laws is a conduct denounced by earlier philosophers who contended that religion and the law operate at different realms.<sup>13</sup> The law certainly cannot always attain the perfection espoused by religion. Advocating disobedience to such laws is an obvious invitation to chaos and anarchy in a multi-religious world of human existence.

A more moderate approach, more aligned to Pentecostal teaching, but surprisingly emanating from an earlier Catholic Pontiff, Pope Pius XII, recognised that life must not be preserved at all cost. According to the Pontiff:

10 Available at <http://www.shef.ac.uk/content/1/c6/04/11/45suicide.pdf>.

11 Pope John Paul II, 'On the value and inviolability of human life' *Evangelium Vitae* (1995): 73. Available at [http://www.evangelium-vitae\\_en.html](http://www.evangelium-vitae_en.html). Pope Benedict XVI, obviously an apostle of Pope John Paul II, could not have been expected to hold a contrary view. His view is encapsulated in unequivocal condemnation of the Luxembourg parliament's passage of a bill on euthanasia. According to the Pontiff, 'Political leaders, whose duty is to serve the good of man, as well as doctors and families should remember that 'the deliberate decision to deprive an innocent human being of his life is always evil from the moral point of view and can never be lawful.' See 'Pope Decries as Evil as Luxemburg Parliament Advances with Assisted Suicide legislation' available at <http://www.freepublic.com>.

12 For as stated by the Pontiff, euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person. Consequently, a civil law authorising abortion or euthanasia ceases by that very fact to be a true, morally binding, civil law. J. Paul, 'Euthanasia. What are Catholic perspectives on euthanasia and physician-assisted suicide?' (1995), available at <http://searchwarp.com/swa459258-Euthanasia.htm>.

13 See 'Philosophy of Law Spring 2007 – Positive Law Theory', available at <http://www.hku.hk/philodep/courses/law/positivelawhd.htm>.

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Man has a right and a duty in case of severe illness to take the necessary steps to preserve life and health. That duty devolves from charity as ordained by the Creator, from social justice and even from strict law. But he is obliged at all times to employ only *ordinary means* . . . That is to say those means which do not impose an *extraordinary burden* on himself or others.<sup>14</sup>

The pontiff appreciated that asking for more than an 'ordinary means' in the preservation of life would be too burdensome for most people and would render the attainment of the 'higher, more important good' too difficult. The distinction between ordinary and extraordinary treatment has been found to be useful in the medical circle in determining when a physician's obligation to continue the preservation of life or prolonging the death of a terminally ill patient should cease. The decision making is concentrated within the context of the individual patient and the patient's unique condition.<sup>15</sup> Factors such as the physical and psychological pain involved in the treatment, its claim on scarce resources and the general prospects for the patient and family may all be taken into account in deciding whether or not a treatment is productive.<sup>16</sup>

These considerations invariably lead to the question as to who takes the decision: the patient, the relations or the physician? The liberal Christian denominations believe that the decision should be that of the individual (patient).<sup>17</sup> But such a vital obligation (decision making) cannot be fulfilled by a terminally ill patient who is in a state of unconsciousness or a neonate. A person in such a condition is *doli incapax* and a decision must be taken on that person's behalf. Lord Keith in the House of Lords considered that such a decision to discontinue treatment could be taken by 'a large body of informed and responsible medical opinion . . . to the effect that no benefit at all would be conferred by continuance'.<sup>18</sup> Mason and Smith expressed a preference for what they referred to as 'substituted judgement', which is usually reached by finding out what that patient would

14 (1957) 49 Acta Apostolicae Sedis 1027. Emphasis mine. By this statement the Pontiff re-echoed, and invariably approved, the earlier distinction by Gerard Kelly between the concept of 'ordinary means and extraordinary means' of preservation of human life as follows: "**Ordinary means**" are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience. "**Extraordinary means**" are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit'. See G. Kelly, 'The Duty to Preserve Life', 12 *Theological Studies* (1951): 550. 'Consequently, to interpret the statement of Pope Pius XII correctly, it is not only necessary to "weigh up" the benefits and burdens according to the patient's explicit situation, but, more importantly, to relate these benefits and burdens to the purpose or ultimate meaning of the individual's life. Thus it becomes necessary to "demarcate" the limits of the obligation to keep oneself alive'. See M. McCabe, 'Ordinary Means – Extraordinary Means: A Valid Distinction?' available at <http://www.nathaniel.org.nz>.

15 Both the Anglican Church and the Roman Catholic Sacred congregation agree with this interpretation. See Mason and Smith, *Law and Medical Ethics*, *supra* note 6, p. 431.

16 *Ibid.*

17 'Euthanasia and physician assisted suicide-all sides', available at <http://www.religioustolerance.org/euth2.htm>.

18 *Airedale NHS Trust v Bland* [1993] 1 All E.R 821, p. 861.

have wished if he or she were competent through the relations of the patient. The opinion of the relation in such a case is seen as the patient's position, and can also be assessed objectively by asking what a reasonable person in a similar position and condition would have decided under the prevailing circumstances.<sup>19</sup> The decision of the physician to either continue or discontinue treatment should be informed by the response to these questions, notwithstanding any misgiving in some religious quarters.

No case better illustrates this approach than the recent widely publicised case of Mrs Terri Shiavo, a brain-damaged American woman who was in a permanent vegetative state for 19 years and was being fed through a medical tube inserted into her abdomen. On 18 March 2005, her husband obtained an order from the Florida State court to compel the doctors to withdraw the feeding tube and allow Mrs Shiavo to end her pain and suffering by dying gracefully. Mr Shiavo contended and the court accepted that this would be the desire of Mrs Shiavo were she conscious. The doctors in obedience to the court order withdrew the feeding tube. But Mrs Shiavo's parents, family members and the church were against this decision and took the matter to the Parliament. On 21 March 2005, they successfully lobbied the US Parliament to pass a bill referring the matter to the Federal court. The Democrats who opposed the bill considered the issue a private matter that should be left to the doctors; they accused the Republicans of playing God and usurping the functions of the doctors. Nevertheless, the bill was passed by the majority of the members of Parliament. The President had to cut short his vacation on a Sunday and hurriedly signed the bill into law. The decision of the Florida State court was accordingly taken to the Federal court for a review. The Federal court, after hearing the argument of the parties, declined to order the doctors to restore the feeding tube. The parents of Mrs Shiavo appealed to the Court of Appeal and the appeal was dismissed on 23 March 2005. On 24 March 2005, the Supreme Court refused an appeal to restore the feeding tube and on the same day the Florida State court dismissed an application by the State to take Mrs Shiavo into State custody. On 31 March 2005, Mrs Terri Shiavo died peacefully in the Florida hospital.<sup>20</sup>

This US courts' approach is in consonance with the decision of the World Medical Assembly at Helsinki (otherwise referred to as the Helsinki Declaration of 1964) to the effect that if the patient is legally incapacitated the consent of the legal guardian should be procured and in the case of physical incapacity the permission of the legal guardian replaces that of the patient. The Florida hospital in Terri Shiavo's case could not have proceeded with the administration of artificial feeding when the husband who is the legal guardian has withdrawn his consent and backed the same with a court order. The court in making the decision was giving expression to the wish of the incapacitated patient as expressed by her husband.

<sup>19</sup> Mason and Smith, *Law and Medical Ethics*, *supra* note 6, pp. 404–5.

<sup>20</sup> Available at <http://news.bbc.co.uk>. Detailed account of the case including various views on the final result is available at [http://en.wikipedia/wiki/Terri\\_Schiavo](http://en.wikipedia/wiki/Terri_Schiavo).

#### IV. AFRICAN TRADITIONAL RELIGION AND EUTHANASIA

African traditional religion is the religious and cultural tradition indigenous to Africa. Religion so pervades the traditional life of the Africans that it is almost inseparable from culture. It is a religion that involves the totality of life.<sup>21</sup> The traditional belief in Africa is that life is sacred. There is almost a feeling of a divine imperative that life must be given, life must be lived, life is to be enjoyed, life is to be whole, life is to be honourable, and life is to be long and peaceful. For these reasons, many African societies have taboos and rituals to protect the divine gift of life. Wilful murder is an abomination, sometimes requiring complicated rites of purification, which may include going into exile for several years and paying for the upkeep of the family of the murdered person. Abortion is also regarded as an abomination. Great concern is shown to the weak members of the community. The sick are not left alone; the aged are not abandoned in 'Old People's homes'. They live with members of their families. Euthanasia is not considered as an option to end the pains of these weak members of society. They are loved and cared for until they die and join their dead family members.<sup>22</sup> The African traditional view of life may be illustrated with two African communities: the Igbo and the Sidama in Nigeria and Ethiopia, respectively.

The Igbo inhabit the south-eastern part of Nigeria. They are very particular about constructive coexistence on earth. In the saying '*egbe bere ugo bere*' (let the eagle perch, let the hawk perch), the Igbo express the golden rule of their religion: live and let live. Some go further and add '*nke si ibe ya ebene, nku kwaa ya*' (whichever says the other shall not perch, may its wing break). This seeks to ensure that whichever of the Earth's components wants the other not to survive shall not share of the food chain and shall eventually become extinct so that others may thrive well in the ecosystem. Hence, the protection of lesser lives is imperative to good existence on earth. Indiscriminate slaughter of animals or killing of human beings is an abomination of the highest order. To kill a female being is even more atrocious because she assures the continuation and preservation of the species. But, most importantly, every life on earth is predestined.<sup>23</sup>

The Sidama nation is located in north-east Africa, now southern Ethiopia. Fr. Markos Beyene, a Sidama priest, observed that the Sidama people see the direct action of God in creation more than the natural laws. Everything comes from God; fulfilment and success in life are achieved only by the will of God. They believe that if people misbehave God goes away from them. Killing

21 E. Ikenga-Metuh, 'Dialogue with African Traditional Religion (ATR): The Teaching of the Special Synod on Africa' available at <http://www.afrikaworld.net/afrel/metuh.htm>. Holloway observed that 'religion among most African ethnic groups was not simply a faith or worship system; it was a way of life, a system of social control, a provider of medicine, and an organising mechanism'. J. Holloway, *Africanisms in American Culture*, Bloomington (1990), p. 37.

22 C. D. Isizoh, 'African Traditional Religions', available at <http://www.africansocieties.org/n4/eng/chidi.htm>.

23 M. O. Ene, 'The Fundamentals of Odinani', available at <http://www.kwenu.com/odinani/odinani.htm>.

a Sidama person by a Sidama is prohibited. For Sidamas, morality holds a holistic approach; it transverses relationship among individuals, with God, and other creations (land, animals, plants, trees, etc.). The dictums *Gafo ikkanno* and *Maganu di-baxxanno* (God does not like it) are the keys that regulate an individual's attitude towards the other. The Sidama religion is an example of God's universal salvific act. God truly acts and Christianity is not the only way for salvation.<sup>24</sup>

A unique feature of the African traditional religion is the seeming universality of religious beliefs and cultural practices. This common factor has been attributed by some writers to either the fact of diffusions or the fact that most Africans share common origins with regard to race and customs and religious practices.<sup>25</sup>

But these revered traditional beliefs are gradually crumbling under the weight of western civilisation. Isizoh submits that in the last one hundred years the world has witnessed tremendous changes in the social, economic, political and even religious spheres of life. The changes have been brought about by the possibility of frequent contacts between peoples. It is a matter of hours for an event in India to be heard in Brazil, Spain and Zimbabwe, thanks to the mass media. People frequently travel by air, road or sea, from one end of the globe to the other. Religious missionaries are on the move. Mother Teresa of Calcutta is known worldwide and her sisters are easily identified in most countries of the world. All these movements mean that cultures meet one another, new ideas are acquired, prejudices are reduced and friendship is fostered. African traditional religion and its values are not in isolation. In the course of history, they have met with world religions such as Christianity, Hinduism, Buddhism and Islam. Foreign cultures have impacted with local traditions. Urbanisation, industrialisation, modern science and technology, and local and national politics are realities that African people have to reckon with.<sup>26</sup> In the ensuing global *mêlée*, African traditional believers must find room to accommodate the 'strange' concept of euthanasia.

## V. MEDICAL ETHICS AND THE LAW

Medicine is a highly regulated profession practised by men and women of untrammelled intellectual esteem who enjoy the unequivocal confidence of their patients. The quest to curtail abuses of such confidence and to ensure optimal exercise of dexterity by the physician in the care for his or her patient necessitated the formulation of some moral codes of conduct, some of which have over the years metamorphosed into rules of law, to serve as guides in directing the services of the physician to his or her patient. These bodies of moral rules are

24 K. Wansamo, 'Introduction to Sidama Religion', available at <http://www.afrikaworld.net/afrel/sidama.htm>.

25 See A. Shorter, *African Christian Theology*, Geoffrey Chapman (1975), p. 48; E. B. Idowu, *African Tradition Religion; a Definition*, SCM Press Ltd (1973), p. 103.

26 Isizoh, *supra* note 22.

simply referred to as the ethics of the profession or rules of professional conduct. The earliest of such medical ethics is embodied in a statement attributed to a great physician, Hippocrates, who in present times is referred to as the father of modern medicine, and whose statement is administered as an Oath<sup>27</sup> to practitioners of medicine. Part of this Oath enjoins a physician neither to give a deadly drug to anybody if asked for it nor make a suggestion to this effect. The World Medical Association has made some modifications to this Oath to bring it in line with the practice and language of modern medicine<sup>28</sup> but without losing the precepts. The modified version, otherwise referred to as the Geneva Declaration of 1949, enjoins the physician to maintain utmost respect for human life from the time of conception, even under threat, and not to use his medical knowledge contrary to the laws of humanity.<sup>29</sup>

The physician's obligation to preserve human life as contained in the International Code of Medical Ethics raises questions as to whether life must be preserved at all cost and at all times even against the expressed wish of the patient. This question raises two pronged issues: the first is whether treatment should be administered or continued when the only essence of it is to prolong the pain and suffering of the patient while keeping the patient alive, and without any curative value; the second is whether the consent or expressed wish of the patient or the patient's guardian can act as an exculpatory factor where the physician fails to fulfil the obligation to his patient as imposed by the Code of Medical Ethics.

The first question centres on the concept of medical futility. An inevitable fact about life is that it must die. To the religious, it is usually the teaching and belief that every minute that passes brings one closer to his or her grave, hence the need to be prepared at all times for all-conquering death. Notwithstanding the certainty of death, the talk of death is dreaded by many even where life has become worthless and death is tenaciously knocking at the door. A physician in whose care a patient in such a worthless state of life is placed is often in a dilemma as to whether to continue to prolong the death of such a patient by sustaining life through artificial medical means, or to withdraw such treatment and allow the patient to die gracefully and peacefully, having regard to the physician's oath and ethics of practice. What informs the decision of the physician in a situation of this nature has always been the best interest of the patient, and which can be objectively tested by determining what the patient would have wished for if he or she were competent? Mason and Smith have made succinct deductions of the guiding factors from the decision of the House of Lords in the case of *Airedale NHS Trust v Bland*<sup>30</sup> as follows:

27 'The Hippocratic Oath', available at <http://members.tripod.com/nktiuro/hippocra.htm>.

28 See P. I. Okolo, 'Medical Ethics in Nigeria', in B. C. Umerah (ed.) *Medical Practice and the Law in Nigeria*, 1<sup>st</sup> edn, Longman Publishers (1998), p. 9.

29 Other conventions have continued to expound and expand the scope of this declaration. See International Code of Medical Ethics (as amended at Venice, 1983), Declaration of Geneva (as amended at Stockholm, 1994), Declaration of Tokyo 1975 and Declaration of Oslo 1970.

30 [1993] 1 All ER 821, [1993]12 BMLR 64.

- (a) Treatment of the incompetent is governed by necessity and necessity is in turn defined in terms of the patient's best interest.
- (b) Once there is no hope of recovery, any interest in being kept alive disappears and with it the justification for invasive therapy also disappears.
- (c) In the absence of necessity there can be no duty to act, and in the absence of a duty there can be no criminality in an omission.<sup>31</sup>

In that case, Anthony Bland was crushed at Hillsborough football stadium in April 1989 and sustained severe brain damage, as a result of which he relapsed into a 'persistent vegetative state'<sup>32</sup> and remained in that condition till September 1992. The pathetic condition of Mr Bland was lucidly set out in the judgement of Hoffman, LJ at the Court of Appeal as follows:

He lies in Airedale General Hospital in Keighley, fed liquid food by a pump through a tube passing through his nose and down the back of his throat into the stomach. His bladder is emptied through a catheter inserted through his penis, which from time to time has caused infections. His stiffened joints have caused his limbs to be rigidly contracted so that his arms are tightly flexed across his chest and his legs unnaturally contorted. Reflex movements in his throat cause him to vomit and dribble. Of all of these and presence of members of his family who take turns to visit him, Anthony Bland has no consciousness at all.<sup>33</sup>

The doctors in the hospital were of a unanimous opinion that the condition of Mr Bland would never improve and advised the hospital to seek declarations from the court empowering it to discontinue all forms of life-sustaining treatment and medical support measures except those that would allow the patient to die with dignity and be freed from pain and suffering. The court of first instance granted the reliefs on the ground that it is in the patient's best interest that treatment be discontinued. The official solicitor appealed to the Court of Appeal which dismissed the appeal and a further appeal was made to the House of Lords on the ground that to withdraw treatment would be a breach of the duty of the doctor to a patient and a criminal offence. At the Court of Appeal, Hoffman, LJ considered that the court must reach a decision that would be both morally and legally acceptable for,

this is not an area in which any difference can be allowed to exist between what is legal and what is morally right. The decision of the court should be able to carry conviction with ordinary person as being based not merely on legal precedent but also upon acceptable ethical values.

31 Mason and Smith, *Law and Medical Ethics*, *supra* note 6, p. 398.

32 A term defined by the Multi-Society Task Force in America as a vegetative state present one month after acute traumatic or non-traumatic brain injury ... a permanent state can be assumed if it has been present for a year. See Multi-Society Task Force on PVS, 'Medical Aspects of the Persistent Vegetative State', 330 *New English Journal of Medicine* (1994): 1499.

33 (1993) AC 789, pp. 824–5.

Having so found, his Lordship then concluded as follows:

In my view the choice the law makes must reassure people that the courts do have full respect for life, but that they do not pursue the principle to the point at which it has become almost empty of any real content and when it involves the sacrifice of other important values such as human dignity and freedom of choice. I think that such reassurance can be provided by a decision properly explained to allow Anthony Bland to die.<sup>34</sup>

This judgement emphasised the limitations of the concept of sanctity of life. The obligation to preserve life must at a certain point yield to other considerations such as the value of such life to the individual and society as well as the individual's will for self-determination and human dignity. It is doubtful that a competent adult who had previously lived and enjoyed a healthy life would prefer to sustain such life in a permanent vegetative state with the attendant pain, suffering and cost to himself or herself, his or her relations and society. Continuance of treatment in such a situation is certainly of no benefit to the patient and society, as there is no prospect of recovery but rather the prolonging of pain and suffering and ultimately the death of the patient. The doctor's duty of care to the patient ought not extend beyond the administration of such medical treatment that would be of some benefit to the patient in terms of providing a relief from pain and suffering with prospects of recovery and not merely that of prolonging the death of the patient. Lord Keith in *Bland's case* gave vent to this view where he said:

In general it would not be lawful for a medical practitioner who assumed responsibility for the care of an unconscious simply to give up treatment in circumstances where continuance of it would confer some benefit on the patient. On the other hand a medicinal practitioner is under no duty to treat such a patient where a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance.<sup>35</sup>

## VI. NIGERIAN CRIMINAL LAW REGIME

Applying this principle to the Nigerian Criminal Law regime relating to the offence of murder may not be as smooth sailing as it is under the English Law. The Nigerian Criminal Law criminalises any act or omission that leads to the death of a person. Section 311 of the Criminal Code,<sup>36</sup> for instance, provides the following:

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

34 [1993] 1 All ER 821, pp. 850 and 855, respectively.

35 [1993]1 All ER 821, p. 859.

36 Criminal Code Act, Cap. 77 Laws of the Federation of Nigeria, 1990.

The statutory requirement here is that the ‘act’ or ‘omission’ must have ‘caused’ or ‘hastened’ the death of the deceased. Omission in this context can only be of relevance where there is a legal duty on the part of the person making the omission. There is no doubt that a physician owes a duty to the patient to administer the best treatment, which will alleviate the patient’s pain and suffering. But must that duty persist even when the patient’s condition unequivocally suggests that such treatment has ceased to be of any curative value to the patient. The utility of performance of a duty is as fundamental (if not more) as the duty itself. Where the performance of a duty lacks or has lost its utilitarian essence to whom it is owed, it is of no substance insisting that such duty should continue to be performed. Withdrawal of treatment or failing to treat the patient by a physician in such a case is not primarily aimed at bringing about the death of the patient, but to ease the patient’s pain and suffering, ending the prolongation of life which has become, from the patient’s point of view, completely worthless and absolutely unnecessary. Taylor, LJ toed this line of argument in *Re J (a Minor)*, where he emphasised that

The court never sanctions steps to terminate life. That would be unlawful. There is no question of approving, even in a case of the most horrendous disability, a course aimed at terminating life or accelerating death. *The court is concerned only with the circumstances in which steps should not be taken to prolong life.*<sup>37</sup>

This clarification by the judge was apparently informed by the dissensions that followed the decision in *R v Arthur*,<sup>38</sup> a case in which Dr Arthur, a renowned paediatrician, withheld treatment from a baby suffering from Down’s syndrome on the ground that the parents did not want the baby to live. He was acquitted in a charge of attempted murder.

The English Attorney General issued an official statement shortly after the trial reasserting the position of the law relating to murder and attempted murder and emphasised that ‘a person who has a duty of care may be guilty of murder or attempted murder by omitting to fulfil that duty as much as by committing any positive act’.<sup>39</sup>

It is considered that criminalisation of deliberate omission by physicians is desirable and should by no means be overlooked. Suffice it, however, to state that there is a world of difference between the withholding of treatment from a dying patient and refusing to sustain one who shows firm evidence of a will to live.<sup>40</sup> In every case where death results from an omission to treat, the primary consideration should always be the benefit of such treatment to the patient if it had been administered. There should not be any obligation to administer treatment that will not in any way enhance the patient’s quality of life.

37 [1990] 3 All ER 930. Emphasis mine.

38 [1981] 12 BMLR 1.

39 19HC Official Reports (6<sup>th</sup> Series) written answer col. 349, 8 March 1982.

40 See Mason and Smith, *Law and Medical Ethics*, *supra* note 6, p. 370.

Withdrawing or withholding treatment based on the patient's expressed wish does not pose as much difficulty to the court and the physician in spite of the statutory provision criminalising omission. The judicial attitude is that obligation to treat on the part of the physician must yield to the patient's autonomy as embedded in the right of self-determination, and that any treatment of an adult person of sound mind against the person's wish may result in a civil wrong of assault and battery.<sup>41</sup> The physician's duty of care stops where the patient has expressed a contrary desire. It will amount to erosion of the autonomy of the patient and undue exhibition of medical paternalism to continue to administer treatment against the patient's wish. In the Canadian case of *Malette v Schutman*<sup>42</sup> the patient had given an advance directive, which reads as follows:

NO BLOOD TRANSFUSION

As one of Jehovah's Witnesses with firm religious convictions, I request that no blood or blood products be administered to me under any circumstance. I fully realize the implication of this position but I have resolutely decided to obey the Bible command: Keep abstaining ... from blood (Acts 15:28,29). However, I have no religious objection to use the non-blood alternatives.

The doctor who administered blood transfusion contrary to this instruction was found liable in an action for battery.

Davies has offered some useful guides to doctors who are confronted with a patient's decision contrary to their professional ethics. The questions to ask in considering the patient's directive against treatment are the following:

- (a) Was the directive made while competent?
- (b) Was it meant to apply in the situation that has arisen?
- (c) Was it an autonomous freely made decision?<sup>43</sup>

Once these questions are answered in the affirmative, the doctor should refrain from administering treatment. A Nigerian case which recognised a patient's right of self-determination as guaranteed by the Nigerian constitution<sup>44</sup> but which unfortunately has attracted some critical comments from the academic circle is worth considering at this point. The case is *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*.<sup>45</sup> Mrs Martha Okorie, a 29-year-old housewife, was of Jehovah Witnesses religious sect. She was delivered of a baby and had complications requiring blood transfusion, which she declined on the ground of her religious belief. She was discharged by the first hospital she consulted after the hospital had explained the dire consequences of her refusal of blood transfusion, including the likelihood of her death. She was taken by her husband to another

41 See *R v Cox* (1992) 12 BMLR 38.

42 (1990) 67 DRL (4<sup>th</sup>) 321. See more particularly Davies, *Textbook on Medical Law*, *supra* note 3, p. 361.

43 See Davis, *Textbook on Medical Law*, *supra* note 3, p. 578.

44 See ss 37 and 38, Constitution of Federal Republic of Nigeria 1999.

45 [2001] 7 NWLR (pt.711) 206 SC.

hospital where the defendant admitted her. Her husband presented a card signed by the patient and two witnesses to the doctor, which reads as follows:

**MEDICAL DIRECTIVE/RELEASE**

I, Martha K. Okorie, direct that no blood transfusions be given me, even though physicians deem such as vital to my health or my life, I accept non-blood expanders such as Dextrin, saline or Ringer's solution hetastarch, I am 29 years old and execute this document of my own initiative. It accords with my rights as a patient and my beliefs as one of Jehovah's witnesses. The bible commands: keep abstaining from blood (Acts 15 : 28,29). This is and has been my religious stand for 6 years. I direct that I be given no blood transfusion, I accept any added risk this may bring. I release doctors, anesthesiologists, Hospitals and their personnel from responsibility for any untoward results caused by my refusal despite their competent care. In the event that I lose consciousness, I authorize either witness below to see that my decision is [up]held.

The directive was witnessed by the patient's husband and uncle, respectively. The husband also wrote a similarly worded directive addressed to the hospital instructing that no blood transfusion be administered to his wife and absolved the hospital from liability for any adverse consequence. After explaining the consequences of such a directive, the defendant acceded to the patient's and her husband's instructions and proceeded to administer alternative treatment. Five days after the patient was admitted to the hospital, she died. The defendant was arraigned before the Medical and Dental Practitioners Tribunal on a charge of attending to a patient in a negligent manner contrary to 'medical ethics'. He was convicted by the Tribunal and suspended from practice for a period of six months. His appeal to the Court of Appeal was successful and the Tribunal's appeal to the Supreme Court was dismissed. Ayoola, JSC, while delivering the Supreme Court judgement, gave vent to individual's autonomy founded on the constitutionally guaranteed right to liberty, privacy and freedom of thought, conscience and religion which can only be eroded:

Where they impinge on the right of others or where they put the welfare of society or public health in jeopardy. The sum total of the rights of privacy and of freedom of thought, conscience or religion which an individual has . . . is that an individual should be left alone to choose a course for his life, *unless a clear and compelling overriding state interest justifies the contrary.*<sup>46</sup>

His Lordship emphasised the helpless position of the physician whose patient has refused a particular treatment where he said:

46 *Id.* p. 244. Emphasis mine.

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Since the patient's relationship with the practitioner is based in consensus, it follows that the choice of an adult patient with a sound mind to refuse informed consent to medical treatment ... leaves the practitioner helpless to impose a treatment on the patient.<sup>47</sup>

The judge merely stopped short of saying that any such imposition of paternalistic treatment by the practitioner on the patient will open the door for action in assault and battery against the physician. This gap was however filled by Uwaifo, JSC in a concurring decision where he stated *inter alia*:

I am completely satisfied that under normal circumstances no medical doctor can forcibly proceed to apply treatment to a patient of full and sane faculty without the patient's consent, particularly if the treatment is of a radical nature such as surgery or blood transfusion. *So the doctor must ensure that there is a valid consent and that he does nothing that will amount to a trespass to the patient.* Secondly, he must exercise a duty of care to advise and inform the patient of the risk involved in the contemplated treatment and the consequence of his refusal to give consent.<sup>48</sup>

Once the doctor has discharged the obligation of informing the patient of the consequence of declining to accept particular treatment, he is completely absolved of liability for any consequence, however fatal, arising from an omission to administer treatment. Achike, JSC in the same case buttressed this point in a concurring judgement where he said:

It was at best an omission *to do something by a caring medical officer* in respect of a complex matter which involved respecting personal decision-albeit, of religious beliefs-of a patient in the face of the patient's obduracy in being treated. I was relieved that I found nothing delinquent, not to mention infamous, about the conduct of the respondent throughout the circumstances of the case.<sup>49</sup>

This laudable decision of the court has not, and rather unfortunately, found acceptability in the minds of those against all aspects of euthanasia. It has been suggested by a writer that the subjective decision of the patient should have been overridden by other extraneous considerations. In the words of the writer:

The point we are making is that the patient's rights should be balanced against the greater good, ie the rights of other persons who will be affected by the exercise of the patient's rights ... the patient was a nursing mother *with other dependant minor children whose interests would have attracted a weightier consideration if judicial intervention had been sought.*<sup>50</sup>

47 *Id.* p. 245.

48 *Id.* p. 255. Emphasis mine.

49 *Id.* p. 254. Emphasis mine.

50 E. O. Nwosu, 'Disciplinary Powers of the Medical and Dental Practitioners Disciplinary Tribunal', 8 *Nigerian Juridical Review* (2000–2001): 253–4. Emphasis mine.

Interestingly, judicial intervention was not sought by the medical practitioner and as such one is left to speculate on what would have been the attitude of court in that regard. It is, however, preposterous to suggest that interests such as those of the dependants of the patient, who may likely suffer, would constitute such overriding consideration to erode an adult patient's informed decision. The right of self-determination is an individual's right, which guarantees paramount freedom to the individual in the way he or she desires to live his or her life, including the type of treatment he or she may desire to maintain a good state of health.

Self-determination in this context envisages the free choice of one's own acts without external compulsion. It is an aspect of the development of human rights law which is predicated on the notion of giving individuals control over their lives.<sup>51</sup> Though this concept is more popularly invoked in international law in asserting group freedom, it also applies to individual's autonomy which is recognised by various national, regional and global legal instruments.<sup>52</sup> In Africa, the freedom to exercise an individual's autonomy is given impetus by the establishment of the African Commission on Human and Peoples Rights (ACHPR), a quasi-judicial body tasked with promoting and protecting individual and collective rights in the continent. That the Commission's power to entertain disputes is not restricted to group complaints is a good pointer to the fact that the concept of self-determination has shifted from the original idea of assertion of a nation's independence and secession, and presently accommodates the more important and volatile area of an individual's autonomy.

Any other interest, which will override this freedom, must not be another individual's interest. It must be an interest that will benefit the public generally. Ayoola, JSC alluded to this at the Supreme Court where he stated that, 'where, for instance, the health and safety of the society is under threat, for instance in an epidemic, public health and safety may be given a higher weight than the individual's human rights'.<sup>53</sup> This obviously is a true exposition of the law. The interest of the dependants cannot be weightier than that of the individual who is exercising a personal right guaranteed by the constitution.

Rules of law apart, the modern trends in the African way of life are geared towards liberalism. The consideration of self is increasingly overriding the traditional communal concept. This is one of the legacies of the continent's incorporation into the Euro-American-dominated global political economic system anchored on liberalism,<sup>54</sup> under whose heritage African thought and

51 E. Brahm, 'Self-Determination Procedure-Beyond Intractability', in G. Burgess and H. Burgess (eds), *Conflict Research Consortium*, University of Colorado, Boulder (2005), available at [http://www.beyondintractability.org/essay/self\\_determination/](http://www.beyondintractability.org/essay/self_determination/).

52 See for instance, The African Charter on Human and Peoples' Rights 1981, articles 4, 5, and 6; United Nations Universal Declaration of Human Rights 1948 articles 3 and 4; International Covenant on Economic, Social and Cultural Rights 1976, article 12; and International Covenant on Civil and Political Rights 1976, articles 17 and 18; all of which provide for the inviolability of human person and freedom of thought, conscience and religion.

53 [2001] 7 NWLR (pt.711) 206, p. 244.

54 An instance of which could be illustrated with the recent decision of the UK Court of Appeal in *Yearworth v . . .* where it was held that the plaintiffs have property interest in their body parts and could claim damages for their damaged sperm that was preserved in the hospital.

society are undergoing a crisis of the meaning of life, persons and community. Western liberalism, as it manifested itself in colonialism and the Christian evangelisation of Africa, imposed on Africans its notion of the world, values and manner of living.<sup>55</sup> Many Africans, including Nigerians, in the modern era will certainly wink at any suggestion that the interest of dependants should override that of self.

The perilous and unenviable position a physician will be exposed to by any suggestion that he should proceed with treatment against the patient's wish or in the absence of consent is amplified by the case of *Okekearu v Tanko*,<sup>56</sup> where the appellant, a physician, amputated part of the middle finger of the patient, a 14-year-old boy, without the patient's consent. In his evidence the physician testified that on examination he found that the respondent had a crushed injury. There were jagged lacerations on the affected finger. There was a compound fracture of the finger. Only the skin and underlying tissues held the finger. The finger bled profusely. On these facts the physician honestly considered that the best interest of the patient demanded that the finger be amputated. In upholding the judgement of the lower courts which found the appellant liable for battery, Tobi, JSC justified the Supreme Court's decision on absence of consent of the patient where he said:

The appellant did not tell the trial court why he ignored Tanko a young man who gave lucid evidence as plaintiff . . . there is also no evidence that Tanko was in a state of coma, a state which should have made it impossible for the young man to give his consent. The point I am struggling to make is that there is no evidence on record why effort was not made to obtain the consent of Tanko, a rational human being of fourteen years.

This decision re-enforces the earlier Supreme Court decision in Okonkwo's case<sup>57</sup> where Uwaifo, JSC in a concurring opinion said:

I am completely satisfied that under normal circumstances, no medical doctor can forcibly proceed to apply treatment to a patient of full and sane faculty without the patient's consent particularly if that treatment is of a radical nature such as surgery or blood transfusion.

Consent is a threshold issue in the administration of any radical medical treatment by a physician to the patient. A physician cannot and should not be held liable for any fatal consequence arising from withholding or withdrawing treatment due to the patient's refusal or withdrawal of consent. Nigerian judicial decisions support this and that is the concept of passive euthanasia.

55 P. C. Aka, 'Africa's Agenda: The Legacy of Liberalism and Colonialism in the Crisis of African Values', *Journal of Third World Studies* (1998), available at [http://findarticles.com/p/articles/mi\\_qa3821/is\\_199804/ai\\_n8785067/](http://findarticles.com/p/articles/mi_qa3821/is_199804/ai_n8785067/).

56 [2002] FWLR (pt.131)1888, p. 1898.

57 *Supra* note 45, p. 255.

## VII. ETHIOPIAN PERSPECTIVE

Ethiopia has a threaded chequered political history, transcending from imperial rule to military dictatorship and presently a democratic regime. Its laws at every point in time have been tailored and interpreted to suit the ideology and policies espoused by the extant political authority.

In the era of socialism, for instance, which were spearheaded by a military ruler, Colonel Mengistu Haile Mariam, between 1974 and 1991, the interpretation and application of Ethiopian laws were given socialist colouration which imposed obligation on every man, and in the present context a physician, to do all within his power to save the life of his patient. Liability for failure to act could be based not only on the specific requirements of the law, but also on the fundamental propositions of the constitution. Lowenstein portrayed judicial attitude in that era where he said:

The court ... must establish whether a given person is required to render assistance to another from the point of view of the relationship which ought to exist in a socialist society ... it would violet ... the constitution if a healthy person who knew how to swim failed to render aid in the summer to another person who was drowning in a river not far from the bank.<sup>58</sup>

Since a democratic regime was established, primacy is accorded to an individual's inalienable right to self-determination,<sup>59</sup> which enables every individual to live his or her life as he or she desires within the confines of the law, and to die with dignity. In relation to the subject of this discussion, article 1 of the Medical Ethics for Physicians Practicing in Ethiopia provides the following:

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No doctor can take life deliberately as an act of mercy even at the request of the patient or the patient's family.<sup>60</sup>

This provision when read in isolation gives the impression that a patient is denied of his or her constitutionally guaranteed right to self-determination, which invariably grants a choice as to the manner of death by a sick person, and as imposing an obligation on the physician to administer treatment against the patient's wish. But other provisions in the Medical Ethics have cleared the obvious absurdity by shedding some light on the true position of the law. Article 24, for instance, provides the following:

### PATIENTS' INFORMED CONSENT

It is the duty of the physician to inform the patient about the treatment (including surgical procedures) the physician intends to carry out. He

58 S. Lowenstein, *Materials for the Study of the Penal Law of Ethiopia*, Faculty of Law, Haile Sellassia I University, Addis Ababa (1965), p. 87.

59 See chapter three of the Constitution of the Federal Democratic Republic of Ethiopia, 1995 (hereinafter referred to as 'Ethiopian Constitution').

60 Hereinafter called 'Medical Ethics'.

is always obliged to obtain a written consent of the patient before carrying out procedures. In the case of minors or persons who are unconscious or of unsound mind, the necessary consent should be obtained from parents or legal guardians, if there is no legal provision.

The above provision is strengthened by the Declaration of Lisbon on the Rights of Patients, 1981, which provides that:

The patient has the right to accept or to refuse treatment after receiving adequate information.

The patient has the right to die in dignity.<sup>61</sup>

The only duty imposed on a physician, by the tenure of the provisions set out above, is to explain to the patient the implication of a particular treatment he intends to administer to the patient and the consequence of the patient's decision not to accept particular treatment. The decision to accept or refuse such treatment is entirely that of the patient (or the patient's legal guardian if the patient is unconscious or incapacitated in any way). Once that decision is made, the physician is absolved of any consequence on the patient even if fatal. This approach is in accord with the Nigerian Supreme Court decision in *Okonkwo's case*,<sup>62</sup> which gave primacy to the right of the patient to self-determination.

These provisions will readily absolve a physician who allows a patient to die by withdrawing or withholding treatment at the request of the patient, that is passive euthanasia. They may not, however, be of much assistance to a physician who positively administers fatal treatment even at the request of the patient or the patient's guardian. The withdrawal or withholding of treatment is at best an act of omission which is informed by the physician's respect for the patient's right to self-determination as provided by law. A strong exculpating provision can be found in article 520 of the Ethiopian Penal Code, which provides *inter alia*:

Any doctor [...] or any other person lawfully entitled to render professional attention and care, who contrary to his duty and without just cause, refuses to provide his services in a case of serious need, whether from indifference, selfishness, cupidity, hatred or contempt, or for any other similar motive, is punishable with fine.<sup>63</sup>

The first element of the offence created by this provision is that of omission to act which must be 'contrary to his duty' as a doctor. A doctor cannot be said to have acted contrary to his or her duty when the patient has declined to accept the administration of particular treatment after being duly informed of the consequence. The patient's refusal also negatives the second element of the offence which is 'without just cause' as justification is founded on the patient's withholding or withdrawal of consent. Incidentally, the incriminating motives enumerated in article 520 are all personal to the physician, so that once the reason

61 Incorporated as Appendix 1 to the Medical Ethics.

62 *Supra* note 45.

63 See *Negarit Gazette – Extraordinary Issue No. 1 of 1957*.

for not administering treatment can be attributed to the patient, the physician is completely exculpated.<sup>64</sup>

It is apparent from the foregoing discussions that in spite of the provision of article 1 of the Medical Ethics, which unequivocally forbids euthanasia, the Ethiopian law, like its Nigerian counterpart, is not likely to hold a physician liable for the death of a patient simply by withdrawing or withholding treatment in complete deference to the wish or expressed desire of the patient or that of the patient's guardian. The blameworthy element in case of death is on the patient and not on the diligent physician. At best that provision prohibits active and not passive euthanasia.

### VIII. CONCLUSION

The strongest objection to the concept of euthanasia as is apparent from discussions above is that euthanasia is simply seen as the unjustifiable termination of human life. As humans, the sanctity of life is to be respected by all and sundry. The Nigerian former President, Olusegun Obasanjo, alluded to this where he said: 'Both Christianity and Islam hold life as sacred. Any one who kills or instigates the killing of another human being except on established judicial judgment is a murderer and must be treated as such'.<sup>65</sup>

It is also this belief in the sanctity of life that informed the denial by Hoffman, LJ in *Bland's case*<sup>66</sup> that the consideration of withdrawal of life-sustaining equipment from a terminally ill patient has anything to do with euthanasia. The opponents of euthanasia have failed or refused to see any utilitarian value in this concept. The question must be asked as to what is really the joy in a life which is devastated by ailment that has defied treatment by the most advanced medical technology? Of what benefit is life in a patient who is groaning under severe pain and suffering with no hope of recovery? Would such a person not prefer to be allowed, if not actively assisted, to die and return to his or her Creator with some vestiges of a human being?

The religious are bound to fall back on the idea of divine intervention or a miracle occurring when all hope is lost, insisting that the same God who moulded life in the womb of the mother should have a final say on when such life should cease. The traditionalist perspective is that the tenure of life on earth is predestined and should not be interrupted by human action.

If it is conceded, without sounding irreligious, that the ultimate goal of every human being is to be reunited with his or her Creator after life on earth, and the only certainty in life is that it must end one day and life must return to the Creator, then consideration as to how one dies will be of little consequence. Suffice it to

64 Note that Ethiopia unlike Nigeria does not rely so much on judicial precedents which are enhanced by systematic and synchronised law reporting; as such the writer could not lay hands on any reported judicial precedent to provide a guide in this research.

65 See 22 *The News Magazine* (7 June 2004), p. 36. This is a clear reflection of the African traditional religion's view of life.

66 *Supra* note 35.

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firmly assert that one is not by any means advocating indiscriminate termination of life as this writer subscribes unequivocally to the concept of sanctity of life. But where such life has lost its value in its entirety due to terminal ailment with the attendant severe pain and suffering, the physician should be at liberty to accede to the patient's request or that of the legal guardian, not only to withdraw or withhold treatment but also to actively assist the patient to die.<sup>67</sup> This stand falls squarely within the patient's right to self-determination guaranteed by various statutory instruments.

Some countries have already taken positive steps in this direction. The Netherlands was the first to legalise active euthanasia. Belgium followed suit in September 2002, and it is on record that at present 259 terminally ill patients have been actively assisted by physicians to die quietly and find peaceful repose in the bosom of their Creator. The issue is now before the Scottish parliament for debate on whether a physician can lawfully prescribe fatal medication that will facilitate the death of a terminally ill patient.<sup>68</sup> It is believed that in the not so distant future more countries in Africa, including Nigeria and Ethiopia, will find reason to follow the laudable examples of Belgium and the Netherlands in legalising active euthanasia.

67 It may be of interest to observe here that the late Catholic Pontiff, Pope John Paul II, in spite of his avowed stand against euthanasia, expressed a wish at the terminal days of his life, and which was respected by the College of Cardinals, as widely reported in the news media, to be allowed to die peacefully in the Papal home at the Vatican. Could his pains, suffering and imminent death not have been prolonged by advanced medical technology if he was taken to the hospital? The only reasonable response at that point in time is that prolonging his death has no utilitarian value. By respecting his wish, the Cardinals had either advertently or inadvertently assisted the Pope to die.

68 This information is available at <http://www.christian.org.uk/news/20090528>. Luxemburg Parliament is presently on the verge of legalising active euthanasia. Available at <http://www.freepublic.com>.