Moral Views on Euthanasia amongst Medical Practitioners in Nairobi, Kenya.

Ngatia Fredrick

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School of Humanities and Social Sciences
Strathmore University
Nairobi, Kenya

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FREDRICK NGATIA

6 June 2019

Approval

The dissertation of Ngatia Fredrick was reviewed and approved by the following:

Dr. John Branya,
Director, Masters of Applied Philosophy and Ethics,
Strathmore University.

Prof. Christine Gichure,
Dean, School of Humanities and Social Sciences,
Strathmore University.

Prof. Ruth Kiraka,
Dean, School of Graduate Studies,
Strathmore University.

ABSTRACT

Euthanasia has provoked raging debate since antiquity. Natural law adherents consider that death should occur naturally i.e. without acceleration by human acts and/or omissions which are intended to cause or hasten death. Since ancient times, the position taken by natural law adherents has not been accepted universally. Indeed, eminent thinkers, for instance, Epicurus (341 BC- 270 BC) stoically remarked that one was entitled to quit life's theatre "when the play has ceased to please us" (Amicus, 2011).

Divergent views on euthanasia exist to date. Hippocrates (460 BC- 377 BC) who is reputed as the father of medicine was against euthanasia. The Hippocratic Oath expressly prohibits doctors from administering any drug that would intentionally induce death. A doctor is expressly required to solemnly affirm that he "will neither give a deadly drug to anybody if asked for it, nor will I make suggestion to this effect" (Edelstein, 1943). The two extreme positions, which have origin in antiquity, have persisted to date and no common view is in sight.

In the modern world, euthanasia is regarded by a segment of the populace to be empowering and liberating. According to the proponents of euthanasia, one need not experience untold pain and suffering or be subjected to extended period of treatment. One can liberate oneself from the illness by administration of euthanasia which hastens death instead of medical treatment or procedures which prolong the eventuality of death. Euthanasia is therefore viewed as a mode or vehicle of liberating oneself from pain, suffering or prolonged treatment.

Since no empirical evidence on life after death is available, it is difficult to discern how one weighs the benefit of death instead of continuance of life, albeit with the discomfort arising from the illness. How death can be liberating instead of continuation of life is therefore an experimentation with the unknown.

This research seeks to ascertain whether euthanasia is administered in Nairobi and if so, the prevalence of the practice. The research also seeks to establish the reasons that patients use to seek euthanasia instead of continuation with life. The research also seeks

to ascertain the moral reasons that medical practitioners use to justify administration of voluntary active euthanasia. The identified reasons are discussed and contrasted to personalistic philosophy viewpoint.

The discussion on moral reasons advanced by medical practitioners is a critical part of this dissertation. A moral reason to justify euthanasia may appear to be a contradiction in that euthanasia is a termination of life. Prima facie, life should continue until death, by a natural process, takes effect. Hence, the question to be considered is whether on account of the grounds advanced by medical practitioners, termination of life can be morally justified. The moral justification is further contrasted to Personalistic philosophy viewpoint as that is the philosophy that guides this dissertation. Personalist philosophy has deliberately been taken as the regulating philosophical perspective due to the eminence it gives to personhood including the transcendental dimensions.

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DEDICATION

This dissertation is dedicated to the numerous unseen, unnoticed and unsung medical care providers who, in their anonymity, toil ceaselessly for their patients.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1. INTRODUCTION

This dissertation considers whether euthanasia is administered in Nairobi and if so, the prevalence of the practice. In the event that voluntary euthanasia is indeed administered in Nairobi, it would be necessary to ascertain the moral reasons that medical practitioners use to justify administering voluntary euthanasia.

Euthanasia implies an intentional termination of human life. The Greek tragedians in antiquity expressed divergent views regarding euthanasia. For instance in the Aeschylean classic drama, Prometheus Bound, one of the characters, Eos, who was suffering immense psychological problems narrates that "it were better to die once and for all than to drag out my lingering days in anguish" (Papadimitriou, 2007). Sophocles on the other hand regarded life as the highest good given to mankind by the gods (Winnington-Ingram, 1980).

The ancient philosophers similarly expressed divergent positions. For instance, Pythagoras believed in transmigration of the soul and based on philosophical and theological beliefs about life, he was against voluntary end to life since life was in itself sacred (Baranzke, 2012). Epicurus on the other hand was of the view that a person who is suffering unbearable pain is free to terminate his life provided that the misfortune is neither brief nor intermittent (Papadimitriou, 2007). Aristotle was emphatic that "to seek death in order to escape from poverty or the pangs of love or from pain or sorrow is not the act of a courageous man, but rather of a coward" (Papadimitriou, supra).

There are several forms of euthanasia namely, voluntary, involuntary and non-voluntary euthanasia. Voluntary euthanasia entails a competent patient making a request for termination of life due to an existing medical condition which the patient seeks to be relieved from. Involuntary euthanasia also relates to a competent patient.

However, in involuntary euthanasia, termination of life is made against the wish or desire of the patient. Involuntary euthanasia is therefore akin to murder. Non-voluntary euthanasia is administered to a patient who is incompetent due to a medical condition such as a coma. It is invariably the patient's next of kin or such other person who make the request for non-voluntary euthanasia since the patient is in a coma or a non-responsive medical condition which is considered to be irreversible.

Voluntary euthanasia can further be classified as active or passive. Active euthanasia refers to a positive act such as injection of a lethal drug which is intended to induce death (Kurutto & Masinde, 2016). Passive euthanasia refers to an omission such as withdrawal of life support or nutrition so that death occurs from the illness itself. Whereas the distinction has been made since antiquity, it is an exercise in semantics since the outcome is the same from a result point of view. From either the positive act or the withdrawal of life support, the consequence is death. However, as regards the moral aspect, "active euthanasia is not any worse than passive euthanasia" (Rachels, 1975). This view does not have universal acceptance since passive euthanasia is more readily accepted as contrasted to an intentional act which is done to induce death which is what active euthanasia entails.

In this dissertation, focus is on voluntary euthanasia since the patient is ordinarily the person who requests for termination of his life. The patient is the main actor. The patient is the one who triggers the process with the full knowledge that death is the intended outcome. Voluntary euthanasia is a topic appropriate for the dissertation because of its ethical significance and actuality. The fact that the patient is competent and makes an informed decision to request for termination of his life makes the patient a focal point of inquiry. In addition, voluntary euthanasia raises tension with the natural law adherents who regard life as scared as the origin of life is beyond man.

Akin to voluntary euthanasia is physician assisted suicide which is the practice of a medical practitioner providing to a competent patient medication for the patient to

ingest so as to induce death. The request for the medication originates from the patient and in countries where that practice has been legalized, a medical practitioner is at liberty to prescribe the medication provided that the practitioner adheres to set legal guidelines (Kurutto & Masinde, 2016).

Reference to voluntary euthanasia in this dissertation shall include physician assisted suicide. In both situations, the patient is competent i.e. has full understanding of his condition and is able to make an informed decision. It is assumed that the patient has a rational understanding about life and all its attributes.

1.2. BACKGROUND TO THE STUDY

The term euthanasia comes from two Greek words; "eu" which means good and "thanatos" means death. In its Greek usage the term euthanasia simply meant gentle and easy death (Lacewing, 2006). The meaning of the word has evolved from "good death" to various forms of ending a person's life. The occurrence of voluntary euthanasia is invariably triggered by a patient making a request for termination of his life. The request is premised upon a supposition that death is a more viable option than prolongation of life.

In the Western countries such as Netherlands, the debate on euthanasia is infused by utilitarian principles (Perreira, 2011). In Netherlands, euthanasia was tolerated for a considerable time and attempts to prosecute doctors in 1970s failed due to inertia in reporting cases. Few cases were investigated, and none were prosecuted. After lengthy public debate, euthanasia was legalized in Netherlands in November 2000. (Perreira, supra). Belgium followed suit in May 2002 whereas Luxemburg legalized euthanasia in 2009 (Perreira, supra).

By contrast, in the United States of America, only six states have legalized euthanasia (Perreira, supra). Interestingly, it is in the United States where some of the most complex cases on euthanasia have been litigated. In a recent landmark case, a lady patient, Terri Schiavo was the subject of protracted and highly publicized

litigation (Goodnough, 2005). The patient was in a vegetative state for a considerable period. Her husband applied to court to discontinue her life support. Her parents vigorously opposed the husband's request for discontinuance of life support. The stage was set for a bruising court engagement which persisted for almost 10 years.

Terri Schiavo was receiving nutrients through a feeding tube and that is how her life, however feeble, was maintained. After numerous appeals and hearings the court finally acceded to the husband's request and authorized the feeding tube to be removed (Theresa M. Schindler Schiavo & 2 others –Vs- Michael Schiavo & 2 others, SC 03-1242). The feeding tube was removed on 18th March 2005 and death took place on 31st March 2005 due to lack of nutrition (Goodnough, supra). Whereas this case deals with an incompetent patient, it is nonetheless necessary to make reference to it to demonstrate the divisive nature of euthanasia and the moral dimensions.

Voluntary euthanasia evokes numerous complexities ranging from a wholesome condemnation from natural law theory adherents who are firm that death should occur naturally to the opposite extreme which holds that man is free and autonomous. In accordance with the later, death which occurs naturally is unacceptable if it involves pain and discomfort as compared to euthanasia which is regarded as empowering, courageous and somehow noble.

Considering that trends elsewhere, particularly in the Western world, readily influence opinion in Kenya, it is necessary to ascertain whether, as a matter of fact, voluntary euthanasia is administered in Nairobi and if so the prevalence of the practice. In addition, thereto, it is necessary to identify the reasons that would make a patient to request for euthanasia and, more pertinent, the moral reason (s) that would justify a medical practitioner to accede to the request. Once that data is obtained then further evaluation will be made. The information that will be obtained will be evaluated against the writings of Thomas Aquinas and other philosophers who are inclined to personalistic philosophy.

Remarkably, there are no studies that have been carried out in Kenya on the incidence of euthanasia and hence there is scarce data on the topic. This research intends to fill that knowledge gap. In addition, neither are there reported cases regarding prosecution of a medical practitioner for administering euthanasia notwithstanding that euthanasia is a criminal offence in Kenya. Ferdinand Sakali, albeit writing about the situation in Africa generally, questioned the absence of data and observed;

> "In the world euthanasia debate, one might wonder whether Africans (except in South) have any problem with dying since they hardly participate in the debate. Most probably, it could be because most Africans may have no access to sophisticated medical technology that would warrant them to undergo futile treatment. It also could be because, in most cases when a patient dies from hospitals in Africa, the family members hardly question the doctor or investigate the circumstances under which a patient lost his/her life, since this involves legal costs. But to be sincere, is it true that doctors in big and sophisticated hospitals in Africa like the Nairobi Hospital, Kenyatta Hospital among others do not experience the dilemma of choosing between quality of life and sanctity of life in their line of duty? Or is it that Africans do not suffer from painful terminal diseases like cancer and diabetes among others? Or, is euthanasia a normal thing to them that needs not to be debated about? Or is it due to the fact that, in most African societies, issues like euthanasia, assisted suicide, abortion, incest, or homosexuality are always kept as family secrets, hence discussions over them are overlooked" (Sakali, 2012).

The issues raised by Ferdinand Sakali are thought provoking and justify a quantitative research to investigate the notable absence of any data on this complex subject. This dissertation is a precursor to a more in-depth empirical research which ought to have a much bigger sample group in order to gather more views from a

larger and more diverse group of persons, unlike this dissertation which I shall restrict to medical practitioners in Nairobi, Kenya.

1.3. PROBLEM STATEMENT

This dissertation seeks to ascertain whether voluntary euthanasia is administered in Nairobi and, if it is administered, to identify the moral reasons that medical practitioners use to justify administration of voluntary euthanasia.

The Constitution of Kenya 2010 confers upon the person various inalienable rights. One of those rights, autonomy, is predicated upon existence of "capacity to think, decide and act freely and independently" (Gillon, 1985). Autonomy or the right to self-determination is closely related to other inalienable rights such as dignity of the person and right to life. An examination is made in this dissertation whether these rights are in conflict with each other, for instance whether self-determination can be diametrically opposed to sanctity of life.

1.4. RESEARCH AIM & OBJECTIVES

The main aim of this dissertation is to ascertain the moral views on euthanasia amongst medical practitioners in Nairobi, Kenya. The following research objectives would facilitate the achievement of this aim;

a) To establish, from medical practitioners who are based in Nairobi, whether voluntary euthanasia is administered and if so ascertain the prevalence.
b) To establish the moral reasons that medical practitioners use to justify administration of active euthanasia (if it is administered).
c) To establish the moral reasons that medical practitioners use to justify administration of passive euthanasia (if the practice exists).

1.5. RESEARCH QUESTIONS

This dissertation seeks to answer the following questions:

a) Whether voluntary euthanasia is administered in Nairobi and if so ascertain the prevalence?
b) What are the moral reasons that medical practitioners use to justify administration of voluntary euthanasia?
c) What are the personalistic philosophical evaluations from responses provided by medical practitioners on euthanasia?

1.6. SIGNIFICANCE OF THE STUDY

It is difficult to assume that voluntary euthanasia is not administered in Nairobi. It is prudent and realistic to undertake research to ascertain whether despite the existing penal sanctions, voluntary euthanasia is administered albeit on the quiet. Equally important is the need to ascertain the moral reasons that medical practitioners use to justify the practice, if the practice does, in fact, exist. It is necessary to ascertain whether the Constitutional rights are considered sufficient to justify the practice of euthanasia similar to the view expressed by Chief Judge Barbara Rothstein as follows;

> "There is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his suffering and hasten an inevitable death" (Vacco v. Quill, 521 U.S. 793 (1997).

The personal decision alluded to is the freedom to voluntarily seek termination of life as an attribute of the right of liberty and an assumed concomitant duty on the medical practitioners to act on the patient's request.

It is necessary to consider whether a request for voluntary euthanasia can be justified as an attribute of personal liberty. Personal liberty in this context means autonomy as well as self-determination as these are rights that enable man to express himself and/or make decision about his person. Critical in the evaluation is a consideration of whether personal liberty can be regarded as a superior right to sanctity of life. In the scheme of human rights, sanctity of life should be pre-emptive as all other rights

are subordinate to it. In absence of life, the individual cannot enjoy those other celebrated rights.

As liberty has been advanced in a number of court judgment as conferring upon the individual the right to terminate his life, this dissertation examines the moral justification of that right from a personalistic philosophy perspective.

1.7. SCOPE OF STUDY

The research is limited; firstly, to determine the incidence of voluntary euthanasia in Nairobi and secondly to consider the moral reasons that medical practitioners use to justify the practice.

The scope of the study is limited geographically as only a targeted group of medical practitioners in Nairobi, Kenya filled the questionnaire. Nairobi, the capital city of Kenya, has a population of 3,138,369 as recorded in the population census conducted in 2009 (Kenya National Bureau of Statistics, 2009, Population and Housing Census). Experts estimate that the population currently should be between 3.5 million to 4 million. The city is a medical hub of Kenya and the neighbouring countries. It has about 35 level 4 and 5 hospitals, both private and public (Ministry of Health, 2014).

Kenyatta National Hospital is located in Nairobi and is the biggest public referral and teaching hospital in East and Central Africa (Ouko, 2012). On average the hospital receives more than 2,000 in –patients and 1,500 outpatients each day (Kenya National Bureau of Statistics, 2014). The hospital serves patients suffering from terminal illness in its intensive and critical care units. Other notable health facilities include Nairobi Hospital, MP – Shah Hospital and Aga Khan Hospital. These facilities have ultra-modern facilities and admit patients diagnosed with degenerative, progressive illness such as Huntington's disease, multiple sclerosis, AIDS, Alzheimer's disease and cancer (Kenya National Bureau of Statistics, 2014). Patients suffering from such diseases often fear, on justifiable grounds, a gradual

loss of the quality of life as the illness progresses. A patient may consider that the loss of autonomy is an unacceptable loss of dignity which the patient was hitherto accustomed to. Loss of continence and inability to attend to one's private needs can be the cause of tremendous distress. Other patients may consider that death is inevitable and imminent and thus wish to be in total control over that eventuality. Without doubt, a segment of the patients may justifiably consider that they do not wish to diminish their assets by incurring substantial medical expenses which would not, in any event, avert the looming eventuality. In that situation, it may be considered more appropriate to save the assets for the benefit of their heirs.

By 2014, Kenya had 9,149 registered medical doctors spread out across the country (Kenya Medical Practitioners and Dentist Board, 2016). Amongst those doctors are medical practitioners who have opted to pursue certain areas of specialization. This dissertation deliberately identified the specialists in critical care medical management, medical oncologists who attend to cancer patients and other medical practitioners who routinely manage patients during their terminal stages.

The research is limited in terms of available time and resources and identified a sample size drawn from medical practitioners in both public and private hospitals in Nairobi. The qualitative method deployed is adequate to give in-depth insights about the situation and can form basis for future quantitative research studies. However, a larger segment of the population encompassing religious and secular groups would be required to determine whether euthanasia can be legalized in Kenya. Whether euthanasia should be legalized is a topic beyond the scope of this dissertation.

In the next chapter, a review is undertaken of pertinent literature and illustrating court judgments. Effort is made to identify the moral grounds and/or philosophical inclination that influenced the court to allow or disallow administration of euthanasia. In addition, an overview of the anthropological as well as utilitarian and personalistic philosophy perspectives is undertaken.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter entails a literature review of scholarly material on voluntary euthanasia. A search was undertaken for any scholarly work or information regarding voluntary euthanasia in Nairobi. Various philosophical perspectives are examined particularly perspectives that accord autonomy pre-eminence over other considerations. Finally, a theoretical framework has been developed based on personalism as a philosophy that considers man together with his transcendentals.

This dissertation focuses on voluntary euthanasia because moral evaluation can only be undertaken on a competent and rational human person. It is only in voluntary euthanasia that a competent patient freely seeks to terminate his life and makes a request for euthanasia to a medical practitioner (Kurutto & Masinde, supra).

2.2 VOLUNTARY EUTHANASIA ADMINISTERED IN NAIROBI

Voluntary euthanasia refers to instances whereby a competent person makes a request invariably to a medical care provider, for assistance to terminate his life. The assistance may take the form of either active or passive euthanasia depending on the medical condition of the patient. Physician assisted suicide; a hybrid of both active and passive euthanasia, refers to a physician providing a prescription wherein the drugs to induce death are prescribed. It is the patient who will, on his own accord, ingest the drugs to induce death. (World Federation of Right to Die, 2012).

The position taken by the International Association for Hospice and Palliative Care to which Kenya is a member party to is that euthanasia should not be administered as it goes against the Hippocratic Oath which states "I will give no deadly medicine to anyone if asked, nor suggest any such counsel" (Edelstein, 1943). The Association argues that euthanasia is incompatible with the medical practitioner's role as a healer. This position is further justified by the belief that euthanasia may violate the trust that the patients have in their medical practitioners (Lima, Woodruff, Pettus, Downing et al., 2017 p. 4). It should be noted however, that the International Association for Hospice

and Palliative care in its position statement on euthanasia and physician assisted suicide states that the right to decline medical treatment is a basic right of the patient and the doctor is not unethical in respecting the patient's wishes (Lima, Woodruff, Pettus, Downing et al., supra p. 4). The patient's right to decline medical treatment is therefore an exercise of a basic right and is not within the parameters of euthanasia.

Remarkably, there are no studies that have been carried out in Nairobi on voluntary euthanasia and hence there is no data on the topic. Nonetheless, all forms of euthanasia or physician assisted suicide are criminal offences in Kenya. No incident has however been reported of a medical practitioner being accused of administering voluntary euthanasia in Nairobi (Wasunna, 2005). It is due to that deafening silence that this dissertation becomes merited; to seek to ascertain whether voluntary euthanasia takes place and if it takes place, seek to determine the prevalence as well as the grounds that trigger request by a patient and the moral justification by the medical practitioner.

2.3 MORAL REASONS THAT MEDICAL PRACTITIONERS USE TO JUSTIFY ADMINISTRATION OF ACTIVE EUTHANASIA

Active euthanasia is more controversial since it involves causing death by a direct act albeit at the request of the patient. A well-known case of active euthanasia is in the video tape that was prepared by Dr. Jack Kevorkian as he administered a lethal medication to Thomas York, a terminally ill patient who was in the last stages of Lou Gehrig's disease. (People v. Kevorkian, 1994). Although it was common ground that the patient requested euthanasia, Dr. Kevorkian was nonetheless indicted for murder.

Dr. Kevorkian considered that compassion was justification for assisting a patient to die since death would relieve the patient from pain and suffering. In response to the claims of compassion as a defence to the charge of murder, the Judge stated;

> "This is a court of law and you said you invited yourself here to take a final stand. But this trial was not an opportunity for a referendum. The law prohibiting euthanasia was specifically reviewed and clarified by the Michigan Supreme Court several years ago in a decision involving your very

> own cases, sir. So the charge here should come as no surprise to you. You invited yourself to the wrong forum. Well, we are a nation of laws, and we are a nation that tolerates differences of opinion because we have a civilized and a nonviolent way of resolving our conflicts that weighs the law and adheres to the law. We have the means and the methods to protest the laws with which we disagree. You can criticize the law, you can write or lecture about the law, and you can speak to the media or petition the voters" (People v. Kevorkian, 527 NW 2d 714. 1994).

The defence raised by Dr. Kevorkian ranging from compassion to the patient's right to die were all rejected. Dr. Kevorkian was found guilty of murder and sentenced to a jail term.

Proponents of euthanasia in the Western world claim that the patient has a right to die or the right to choose to die. Such patients' rights groups lobby for recognition of such inchoate rights such as a "right" to terminate life. Opposition to such groups is largely from medical associations as well as religious groups who are morally opposed to the practice.

In Africa, Ernest Owusu-Dapaa (2013) suggests that although data is not available, euthanasia is practiced quietly in the health facilities. He states;

> "Euthanasia is practised on the quiet in health facilities and private homes especially in the rural areas. Contrary, to the popular reasons assigned, in the literature in the Western world, for the practice or quest for legalization of euthanasia being a necessity for providing relief from pain or hopeless quality of life, empirical data from social and anthropological studies conducted in Ghana reveal that poverty is the motivation for informal euthanasia practice in Ghana rather than genuine desire on part of patients to die or their relatives to see to their accelerated death" (Owusu-Dapaa, 2013).

In Kenya, no information exists on the moral justification that medical practitioners use to justify active euthanasia. Nonetheless, in the questionnaire we availed to the medical practitioners, the reasons that were advanced included patient's autonomy,

compassion and the medical practitioner making a decision that a patient's condition was not reversible. These are the three grounds advanced by medical practitioners in Nairobi.

Compassion is a predominant reason advanced in the Western world and also in Nairobi. There is great danger in justifying active euthanasia on compassion. Compassion can be an emotion as well as a virtue in Christian moral theory. As Thomas Aquinas states, mere pity can distort perception and judgment. (Nussbaum, 2004) Compassion alone cannot be a basis upon which a duty towards a suffering patient can be grounded. Whereas compassion can alert us to the plight of a patient, any meaningful response needs the support of prudential consideration before it can be truly rational and virtuous.

2.4. MORAL REASONS THAT MEDICAL PRACTITIONERS USE TO JUSTIFY ADMINISTRATION OF PASSIVE EUTHANASIA

Withholding life sustaining medication and/or nutrition so that the illness can take its natural course is referred to as passive euthanasia. Examples of such practices include switching off respirators; discontinuing nutrition or failure to resuscitate. Administration of huge doses of morphine to control pain may also have the double effect of inducing death although death is not primarily intended. Since death is not intended, administration of such medication is morally licit and does not constitute euthanasia.

Passive (voluntary) euthanasia is where life-sustaining or life-prolonging measures are withdrawn or withheld in response to a competent patient's request whereas active euthanasia refers to an intentional act of termination of life at the express request of a patient. However, on critical analysis, the distinction between passive and active voluntary euthanasia is neither clear nor morally certain. A distinction cannot be made on the basis of acts or omissions i.e. letting the person to die or taking a step to procure the death. Considering that the act or omission lead to death, the moral distinction may seem blurred. Nonetheless, a distinction is evident given that in active euthanasia death is a direct consequence to a positive death inducing act whereas in passive euthanasia, the natural progression of the illness is allowed to take its course.

Since antiquity, there has been a widespread belief that passive voluntary euthanasia, whereat life sustaining procedures are withdrawn in response to the request made by a competent patient, is morally acceptable. It is taken to be morally licit on account that no steps are taken to prolong life if, for instance, the prolongation of life is not coupled with any reasonable expectation of recovery from the illness. In contrast, active voluntary euthanasia is considered morally illicit on account that it requires intentional act of terminating the life of a patient (Young, 1996).

In Nairobi, a hospital was reported as providing what in essence is an Advance Medical Directive as shown in Appendix C of this dissertation. In this directive, the patient's next of kin is at liberty to authorize the hospital not to administer life prolonging procedures which may sustain life if recovery from illness is not eminent.

Passive (voluntary) euthanasia may take place as an attribute of autonomy or exercise of other rights, for instance where the religion of the patient does not allow the patient to receive certain medical procedures as in the case of Marlette v Shulman (Ont. CA, Can LII 6868 1990). In that case, the patient, a Jehovah witness, was injured in a car crash. The patient had a card in her bag which stated that no blood transfusion should be given to her under any circumstances. The doctor did the transfusion despite being aware of the patient's position. He justified his decision on the basis that blood transfusion was critical to save the patient's life. The medical doctor's moral justification was rejected in a case instituted by the patient. The Court of Appeal held that the patient was entitled to refuse medical treatment on the basis of her religion as well as on the basis of privacy which would protect the patient from invasive medical treatment.

2.5 DECISIONS ON EUTHANASIA

2.5.1 Euthanasia Cases

Since antiquity, numerous instances are recorded of persons suffering intense pain seeking termination of their lives. For instance, in "The Women of Trachis" Heracles is said to have been suffering unbearable pain and he asked his son Hyllus to help him end

his life. Heracles told his son to "lay my body thereupon and kindle it with flame-pine torch. And let no tear of mourning be seen there." Hyllus aptly replied, "what deed dost thou require me my father that I should become the murderer guilty of thy blood?" whereupon Heracles responded "I ask you to be my healer." Death in this instance is equated with healing in that it ends the intense pain that a patient is suffering (Papadimitriou, supra).

In the recent past, numerous cases have been litigated on euthanasia. A few examples will suffice.

In Re Quinlan, the facts were that for reasons which were unclear Karen Quinlan ceased breathing for about two 15 minutes periods (Re Quinlan, 1976). It was determined that she was in a persistent vegetative state due to the brain damage which she suffered arising from prolonged lack of oxygen. The consensus amongst the medical practitioners was that;

> "Severe brain and associated damage, albeit of uncertain etiology, has left Karen in a chronic and persistent vegetative state. No form of treatment which can cure or improve that condition is known or available. As nearly as may be determined, considering the guarded area of remote uncertainties characteristic of most medical science predictions, she can never be restored to cognitive or sapient life. Even with regard to the vegetative level and improvement therein (if such it may be called) the prognosis is extremely poor and the extent unknown if it should in fact occur" (Re Quinlan, 70 N.J. 10,355 A. 2d 647 N.J, 1976 p 7).

The patient's father applied to court to be appointed the guardian of the incompetent daughter so as to have the legal right to discontinue the prolongation of her biological existence. The State of New Jersey opposed the application on the basis that the request would amount to murder. The Supreme Court of New Jersey upheld the father's application on the basis that the right to privacy is a fundamental right and the State must be limited in the intrusion it seeks to the individual's liberties.

The court also took note that it was highly unlikely that Karen Quinlan would recover from her condition. The court concluded that;

> "Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor, she will never resume cognitive life. And the bodily invasion is very great, she requires 24-hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube. Our affirmation of Karen's independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent, and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight. Nevertheless, we have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present" (Re Quinlan, supra p. 7).

This case was decided in 1976 and it upheld the patient's right to privacy (Re Quinlan, supra p.15). The right to privacy was held to be the basis which entitles the court to allow euthanasia to be administered. Privacy is a moral right which may tilt the scale against extra ordinary medical treatment in circumstances where no hope for recovery exists.

In 1988, the United States Supreme Court was confronted by a request made by Mr. and Mrs. Cruzan who intended to discontinue treatment for their daughter who had been on life support for more than 12 months (Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 1990). The Court held that a patient had a right to reject treatment and it would be obstructive to the patient's right of liberty to insist to the contrary. The court found that the medical treatment was intrusive and it made the patient a captive of the procedures. The court held intrusive medical treatment on an unwilling patient infringed the liberty of the patient. The court concluded that;

> "A competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause

> must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water" (Cruzan v. Director, Missouri Department of Health, supra).

The court upheld the patient's right to reject medical treatment as an attribute of liberty. Liberty is a constitutional right.

In Carter –Vs- Canada, the Supreme Court of Canada adopted a utilitarian approach when faced with the question of whether the ban on physician assisted suicide was constitutional. The Supreme Court upheld the finding of the Trial Court that prohibition against physician-assisted suicide denies seriously and irremediably ill persons "the opportunity to make a choice that may be very important to their sense of dignity and personal integrity". The court stated that;

> "An individual's response to grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request the removal of life sustaining medical equipment but denies them the right to request a physician's assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person" (Carter v. Canada, 1 SCR 331 2015).

In Marlette v Shulman, a 57-year-old woman was seriously injured in an accident and taken to the hospital while unconscious (Marlette v. Shulman, supra). A nurse discovered in the patient's handbag a card signed by her identifying herself as a Jehovah's Witness and requesting that no blood transfusion should be given to her under any circumstances. The doctor was informed about the contents of the card but personally administered blood transfusion to the patient after forming the view that transfusion was critically required to preserve her life. The lady made very good recovery from her injuries. She was discharged from hospital after 6 weeks and sued the doctor for negligence, assault, battery and religious discrimination. The trial judge accepted the plea of battery only, concluding that the card validly restricted the

doctor to give the patient blood transfusions and that there was no rational basis for ignoring that restriction. He awarded her damages of $20,000. The Ontario Court of Appeal affirmed the decision at trial. The Court of Appeal upheld the trial court's finding that the right to refuse treatment was an inherent right. In this case the court upheld the right to individual autonomy and self-determination by stating that;

> "Mrs. Marlette's right to protection against unwanted infringement of her bodily integrity outweighed the interest of the preservation of life and health and the protection of the integrity of the medical protection."

The court upheld the right of privacy; which protects a person against invasive medical treatment.

In Airedale N.H.S. Trust v Bland, the House of Lords considered the question whether the Hospital could discontinue life support that sustained the life of Tony Bland Airedale N.H.S. Trust v Bland, AC 789 1993). Tony Bland was a young man and a supporter of Liverpool F.C. He was one of the victims in the Hillsborough crush. He sustained life threatening injuries and in the end, he was in a persistent vegetative state. The patient continued in this state for three years and was kept alive by life support machines. The Court upheld the decision by the medical practitioners that there was no benefit in continuing Bland's life support. The court stated that;

> "In these circumstances, it is perfectly reasonable for the responsible doctors to conclude that there is no affirmative benefit to Anthony Bland in continuing the invasive medical procedures necessary to sustain his life. Having so concluded, they are neither entitled nor under a duty to continue such medical care. Therefore, they will not be guilty of murder if they discontinue such care" (Airedale National Health Service Trust v. Bland, supra).

In the Bland judgment, the court authorized euthanasia on the basis of the medical practitioners' unanimous conclusion that prolongation of life had no affirmative benefit to the patient. Rights of privacy and dignity tilted the scale in favour of euthanasia.

The rights which have been considered in euthanasia litigation include rights to privacy, dignity, liberty, religion, freedom and self-determination.

Courts have had occasions to consider whether compassion can be a defence in voluntary active euthanasia. For instance in August 1991, Dr Cox, a consultant rheumatologist in the United Kingdom, injected Mrs Boyes a lethal dose of potassium chloride (Republic v. Cox, 12 BMLR 38 1992). Potassium chloride is not an analgesic; it will, given intravenously, cause cardiac arrest which would cause death within minutes. Dr Cox had a 'warm relationship' with Mrs Boyes. She had been his patient for 13 years and it was clear that the Boyes family supported Dr Cox's action; indeed, they were grateful to him for administering the lethal dose. Mrs Boyes was terminally ill, in excruciating pain, and had repeatedly asked Dr Cox to end her life. When the case was reported by the duty nurse, the police were called in and Dr. Cox was charged with murder. The Court informed Dr. Cox in terse language as follows;

> "In doing what you did, you allowed what you knew to be your clear duty to be overruled by your deep personal distress and compassion for your patient, who was on the brink of a painful death" (Republic v. Cox, 12 BMLR 38 1992).

Although Dr. Cox was found guilty, he received a suspended sentence. The court was mindful that Dr. Cox was motivated by pity for the patient and implicitly, the moral justification for his act was compassion for the patient.

Similarly, in the leading case of S v Hartmann (3) SA 532 (1975), a South Africa Court considered compassion as the justification for euthanasia. Dr. Hartmann was charged with murder of his father. Dr Hartmann's father suffered progressively and untreatably from prostate cancer. In the terminal and emaciating stages of his illness, with no cure available and suffering great pain, the patient was given a heavy dose of morphine and Pentothal. Death took place within seconds. The court found that Dr. Hartmann had no desire to kill his father; his motives were compassionate and intended to relief his father's pain. The trial court concluded that;

> "This is a case, if ever there was one, in which, without having to be unfair to society, full measure can be given to the element of mercy" (S v. Hartmann, supra).

Compassion was used to greatly reduce the jail term to only one-year imprisonment. Compassion due to the pain that the patient was suffering was an extenuating circumstance and greatly intervened in the reduction of the jail term.

A case that generated intense public debate relate to Mr. Sean Davison. Mr. Davison was a South African scientist and head of the forensic laboratory at the University of Western Cape. Mr. Davison's mother was writhing in unbearable pain consequent to last stage of cancer. He crushed morphine tablets, and assisted his mother to drink the concoction fully aware that it will induce fairly instant death. At his trial on a criminal charge of procuring the death of his mother, Mr. Davison remarked:

> "I did the compassionate thing by helping my mother to her death. I believe any humane person would have done the same thing; if I committed a crime, it was a crime of compassion to help my mother." (The Guardian, 2011)

Proponents for compassion as a justifiable moral ground for administration of euthanasia consider that compassion does obligate one to act so as to relief the pain of the patient. Compassion is taken as creating a duty to act. For instance, Bok Sissela states that compassion adds inherency into the debate on euthanasia. Bok states that; "Far from it being morally wrong to accede to such a request, it would be cruel in the extreme to stand by without coming to the aid of the person pleading for release" (Bok, 1973). Compassion for the patient calls one to act; to relieve the patient from the excruciating pain, it is argued. It is an argument without a moral compass; it does not relieve the patient from the pain; on the contrary, it exterminates the patient altogether.

A detailed analysis of whether compassion can be a moral justification for euthanasia is considered in a subsequent chapter. Suffice to say that compassion cannot justify extermination of life.

2.5.2 Euthanasia in Kenya

In Kenya, nominal literature exists regarding voluntary euthanasia. Euthanasia was discussed at the Annual Association of Medical Councils of Africa Conference which took place in Nairobi in September 2015 (Daily Nation, September 2015). The key speaker, the President of Health Professions Council of South Africa strongly

condemned the practice of euthanasia and recommended better palliative care to alleviate suffering for the terminally ill (Daily Nation, September 2015).

The Constitution of Kenya, 2010 sets out several inalienable human rights. The 'rights' relevant to the dissertation are;

"Article 26 Right to Life

(1) Every person has the right to life

Article 28 Human Dignity;

Every person has inherent dignity and the right to have that dignity respected and protected

Article 31 Privacy;

"Every person has the right to privacy, which includes the right not to have.... their person, home or property searched; their possessions seized; information relating to their family or private affairs unnecessarily required or revealed; or the privacy of their communications infringed."

Article 32 Freedom of conscience, religion, belief and opinion provides;

"Every person has the right to freedom of conscience, religion, thought, belief and opinion.

Every person has the right, either individually or in community with others, in public or in private, to manifest any religion or belief through worship, practice, teaching or observance, including observance of a day of worship.

A person may not be denied access to any institution, employment or facility, or the enjoyment of any right, because of the person's belief or religion.

A person shall not be compelled to act, or engage in any act, that is contrary to the person's belief or religion"

We now proceed to consider how such human rights were litigated in several landmark euthanasia cases.

The Constitutional rights enumerated above which include right to dignity, privacy, religion e.t.c. can be the foundation of a moral and/or legal argument to the effect that a person has full autonomy over his body which is absolute. Such an argument would be similar to the famous statement by Justice Cardozo in the 1914 Schloendorff case to the effect that "every human being of adult years and sound mind has a right to determine what shall be done with his body." (Schloendorff v. Society of New York Hospital, 105 N.E. 92, (NY 1914). Such an absolute utilitarian exposition would thus be a basis for treating man as the sole custodian of the right to decide when to quit the theatre of life and to create a concomitant duty on a medical practitioner to act on that request. It is such statements, made in absolute terms, which have made euthanasia a complex topic for analysis.

For instance, based on the right of freedom of religion, a Jehovah's Witness could thus contend that since the Bible prohibits ingesting blood, adherents of Jehovah Witnesses should never accept blood transfusion or donate blood for transfusion. This argument would be founded on Leviticus 17:10-17 which states;

> "I will set my face against any Israelite or any foreigner residing among them who eats blood, and I will cut them off from the people" [New International Version, 2011].

A Jehovah's Witness could thus claim that medical treatment which would include blood transfusion is against his religious belief and therefore contrary to Article 32 (4) of the Constitution. In those circumstances, the Jehovah's Witness would be agitating a right to refuse medical treatment even if by doing so death was to ensue.

The rights set out hereinabove have been the basis of euthanasia litigation in the Western world and based upon utilitarian principles, voluntary euthanasia was allowed by the courts. The utilitarian principles identify man as complete in freedom. This is reflected in contemporary civil jurisprudence as aptly articulated by Justice Kennedy in

the 1992 United States Supreme Court case of Planned Parenthood – V – Cassey, 1992 that;

> "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." Planned Parenthood – V – Cassey, (505 U.S. 833, 1992).

Man is his own project and builds from scratch freely using such materials as he desires to achieve his project.

Applying Bentham's utilitarianism principles to euthanasia, one would argue that terminating the life of a patient who is suffering from excruciating pain eliminates physical as well as existential pain thus liberating the patient so as to enjoy pleasure and happiness. The fallacy in the argument is that it cannot be said that a euthanized person is in a state of pleasure.

The utilitarian approach leads to the philosophy of individualism. Individualism has become the theme in the Western world. It is all about self; my interest, my satisfaction, my happiness and all else is subordinated. The assumption is that man is free and autonomous (Clarke, 1999).

Notwithstanding the liberal rights set out in the Constitution, the Penal Code (Penal Code, 2014, Chapter 63) contains penal provisions regarding euthanasia. The liberal perspective in the Constitution that appear to identify man as free and autonomous contrasts sharply with a conservative natural law order set out in the Penal Code. The relevant provisions in the Penal Code are as follows;

Section 202 provides for the crime of manslaughter;

> "(1) Any person who by an unlawful act or omission causes the death of another person is guilty of the felony termed manslaughter.

(2) An unlawful omission is an omission amounting to culpable negligence to discharge a duty tending to the preservation of life or health, whether such omission is or is not accompanied by an intention to cause death or bodily harm."

Section 225 provides for the crime of aiding Suicide;

"Any person who-

(a) procures another to kill himself ; or

(b) counsels another to kill himself and thereby induces him to do so; or

(c) aids another in killing himself, is guilty of a felony and is liable to imprisonment for life."

Section 239 provides that;

"Any person who, being charged with the duty of providing for another the necessaries of life, without lawful excuse fails to do so, whereby the life of that other person is or is likely to be endangered or his health is or is likely to be permanently injured, is guilty of a felony and is liable to imprisonment for three years."

From the foregoing, it is evident that in Kenya, active voluntary euthanasia is likely to be regarded as manslaughter committed by a medical practitioner who by lethal injection, induces death. The lethal injection would be the unlawful act since euthanasia is not a permitted act in Kenya. A medical practitioner who prescribes drugs to a patient for the patient to use so as to induce death would be accused of aiding suicide. The act of prescribing the drugs and availing the prescription would be regarded as aiding the patient to commit suicide and thus within the provision of section 225 of the Penal Code. Finally, as regards passive euthanasia, the withdrawal of life support would be regarded as a failure to provide the necessaries of life and thus an indictable offence under section 239 of the Penal Code. A medical practitioner is charged with a duty to provide the necessaries of life for the patient hence the withdrawal of such necessaries is the offence envisaged by the section.

Hence euthanasia or physician assisted suicide are indictable offences under the Penal Code.

2.6. ETHICAL VIEWS ON EUTHANASIA

2.6.1. Anthropological Perspective of Euthanasia

Anthropology is a study of man (Tylor, 1881). As a philosophical discipline, it enquires into the essence of the nature of man. It seeks to inquire into all aspects of human nature.

For instance, Plato considered man as a rational spirit and soul. Man, as a personal being transcends family and society. The difficult problem in anthropology is the fact of human death. If we accept that the existence of the soul is independent of matter, it means that at the time of disintegration of the body, the independently existing soul cannot cease to exist. In relation to this analysis, Benedict de Spinoza states that "which possesses existence by itself cannot arise or be destroyed except through itself" (Kisner, 2011).

Death is thus a disintegration of the human body simpliciter. However, since man possesses a soul then death is also an experience of the human spirit. To consider death as an end of life is to engage in fallacy as man has transcendental dimension.

Support for voluntary euthanasia therefore appears to be erroneously founded on the supposition that man has only one faculty namely, the body which disintegrates upon death. Voluntary euthanasia is thus seen as the instrumentality which extinguishes the pain and suffering endured by the patient by disintegrating the body. Disintegrating is thus perceived as the end of man.

Commenting of this view of man, Cormac Burke stated:

> "It follows that every individual is his own project: also, in the sense that in designing himself there are no given norms to follow. He builds from scratch, as he chooses, freely using the materials and situations of life so as to achieve his project" (Burke, 1995).

This view of man as a self-complete project is fallacious. Man cannot fulfil himself even at the most elementary level and to regard man as a self-complete project is to indulge in falsehood. Philosophy that accentuates individualism is incomplete and incorrect.

2.6.2. Kant's Moral Perception of Euthanasia

To evaluate moral philosophy of Immanuel Kant (1724-1804), it is necessary that one understands Kantian philosophy on the morals of man and his writings on reason. Immanuel Kant's most influential writings on moral philosophy are The Groundwork of the Metaphysics of Morals and his later works such as The Critique of Practical Reason and Lectures on Ethics.

Immanuel Kant is the proponent of the school of thought in Philosophy which advocate that the supreme principle of morality is the standard of rationality of the subject (Gregor, 1996). This means that a person derives moral principles from practical reason. Kant refers this principle to as Categorical Imperative.

Categorical imperative is an objective, rationally and unconditional principle that one must follow despite natural desires to act to the contrary. Accordingly, immoral actions are irrational and violate categorical imperative.

Morality has been defined as a set of rules, laws and principle which are the same for everyone. By analysing moral concepts such as duty and good will, Kant concludes that we are only free and autonomous as long as morality exists (Gregor, 1996).

Morality can only be derived from reason. A person does not just do things; rather he makes choices which are guided by maxims that explains the true justifications for his acts. Kant addressed the question on moral philosophy to the first person, i.e. what ought I to do? In answering this question, man has to understand the nature and extent of the specific moral duties that apply to him.

Kant attempts an analysis of moral concepts of duty and good will. Kant's basic idea is that what makes a person good is the possession of a will that makes its decision on the basis of moral law. A good will enables a person to make decisions that he holds to be morally worthy and considers moral questions to guide his behaviour. In Kant terms, "a good will is a will whose decisions are wholly determined by moral law" (Johnson,

2004). Kant concludes that, "man cannot have the kind of freedom which morality presupposes because the knowledge and experience of man only arises within the limits of his cognitive powers" (Johnson, supra). Secondly, man can pursue pleasure only on the condition that he does not give up his moral convictions. Accordingly, a good will must be good in itself and not in relation with the agents' happiness or welfare. Kant concludes that a good will shine like a jewel even if it were completely powerless to carry out its aim (Johnson, supra).

According to Kant, motivation by duty consists of respect for moral law. Kant defines duties as rules or laws of some sort combined with some sort of felt constraint or incentive on our choices, whether from external coercion by others or from our own powers of reason. For instance, the constitution of a society lays down duties for its members and enforce them with sanctions. Likewise, the Constitution of Kenya establishes the duties of citizens and enforce them with coercive legal power. Therefore, we are duty bound to respect laws that pertain to us.

Man recognises that moral law is the supreme authority that binds everyone; also referred to as 'universal law'. Therefore, the feeling of constraint to be bound by moral law is one's recognition that moral law as a source of moral requirements. Only universal laws could have the force of morality.

By comparing motivation by duty with other motives such as self-interest, self-preservation, sympathy and happiness, Kant confirms that if a dutiful action arises from such motives, however praiseworthy it may be, it does not express a good will. It is only when one overrides these motivations with the motive of duty, the morality of the action would be out of the respect for moral law. The controversy lies with the fact that moral worth arises only out of one's actions motivated by duty; such a conclusion undermines other motives such as love and friendship. Kant affirms that man should not perform an act if it is morally forbidden and to perform an action if it is morally required (Gregor, 1996).

Kant inspired western philosophers because of the idea of the respect of persons also known as humanity formulation of the Categorical Imperative. Kant states that, "man should never act in such a way that we treat humanity, whether in ourselves or in others as a means only but always as an end in itself" (Gregor, 1996). By humanity, Kant

means our ability to rationally determine which ends to adopt and pursue. If one's humanity is treated as a means, and not also an end, then their power of making a rational choice is undermined. Man's ability to make free, rational choices gives human beings dignity and also the basis of man's absolute value. Kant argues that everything else only has value because it is adopted by a being with humanity.

The idea of autonomy is an important aspect of Kant's moral theory. Kant affirms that man can only understand and justify the moral requirements over him once he understands the limitation to his freedom. In support of Kant, Rousseau states that, "Freedom does not consist in being bound by no law, but by the laws that are in some sense of one's own making" (Gregor, 1996).

Kant concludes that people who commit suicide destroy their rationality in service to pain. Rationality is what bestows dignity on human beings. The act of termination of human life is related to virtue and justice. It is clear that Kant's philosophy does not support the practice of euthanasia. A Kantian approach would disagree that euthanasia is a licit act since it is prohibited by the law. According to Kant, whatever you do that is acceptable creates universal law. Universal laws do not have exceptions.

The shortfall of the Kantian argument regarding this study is that Kant believed that the act and not the consequence inform the moral concept. Kant fails to consider the benefit or the empirical end that an action will impact upon man. Euthanasia is an act that can only be understood from the consequential perspective.

2.6.3. Utilitarian View On Euthanasia

Jeremy Bentham in his scholarly works, Introduction to the Principles of Morals and Legislation, contends that the human person can be explained by pain and pleasure;

> "Nature has placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do. On the one hand the standard of right and wrong, on the other the chain of causes and effects, are fastened to their throne. They govern us in all we do, in all we say, in all we think:

> every effort we can make to throw off our subjection, will serve but to demonstrate and confirm it" (Bentham, 1789).

Bentham writes that the definition of the principle of utility is that which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question: or, what is the same thing in other words, to promote or to oppose that happiness (Bentham, 1789). Bentham also supposes that if pleasure is good, then it is good irrespective of whose pleasure it is. This means that pleasure or pain acts independently from the interest of the person acting.

Bentham dismisses natural rights on the basis that the rights are general and ambiguous. Rights can only be real if they are legal rights and have a specific object and subject. Accordingly, Bentham contends that there are some services that are essential to the happiness of human beings and those services cannot be left to others to fulfil at their discretion, but these individuals must be compelled, on pain of punishment, to fulfil them.

It can therefore be inferred from Bentham's theory that a terminally ill patient is essentially suffering, and the administration of euthanasia would contribute to the greatest happiness therefore making administration of euthanasia a compellable service to the patient. Further, according to Bentham, a legislation that limits the achievement of this happiness such as the penal law in Kenya is incorrect as this service would be essential in contributing to the greatest happiness of a patient.

Utilitarianism represents a philosophical school of thought that believes that the central theme of man is that he is an autonomous being. John Stuart Mill in his book, On Liberty, tells the struggle in Britain between the rulers and the ruled (Mill, 1859). Stuart Mill attempts to disprove the conduct of the majority and ruling elite in Britain during the 18th century who tried to make everyone act in a particular way. He acknowledged that there is need for a rationally grounded principle which governs a society's dealing with the individual.

In advocating for the harm principle, Stuart Mill states that;

> "The sole end for which mankind are warranted is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise" (Mill, 1859 p.13).

Mill believes that if man is to abide by the harm principle then it will lead to the development of individuality or the development of humanity. He states that;

> "In the part which merely concerns himself, his independence is a right absolute. Over himself, over his body and mind, the individual is sovereign" (Mill, supra p. 13).

Mill creates a territory upon which man exercises self-rule. In respect to that territory, man is the absolute ruler and neither state nor society has any role.

It is an oversimplification to regard an individual as sovereign. An individual depends on others and cannot be self-sufficient. Indeed, man by his nature cannot sustain himself but requires the complementarity of a female for continuance of the human race.

An example of the fallacy inherent in individualism is the life of Ernest Hemingway. Ernest Hemingway, Nobel Prize winner and one of the great American writers of the 20th century, lived the life of individualism to the end. In June 1961, A.E. Hotchner, a friend and his biographer, visited him in an attempt to talk him out of his depression and delusions. Hotchner stated in his book that, "Hemingway is not quite sane; but not (at least yet) quite mad either. He can express the issue very clearly, terribly clearly" (Stocco, 2016 p. 160). When Hotchner asked Hemingway why he wanted to kill himself, Hemingway retorted that; "Hotch, if I can't exist on my own terms, then existence is impossible. Do you understand? That is how I've lived, and that is how I must live - or not live" (Stocco, supra). A month later, Hemingway shot himself. His

terms were to be on top of life: writing, hunting, drinking etc. When he found himself, at 62, with waning powers and the prospect of nothing to live for, his mind - and his will to live - went. Happiness on his own terms had not proved possible and therefore life was not worth living. Identical with the Mill postulation, Hemingway considered that "over his body and mind" he was sovereign.

Individualism prescribes to the school of thought that what matters is the "self" i.e. my interests, my satisfaction, my happiness and all else is subordinated to self. "Individualism is never so powerful or as destructive as when the happiness it proposes to seek is also declaredly self-defined; I have the right to my happiness - as I understand it; and no one can question that right or the type of happiness I seek" (Hegel , 1837).

For many people today, to be happy on one's own terms is a right and a sacred principle of living. But life itself does not always respect a person's own terms. Practical experience clearly shows otherwise.

This dissertation debunks the notion that man can be assessed in terms of utility. By viewing a patient who is terminally ill in terms of utility, a medical practitioner could erroneously consider that administration of euthanasia is permissible so that the practitioner could commit his time to patients more likely to bounce back to health. The error in that conclusion arises from the premise that man can be viewed from a utility viewpoint.

Utilitarian philosopher for instance Mill believes that development of the individuality is the chief requirement for personal well-being. In cases of euthanasia, it can be said that patients who are in a vegetative state cannot develop their individuality. Mill also insists that a person is the best judge of his needs. Therefore, if a terminally ill patient requests for euthanasia, according to Mill then the medical practitioner should honour the request.

Utilitarianism is the foundational principle in the judgments of court cases where euthanasia was allowed. The hallmark of how revolting utilitarianism can be is manifested in the case of Dr. Chabot who performed euthanasia on a 50-year-old lady who was "unresponsive to treatment". He was convicted not for administering

euthanasia but for not following the set guidelines of seeking a second opinion from a physician. Peter Singer while reviewing the conviction states;

> "The Supreme Court of Netherlands accepted the more important claim that unbearable mental suffering could, if it was impossible to relieve by any means, constitute a ground for acceptable voluntary euthanasia. From a utilitarian perspective, Chabot and the Dutch Courts were correct" (Singer, 2003).

The more succinct comment is to note that the Dutch courts have extremely liberal interpretation of their deliberately liberal laws. That approach leads to a permissive culture where termination of life is not a fundamental issue but a choice which one could request for a variety of reasons or possibly for no reason at all.

2.6.4. Personalists' View on Euthanasia

Although Personalism is not a rigid philosophical doctrine, certain distinctive characteristics can be discerned that generally hold for personalism. These include an insistence on the radical difference between persons and non-persons and on the irreducibility of the person. Further personalism affirms the dignity of man.

Personalists have generally insisted on the falsity of Darwin's claim that man's difference from other terrestrial beings is one of degree and not of kind.

According to Boethius (477AD-524AD), a person can be defined as an individual substance of a rational nature. (Gilles Emery, 2011)

Emmanuel Mounier states that:

> "A person is a spiritual being established as such by its manner of subsistence and the independence of being; he maintains this subsistence by adhering to a hierarchy of values, freely adopted, adhered to and lived through responsible commitment and constant conversion; he therefore unifies all his activity in freedom develops through creative acts, the uniqueness of his vocation" (Gendreau, 1992).

Mounier's view of the person is that the person is inclined towards the community because man is a social being; community means united by love. Boethius and Mounier appreciated that a free and rational person must exist within a society.

In stressing the uniqueness of persons vis-à-vis all other entities, personalists influenced by Thomism designate the essential dividing line of reality as that which separates personal and non-personal being. Dealings with persons, therefore, require a different ethical paradigm from that used to describe dealings with non-personal realities. (Williams, 2005) The "rules" of dealing with non-personal reality do not hold when dealing with persons, and vice-versa. This radical dichotomy between persons and non-persons is essentially ontological but produces immediate consequences on the ethical level.

Thomas Aquinas (1225-1274) inspired Thomism as a philosophy. Thomism has its roots from a catholic theology and also Aristotle's eudemonism.

Eudemonism is when an act can be described as good or bad depending on whether it contributes to or deter us from a proper human end. The human end is the final goal at which human actions aim. Often, the final goal is eudemonia/happiness which should be understood as complete, perfect or well-being. Man has to have intellectual and/or moral virtue which enable one to appreciate happiness.

Aquinas claims that goodness and being are one and the same. (ST, q1) Aquinas means something is good so far as it exists. Evil has no actuality on its own. It requires a human being to convey it. (ST, q 5.1) Human goodness depends on performing acts that are in accord with our human nature.

Human have two powers. One cognitive and another appetitive. Cognitive is intellect which allows one to apprehend the goodness of a thing. Appetitive power of reason is the will, native desire for the understood good. An appetite that is responsive to the intellect.

Aquinas accepts that virtues are good qualities of mind where one chooses to live righteously. He states that, "Virtue is a habit that disposes an agent to perform its proper operation."

In 1625, for instance, Grotius wrote; "Man is, to be sure, an animal, but an animal of a superior kind, much farther removed from all other animals than the different kinds of animals are from one another" (Williams, 2005).

According to a typical personalist conception, the fundamental classification of all beings, created and uncreated, is the distinction between persons and non-persons. For many personalists, what makes man "unlike" other animals is different from what makes a baboon different from a giraffe, or even from what makes a baboon different from a rock (Williams, 2005).

Jacques Maritain states that:

> "Whenever we say that man is a person, we mean that he is more than a mere parcel of matter, more than an individual element in nature, such as is an atom, a blade of grass, a fly or an elephant...Man is an animal and an individual, but unlike other animals or individuals" (Maritain, 2012).

William Stern also writes that:

> "Despite any similarities by which persons are identified as members of humankind, a particular race or gender, etc., despite any broad or narrow regularities which are involved in any personal events, a primal uniqueness always remains, through which every person is a world of its own with regard to other persons" (Valsiner, 1998).

Many personalists see human beings as dealing with all other realities as objects (something related intentionally to a subject) but affirm a substantive difference between the human person and all other objects (Williams, 2005). The person alone is somebody rather than merely something, and this sets him apart from every other entity in the visible world. No precise and general position specific to personalists with regard to the nature of animals can be discerned. But the sharp distinction between somebody and something, in particular as applied to such other sentient beings, reflects both the influence on personalism of the Judaeo-Christian tradition and at least some of the general impact or spirit of distinctly modern, Cartesian rationalism, which latter is of course not unaffected by inherited Christian dualisms (Williams, 2005). Only the human being is typically conceived by personalism as simultaneously object and subject, while

at the same time this is held to be true for all persons, irrespective of age, intelligence, qualities, etc. For personalists, personal subjectivity assures that the human being's proper essence cannot be reduced to and exhaustively explained by the proximate genus and specific difference. Subjectivity becomes, then, a kind of synonym for the irreducibility in the human being (Williams, 2005).

But the broader, realist Personalism does posit, in the classical and scholastic tradition, the essential difference between man and all other objects on man's ability to reason, which differentiates a person from the whole world of objective entities (Williams, 2005). Since it is precisely his intellectual and spiritual nature that makes subjectivity possible, one can say that in the subjectivity of the human person is also something objective (Williams, 2005). Yet these personalists insist on the clear separation between non-personal beings and this subjectivity of the person which is derivative of his rational nature in a broader or higher sense. Regardless of how, more precisely, animals are to be understood, the person differs from even the most advanced among them by a specific kind of inner self, an inner life, which, ideally, revolves around his pursuit of truth and goodness, and generates person-specific theoretical and moral questions and concerns (Williams, 2005).

At the centre of personalism stands an affirmation of the dignity of the person, the quality, which constitutes the unique excellence of personhood and which gives rise to specific moral requirements. Dignity refers to the inherent value of the person, as someone and not merely something and this confers an absoluteness not found in other beings. Here classical-realist personalists reject the Hobbesian notion of dignity as the price set on an individual by the commonwealth and ally themselves rather with Kant in his assertion that dignity is inherent and sets itself beyond all price (Williams, 2005). The language of dignity rules out the possibility of involving persons in a trade-off, as if their worth were a function of their utility. Every person without exception is of inestimable worth, and no one is dispensable or interchangeable. The person can never be lost or assimilated fully into the collectivity, because his interrelatedness with other persons is defined by his possession of a unique, irreplaceable value. The agreement

with Kant in this regard can be said to constitute a bridge between personalism in the broader sense and personalism in the narrow sense (Williams, 2005).

Attributing a unique dignity or worth to the human person also throws light on the cardinal virtue of justice (Wojtyła, 1979). Rendering to each his due hinges on one's understanding of what each deserves, and this cannot be correctly ascertained without taking into account the dignity and worth that are at the same time general qualities of all persons, and inseparable from the singularity of each of them (Bowne, 1908). Whereas traditional ethical systems stress the internal mechanisms of the moral agent (conscience, obligation, virtue, etc.) and the effect that free actions have on moral character, personalists add to this a particular concern for the transcendent character of human action and the dignity of the one being acted upon. Mounier agrees that a person's absolute character provides for the possibility of absolute moral norms when dealing with persons (Gendreau, 2012).

The focus on the subjectivity of persons explains many personalists' insistence on the difference between the concept of "person" and that of "individual." Gilson wrote that;

> "Every human person is first an individual, but he is much more than an individual, since one only speaks of a person, as of a personage, when the individual substance under consideration possesses in his own right a certain dignity" (Gilson, 1932).

The major distinction is that an individual represents a single unit in a homogenous set, interchangeable with any other member of the set, whereas a person is characterized by his uniqueness and irreplaceability.

Von Balthasar, for example, wrote:

> "Few words have as many layers of meaning as person. On the surface it means just any human being, any countable individual. Its deeper senses, however, point to the individual's uniqueness which cannot be interchanged and therefore cannot be counted" (Williams, 2005).

In this deeper sense persons cannot, properly speaking, be counted, because a single person is not merely one in a series within which each member is identical to the rest for

all practical purposes and thus exchangeable for any other. Von Balthasar goes on to say:

> "If one distinguishes between individual and person (and we should for the sake of clarity), then a special dignity is ascribed to the person, which the individual as such does not possess...We will speak of a 'person'...when considering the uniqueness, the incomparability and therefore irreplaceability of the individual" (Williams, 2005).

According to Thomas D Williams, personalism embraces any school of thought or intellectual movement that focuses on the reality of the person i.e. human, angelic, divine and on his unique dignity, insisting on the radical distinction between persons and all other beings that are non-persons in nature (Williams, 2004). At the centre of personalism is the idea of person. Thomas Williams, further states that as a philosophical school, personalism draws its foundations from human reason and experience, though historically personalism has nearly always been accompanied by biblical theism and insights drawn from revelation (Williams, 2004).

As an ethical theory, personalism is fundamentally phenomenological by nature; it is based on the results of observation of and participation towards reality. Personalism is based upon our shared human nature. A human person is the only being capable of self-reflection and comprehension of the meaning of life. Thomas Williams argues that it is Karol Wojtyla who presented in schematic form the essentials of personalism grounded in Thomas Aquinas. Wojtyla had presented a paper on February 17, 1961, during the Fourth Annual Philosophy Week at the Catholic University of Lublin entitled Thomistic Personalism (Modras, 1980).

Karol Wojtyla refers to the writings of Thomas Aquinas in his Summa Theologica where Aquinas stated that:

> "Consciousness can be considered a derivative of power of the human person, an active power arising from the rational object, a what but also a subject, a who, and primarily so the principle of the human soul. Consciousness is the power to be present to and aware of reality-it is

receptivity to being through experience. Self-consciousness is the power to be self-aware in one's consciousness of reality" (Aquinas, 1274).

Karol Wojtyla correctly acknowledges that, it is not the activity of the person that is important but the nature of being. Human actions arise in and from the being and nature of man; they are manifestations of the being and its nature as specified by rationality.

Accordingly, man can only be understood universally through analysing his relationship with other men, with the world and with God. Other philosophical underpinning such as individualism which is the main justification for euthanasia can be termed as "falsehoods" because they neglect the role of the community and man's relationship with God.

In his encyclical on the Evangelium Vitae, Karol Wojtyla advocates for the protection of life, from conception to its natural end, a highly positive character and great new spiritual thrust (Pope John Paul II, 1995). Karol Wojtyla demonstrates new and unprecedented threats to life and rapid spread of culture of death for instance abortion and euthanasia. The primary role of the encyclical is to proclaim the gospel of the value and dignity of each human life and its worth. Wojtyla also admits that the Church has been entrusted in the cause of the Gospel; which is cause of man and life.

2.7. THEORITICAL BACKGROUND

In discussing euthanasia, this dissertation ascertains the moral reasons that medical practitioners use to justify administration of voluntary euthanasia and consider those views against a personalist point of view. Personalism is essential in the understanding of the nature of man because it puts man at the centre of philosophical reflection. Personalist for instance Karol Wojtyla claim that man is the key in search for self-knowledge for correct insight into reality. Roman philosophy and Christian experience have had a strong influence on the views of personalists. Personalism had influence in drafting human rights treaties for instance, 1948 Universal Declaration of Human Rights (Moyn, 2008). Personalism gained traction after the Second World War. The World War

I gave the world a chance to reflect on the evil actions of war including mass killings and genocide.

Personalism has without doubt a depth of philosophical perspective of man which is not found in Utilitarianism. It is for this reason that this dissertation uses personalism and in particular the works of Karol Wojtyla as the philosophy that explains the nature of man and has the tools to evaluate whether the moral justifications which are ethically valid.

Voluntary euthanasia seeks to give dignity to a culture of death. Man should always seek a culture of life which was explained by Wojtyla as follows;

> "Man is called to a fullness of life which exceeds the dimension of his earthly existence because it consists in sharing the very life of God. The loftiness of this supernatural vocation reveals the greatness and the inestimable value of human life even in its temporal phase. Life in time, in fact, is the fundamental condition, the initial stage and an integral part of the entire unified process of human existence. It is a process which unexpectedly and undeservedly, is enlightened by the promise and renewed by the gift of divine life, which will reach its full realization in eternity. At the same time, it is precisely this supernatural calling which highlights the relative character of each individual's earthly life. After all, life on earth is not an ultimate but a "penultimate" reality; even so, it remains a sacred reality entrusted to us, to be preserved with a sense of responsibility and brought to perfection in love and in the gift of ourselves to God and to our brothers and sisters" (Wojtyla, 1995).

The Sacred Congregation for the Doctrine of the faith rejected euthanasia given that the object is to cause death. The congregation firmly stated;

> "It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a foetus or an embryo, an infant or an adult, an old person or no one suffering from an incurable disease, or a person who is dying" (Ratzinger & Bovone, 1987).

Voluntary euthanasia is a morally illicit act; a penal offence and a practice which dehumanizes any person who participates in it. By a process of introspection or self-

reflection, a care giver who ends up terminating life acts contrary and in direct conflict with his vocation.

2.8. CONCLUSION

Debate on the morality of voluntary euthanasia continues to engage many nations of the world. The intention of this dissertation is to contribute to that debate. Legislation on euthanasia and/or judicial pronouncement on the intricate subject of when it would be permissible to terminate a patient's life should be based upon solid knowledge which, as appears in this paper, should take into account the transcendental nature of the man.

In the cases which are discussed in this chapter, it is evident that the judges were influenced by the utilitarian view of the person as well as the attributes which the law confers upon the person such as rights to liberty, privacy and dignity.

In the next chapter, a review is undertaken of the research methodology which is suitable for a dissertation of this nature bearing in mind the limited time available as well as the resources.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter discusses the research methodology used for the study. In this chapter the author outlines the research strategy, the research method, the research approach and the methods of data collection, The research required a systematic approach that involved appropriate, planning and execution of the set objectives. This task comprised of essential predefined components such as aims, population technique, outcome and statistical considerations.

This chapter entails two critical components: research design and methodology which need to be clarified at the outset.

3.2. RESEARCH

Different researchers and scholars in different fields have proposed the definition of 'research'. According to the Oxford Advanced Learners Dictionary of Current English (1986:720), research is defined as "systematic investigation undertaken in order to discover new facts, get additional information". Saunders, Lewis and Thornhill (2003) define research as "...something that people undertake in order to find out new things in a systematic way, thereby increasing their knowledge..." Another author has described research as " a process for acquiring new knowledge in a systematic approach involving diligent planning of interventions of discovery or interpretation of the newly gained information."

From the foregoing, it follows that research is a planned activity, aimed at establishing new facts and information about a particular phenomeon. The process of research involves the identification of a particular problem or area of interest, translating that problem into a research problem, collecting data, analysing the data and reporting the findings of the research.

3.3. RESEARCH METHODOLOGY

Research methodology is defined (Schwandt, 2007) as a theory of how an inquiry should proceed. It involves analysis of the assumptions, principles and procedures in a particular approach to inquiry. (University of Pretoria, 2010). Methodologies explicate and define the kind of problems that are worth investigating, what constitutes a researchable problem; testable hypotheses; how to frame a problem in such a way that it can be investigated using particular designs and procedures; and how to select and develop appropriate means of collecting data.(Creswell and Tashakkori, 2007)

3.4. RESEARCH DESIGN

Leedy (1997: 195) defines research design as a plan for a study, providing the overall framework for collecting data. Macmillan and Schumacher (2001: 166) define it as a plan for selecting subjects, research sites and data collection procedures to answer the research question(s). It serves to plan, structure and execute the research to maximize the validity of the findings (Mouton, 2001.). They further indicate that the goal of a sound research design is to provide results that are judged to be credible. Hence, research design is a strategic framework for action that serves as a bridge between research questions and the execution, or implementation of the research strategy.

Research designs have over the years been narrowed down to qualitative and quantitative methods. Qualitative and quantitative methods should not be viewed as complete opposites but instead represent different ends on a continuum (Newman & Benz, 1998). They are sometimes distinguished from each other as the use of words or open-ended questions in qualitative as opposed to the use of numbers or closed ended in quantitative (Creswell, 2009). Further, in the quantitative approach, the researcher and what is being researched are viewed as independent of each other, whereas in the qualitative approach, they are interactive and inseparable (Teddlie & Tashakkori, 2009).

Researchers in social sciences gravitated towards the qualitative methods from the mid-20th century (Creswell, 2009). This is because the qualitative method focuses on the experiences of people as well as stressing uniqueness of the individual (Parahoo 2014, p. 59). It has also been said to be a form of social enquiry that focuses on the way people

interpret and make sense of their experience and the world in which they live (Holloway, 2002). The qualitative research method is ideal for the research in question as it adopts a person-centered holistic and humanistic perspective to understand human lived experiences without focusing on the specific concepts (Morse & Field, 1996 p. 8).

Recently, integrating qualitative and quantitative methods has become common in research (Bryman, 2006) as it has been seen to provide detailed and comprehensive data that leads to the achievement of research objectives and answer the research questions. This study employs the use of the mixed method as the researcher uses the qualitative method to explain the information gathered using the quantitative method. This is the explanatory design that is recognized as the most easy and straightforward of the mixed method designs (Creswell & Clark, 2007).

3.4.1. Mixed Methods Research Methodology

This study adopted a mixed method research approach. Kemper, Springfiled and Teddlie (2003) define mixed methods design as a method that includes both qualititative and quantitative data collection and analysis in parallel form. This means that two types of data are collected and analysed in sequential form. Bazely refers this method as the "use of mixed data (numerical and text) and alternative tools (statistics and analysis), but apply the same method.

Creswell, Fetters, Ivankova (2004; 7) argue that mixed methods research is more than simply collecting both qualitative and quantitative data; it implies that data are integrated related, or mixed at some stage of the research process. When used in combination, both qualitative and quantitative data yield a more complete analysis and they complement each other. In pursuit of the same argument regarding the logic of mixed methods research, (Johnson and Onwuegbuzi, 2004: 17) indicate that mixed methods research includes the use of induction which refers to the discovery of patterns, deduction which involves testing theories and hypotheses and abduction which refers to uncovering and relying on the best set of explanations for understanding one's results.

Sale, Lohfield and Brazil (2002: 46) comment as follows with regard to the combination of the two methods:

> "Both approaches can be combined because they share the goal of understanding the world in which we live. They share a unified logic, and the same rules of inference apply to both. A combination of both approaches provides a variety of perspectives from which a particular phenomenon can be studied and they share a common commitment to understanding and improving the human condition, a common goal of disseminating knowledge for practical use. Both approaches provide for cross-validation or triangulation –combining two or more theories or sources of data to study the same phenomena in order to gain a more complete understanding of that phenomenon (interdependence of research methods) and they also provides for the achievement of complementary results by using the strengths of one method to enhance the other (independence of research method)."

In support of this view, Onwuegbuzie and Leech (2006;479) identify the following rationales for mixing qualitative and quantitative approaches: participant enrichment, instrument fidelity, treatment integrity and significance enhancement.

Participant enrichment refers to increasing the number of participants in the research. Leech (2006) contends that the larger the sample, the more reliable and valid the research the research findings will be. In terms of this rationale, the sample used for this study was limited to medical practitioners based in Nairobi where 55 participants filed the questionnaire. All the 55 participants' responded to the questionnaires.

Instrument fidelity refers to maximizing the appropriateness and/or utility of the instruments used in the study. For the purpose of this research, two instruments were used namely; questionnaires and interviews. The questionnaire for medical practitioners is appropriate in as far as it assisted the researcher to solicit biographical information of the medical practitioners, confirm occurrence of voluntary euthanasia, communities practicing euthanasia and moral/ethical consideration of the medical practitioners on voluntary euthanasia.

Treatment integrity refers to mixing qualitative and quantitative research methods in order to assess the fidelity of interventions, treatment or programmes; and significance enhancement refers to maximizing the researcher's interpretation of data.

3.4.2. Quantitative Research Methodology

Quantitative research, (Van der Merwe, 1996) is a research approach aimed at testing theories, determining facts, demonstrating relationships between variables and predicting outcomes. Quantitative research uses methods from the natural sciences that are designed to ensure objectivity, generalizability and reliability (Weinreich, 2009).

The techniques used in quantitative research include random selection of research participants from the study population in an unbiased manner. The standardized questionnaire and statistical methods are used to test predetermined hypothesis regarding the relationship between specific variables. The researcher in quantitative research, unlike in the qualitative paradigm where he is regarded as a great research instrument due to his active participation in the research process, is considered as being external to the actual research and results are expected to be replicable, no matter who conducts the research.

3.4.3. Qualitative Research Methodology

Qualitative research is a research approach aimed at the development of theories and understanding. Denzin and Lincoln (2005) define qualitative research as a situated activity which locates the observer in the world. It involves an interpretive, naturalistic approach to the world, i.e qualitative researchers study phenomena in their natural settings, attempting to make sense of , or interpreting phenomena in terms of the meanings people bring to them. Qualitative research implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured. (Denzin & Lincoln, 2005:10)

In support of this assertion, Patton (2001: 39) defines qualitative research as;

> "An approach that uses a naturalistic approach which seeks to understand phenomena in context-specific settings, such as real world settings, where the researcher does not attempt to manipulate the phenomena of interest... it is any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification but instead the kind of research that

produces findings derived at from real-world settings where the phenomena of interest unfold naturally."

Weinreich (2009) indicates that the purpose of qualitative research is to provide the researcher with the perspective of target audience members through immersion in a culture or situation and direct interaction with the people under study. This implies that in the qualitative paradigm the researcher becomes an instrument of data collection, and results may differ greatly depending on who conducts the research.

The objective of qualitative research is to promote better self-understanding and increase insight into the human condition. Unlike quantitative research which has, as its objective, collecting facts about human behaviour that will lead to verification and extension of theories, qualitative research emphasizes the improved understanding of human behaviour and experience.

Qualitative methods include direct observation, document analysis and overview, participant observation and open-ended unstructured interviewing. These methods are designed to help researchers to understand the meanings people assign to social phenomena and to elucidate the mental processes underlying behaivors. Qualitative inquiry is a research approach that is generally conducted in natural settings utilizing the researcher as the chief instrument in both data gathering and analysis. The benefits of qualitative inquiry are embedded in its thick description, i.e obtaining real, rich , deep data which illuminates everyday patterns of action and meaning from the perspective of those being studied. This view empahsizes the importance of the voice of the researched and gaining first hand information regarding the lived experiences of the research on a particular subject. It tends to focus on social processes, where the established relationship between the researcher and the respondents is valued, rather than primarily or exclusively on outcomes."

Qualitative inquiry involves employing multiple data gathering methods, especially interviews and open ended questions in a questionnaire. Weireich (2009) concludes that the strength of using qualitative approaches is that they generate rich, detailed data that leave the participants' perspective intact and provide a context for the phenomena being studied. A disadvantage of data collection in the qualitative approach is that it may be labour intensive and time consuming.

3.5. RESEARCH METHODS

This is a mixed method research on moral views of medical practitioners in Nairobi regarding voluntary euthanasia. Given this focus, literature reviews, questionnaires and interviews were used to collect data. In theoretical studies such as social sciences the researcher produces his/her evidence to support arguments from existing facts or information. (Van der Merwe, 1996: 290)

3.5.1. Questionnaire

A questionnaire is a form containing a set of questions, especially addressed to a statistically significant number of subjects and is a way of gathering information for a survey. The Oxford Advanced Learner's Dictionary (1997: 952) defines a questionnaire as a written or printed list of questions to be answered by a number of people, especially as part of a survey. For the purpose of the resrarch, the questionnaire formed the second data collection method and its content was guided by the literature reviewed.

This study employed the use of a questionnaire as the tool to collect the relevant data. See "Appendix A"

The questionnaire was designed to collect data from the medical practitioners. The practitioners are based in Nairobi. The practitioners have a large client base from all parts of the country. The questions are designed to cover personal details of the medical practitioners; incidences of euthanasia and patient's rights.

The features of the questionnaire that made it most ideal for this study are; firstly, its impersonal nature which allows the respondents to remain objective in their responses and not be influenced by the researcher. A questionnaire facilitates responses to be gathered from different people in different locations relatively quickly, and cost efficiently (De Vaus, 1991). Thirdly, the standardized wording, order of questions and instructions for recording responses achieve a satisfactory level of uniformity. It has been found that respondents may have greater confidence because, an anonymity and open-ended questions are appropriate tool for enabling the participants respond in their

own words what the topic means to them and finally, it places less pressure on the participant for immediate response. (De Vaus, supra).

The medical practitioners were given adequate time to complete the questionnaire at their own time and with the assurance that their identity will not be disclosed.

The questionnaires were delivered to the medical practitioners by the researcher. The researcher held a brief discussions with the medical practitioners so as to impress upon the importance of the research. Thereafter, the medical practitioners were allowed adequate time to complete the questionnaire. After a few days, the researcher collected the completed questionnaire from the medical practitioners.

3.5.2. Construction and structure of the questionnaire

The questionnaire is in three sections. The first section seeks the medical practitioners' personal data such as age, gender, field of specialization etc. This would enable a further analysis which may involve the views of practitioners in one specialization as opposed to another specialization.

In section II of Appendix A are the incidences of euthanasia. This is the primary data that is sought in this research as no such data was available prior to the commencement of this research.

In section III of Appendix A relating to patients' rights and the moral grounds that would justify administration of euthanasia. Detailed analysis of the data is contained in chapter 4.

3.5.3. Interviews

Scholars have defined an interview as a social encounter where speakers collaborate in producing retrospective and prospective accounts or versions of their past or future actions, experience, feelings and thoughts. This study used focus group interviews (Seale, Giampietro and Silverman, 2004).

A focus group is a technique involving the use of in-depth group interviews in which participants are selected because they are a purposive, although not necessarily

representative sampling of a specific population, this group being focused on a given topic (Rabbie, 2004: 655). Lewis (2000) agrees that a focus group interview as a carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, non-threatening environment. According to Lewis (2000), this type of interview will yield both a more diversified array of responses and afford a more extended basis for designing systematic research into the situation at hand.

3.6.DATA COLLECTION

The researcher used questionnaires to collect quantitative data that provided statistical description, experience and instances of voluntary euthanasia among medical practitioners in Nairobi. The one on one interviews with some of the medical practitioners provided qualitative and exploratory data. In a qualitative perspective, the researcher attempts a first hand, a holistic understanding of a phenomenon and data collection is shaped as the investigation proceeds (De Vos, 1998).

3.6.1. Population and sampling procedures for the quantitave research

Population is "the total number of units from which data can be collected" (Parahoo 2014 p.218). According to Jennifer, population is all the elements that meet the criteria for inclusion in a study. (Jennifer, 2002)

The criteria for the population of this study in determining the population is;

(i) Medical practitioners licensed to practice in Nairobi.
(ii) Medical practitioners who deal with terminally ill patients.

3.6.2. Sampling

A sample is a proportion of a population (Polit, Hungler & Beck, 2001, p. 234). Sampling is premised on the notion that the outcome of the sample will be a representation of the entire population (Polit, Hungler & Beck supra, p. 232).

3.6.3. Sample Size

There are conflicting views in relation to the ideal sample size for qualitative research ranging from 30-1000 cases. However, the concept of saturation has emerged as the most acceptable factor to consider when arriving at sample size in qualitative research (Mason, 2010). This concept is understood on the basis that the data which has been collected or analysed is sufficient and further data collection and/or analysis is unnecessary. Saturation has been achieved when no new information is forthcoming from additional data.

In this study, a sample size of 55 medical practitioners based in Nairobi is adequate as there would be no new information forthcoming from additional medical practitioners. Kenya has about 9,149 registered medical doctors spread out across the country (Kenya Medical Practitioners and Dentist Board, 2016). Amongst those doctors only about 2,000 are specialists spread across the country (this number also includes inactive practitioners).

The sample is considered sufficient due to the small number of medical practitioners who have specialized in treatment of patients suffering from terminal illness. According to data from the Kenya Medical Practitioners and Dentist Board, there are only twenty (20) medical oncologists; two (2) critical care physicians and two (2) anaesthetists, critical care sub-speciality practicing in Nairobi. According to the data, there are no medical practitioners registered to practice in palliative care (See appendix "D", letter from Medical Practitioners and Dentists Board).

The study considers medical practitioners who are specialists in divergent fields and whose practice areas deal with terminally ill patients. From the small number of specialists in Nairobi it follows that a sample size of 55 medical practitioner in Nairobi with a wealth of experience in their areas is sufficient and any number beyond that would be repetitive.

In addition, due to Nairobi being a medical hub, patients from other parts of the country as well as neighbouring countries seek advanced medical treatment in Nairobi. The

medical practitioners based in Nairobi therefore attend to a large patient base. The wealth of experience reposed by medical practitioners based in Nairobi is unlikely to be found in other parts of the country.

3.6.4. Sampling Technique

This is the process used to select the group of people for the study. The processes are divided into; probability (random) sampling and non-probability methods. In probability sampling, all the members have an equal chance of being selected. However, in non-probability sampling researchers use their judgment to select the participants to be included in the study based on their knowledge of the phenomenon (Parahoo, 2014).

This study used non-probability sampling method more specifically purposive sampling so as to arrive at a sample with medical practitioners who would have the relevant knowledge as regards euthanasia. Purposive sampling is a non-probability method where the researcher deliberately chooses who to include in the study based on their ability to provide necessary data (Parahoo, 2014). The members are selected on the basis of their knowledge, relationships and expertise regarding a research subject

The justification of choosing this method is that it is paramount to get information from medical practitioners who handle terminally ill patients thus have the insight and experience required in providing information on the research subject.

3.7. ETHICAL CONSIDERATIONS

Clough and Nutbrown (2002: 84) view on ethics in research is as follows:

> "....in order to understand, the researchers must be more than technically competent. They must enter into chattered intimacies, open themselves to their subjects' feeling worlds, whether these worlds are congenial to them or repulsive. They must confront the duality of represented and experienced selves simultaneously, both conflicted, both real....."

It follows that in planning, the researcher had to protect the confidentiality of the medical practitioners and also to ensure than no self-incriminating answer was sort (See

Appendix E, Ethical Clearance Certificate from the Ethics Committee at Strathmore University).

3.7.1. Beneficence

Beneficence means doing good (Churchill, 1995). The researcher explained to all the participants the purpose of the study and the benefits that would be accrued from it. A letter from Strathmore University was most useful as an introduction. The letter was attached to each questionnaire. A sample of this letter is attached. See "Appendix B".

3.7.2. Voluntary and Informed Consent

Having been informed of the purpose of the research and the use of their information, the participant gave voluntary and informed consent for the information to be used for purposes of this study.

3.7.3. Maintaining Anonymity, Confidentiality and Privacy

The information provided by the medical practitioners was received in confidence. Further, there is no link between the information given and the medical practitioners thus maintaining anonymity as the identity of the medical practitioners were not disclosed in any way. There was also no intrusion of the medical practitioners' privacy as they completed the questionnaire on their own and not in the presence of the researcher.

3.7.4. Non-Maleficence

The researcher endeavoured to prevent any harm. Harm could include physiological, emotional, social or even economic in nature (Fouka & Mantzorou, 2011). The use of the anonymous questionnaire in particular significantly reduced the chances of psychological harm that would have been otherwise posed to the medical practitioners as the research subject is sensitive and has penal consequences.

3.8. DATA ANALYSIS

The sources of data were identified for this study as interviews and questionnaires, which are referred to as primary source of data and literature review as secondary data.

(Mounton, 2006: 164) Secondary data is collected for the primary purpose of re-analyzing the data.

3.9.ENSURING VALIDITY AND RELIABILITY

As this study entails the use of both qualitative and quantitative research data, the concepts used to express validity and reliability are broader than those traditionally associated with quantitative research. When examining qualitative data, the concepts of credibility; dependability; transferability and confirmability.

3.9.1. Credibility

This is the establishment that data is believable. In other words credibility is the confidence in data (Polit, Hungler & Beck, supra). Unfortunately, ultimate credibility using our qualitative method can only be given by the participants as the truth is subjective. The researcher however used the triangulation method to verify the credibility of the data. Triangulation involves the use of multiple and different methods, investigators, sources and theories to obtain corroborating evidence (Leech & Onwuegbuzie, 2007).

While employing triangulation, the researcher not only reviewed the data but verified the truth worthiness of the data by also reviewing the consistency of the data.

3.9.2. Dependability

A dependable study is accurate and consistent (Lincoln & Guba, 1985) It is also referred to as the stability of findings over time (Bitsch, 2005). It is the researcher's contention that the data is dependable as the conclusion arrived at as a result of it is also supported by literature (triangulation).

Further, the data was collected from medical practitioners with different years of experience, different areas of practice in medicine and different parts of Nairobi. The method that was used in this research has been laid out in detail in this study creating a "blueprint" that can be followed by another researcher to arrive at the same conclusion.

3.9.3. Transferability

Transferability essentially means that the findings of this study can be applicable to other scenarios with other Respondents. It is also referred to as generalizability (Holloway & Wheeler, 2002 p.255). A researcher enables transferability by a potential user through thick description and purposeful sampling (Bitsch, 2005 p.85). The researcher in this study used purposive sampling which targeted the specific medical practitioners who were in a position to give proper insights on the research topic. Through this sampling method, the researcher has facilitated transferability.

3.9.4. Confirmability

Confirmability is the establishment that data and interpretations of the findings are not a creation of the inquirer's imagination but indeed from the data (Tobin & Begley, 2004, p. 392). The means of confirmability is most often an audit trail that traces every step taken in data analysis in order to provide a rationale for the decisions. The researcher has detailed the process of data collection, data analysis, and interpretation of the data thus creating an audit tail and ensuring confirmability.

3.9.5. Triangulation

Cohen, Manion and Morrison (2000:112) define triangulation as the use of two or more methods of data collection to study a particular phenomenon. Jacob (2002) suggests that "often the purpose of triangulation in specific contexts are to obtain confirmation of findings through convergence of different perspectives. The point at which the perspectives converge is seen to represent reality."

Triangulation is a system of sorting though the data to find common themes or categories by eliminating overlapping areas. Triangulation was employed in this study. The 55 medical practitioners who were identified to complete the questionnaires and had a general discussion about the research for the focus group interviews from different hospitals in Nairobi.

For the purpose of this study, the 3 sources of data namely literature review, questionnaire and interviews are placed at the points of a triangle, where each data source provides a philosophical starting point for the other data sources.

The literature review was used to provide secondary data which assisted the researcher to formulate questions for the questionnaires and discussion points with various medical practitioners. Two types of data triangulation were used in this study, namely data triangulation and methodological triangulation.

Data triangulation concerns itself with the use of various data sources and in this study interviews, questionnaires and an in-depth literature review were conducted. Methodological triangulation concerns itself with the use of both qualitative and quantitative methods in the same study.

Triangulation offered numerous benefits for this study. First, it provided additional sources of valuable insight that could not be obtained from the literature review alone. It also minimized the inadequacies of single-sourced research by engaging three data source which complemented and verified each other, and it also provided richer and more comprehensive information in the sense that the researcher was able to draw information from various sources including first hand, lived experiences of medical practitioners in Nairobi. In this study, the researcher undertook to conduct focus group discussions as well as questionnaires to triangulate quantitative data.

3.10. CONCLUSION

The research methodology has focused on the research design and methodology that underpin this study. Detailed information regarding the mixed method design, its origins, its relevance to this study and its general characteristics were explored in this chapter.

Verifiability of the data can be ascertained with ease by cross referencing to answers provided in relevant questions.

In the next Chapter, the data that was obtained for the medical questionnaire is analysed so that answers to the research questions can be found. The answers are derived from the information that is provided by the medical practitioners.

CHAPTER FOUR

PRESENTATION OF RESEARCH FINDINGS

4.1. INTRODUCTION

In this chapter, the data which was obtained from medical practitioners is analysed and presented. The questionnaire is in three sections. Adequate care was given to the manner in which the questions were framed to ensure that nothing self-incriminating was included. In addition, every effort was made to ensure that no leading question was raised i.e. a question which suggests an answer. An assurance was made to the medical practitioners that answers to the questions will only be used for this dissertation.

4.2. SECTION I: PERSONAL INFORMATION

The first section of the questionnaire required the medical practitioner to provide personal details which are analysed as hereunder.

Question 1: Gender of the Medical Practitioners

In this question, the medical practitioner was requested to indicate his/her gender as an introductory exercise. The data that was gathered in gender is as hereunder;

Item	Gender of the Medical Practitioner	Number of Medical Practitioners
	Male	41
	Female	14
	Total	55

Table 4.1 Gender of the Medical Practitioners

Question 2: Age of the Medical Practitioners.

In this question, the medical practitioners were requested to indicate their biological age. The data that was collected is as hereunder;

Item	Age bracket	Number of medical practitioners
1	21-30 years	9
2	31-40 years	12
3	41-50 years	11
4	51-60 years	14
5	65-70 years	9
6	Over 71 years	0
	Total	55

Table 4.2 Age of the Medical Practitioners

It is apparent that a large number of the medical practitioners were between the ages of 31 years to 70 years.

Question 3: Experience

In this question, this medical practitioners were required to indicate the number of years the practitioner has practiced. The data that was received is as hereunder.

Item	Duration of Practice	Number of medical practitioners
1.	1-5 years	2
2.	6-10 years	16
3.	11-20 years	11
4.	21-30 years	16
5.	Over 31 years	10
	Total	55

Table 4.3 Experience

It is discernible that majority of the medical practitioners have served for a relatively long period of time as only 2 practitioners had served for 1-5 years.

Question 4: Current place of work.

The next question required the medical practitioners to indicate whether the practitioner is employed in a public institution, a private institution or both public and private sector. The data collected is summarized in the table below;

Item	Area of Practice	Number of Medical Practitioners
1.	Public institution	16
2.	Private Institution	36
3.	Both Public and Private Institution.	3
	Total	55

Table 4.4 Current place of work

Question 5: Specialization

The last question in this Section required the medical practitioners to indicate the areas of specialization. The data collected is as hereunder;

Item	Area of Specialization	Number of Practitioners
1.	Resident medical doctor	1
2.	Surgeons	8
3.	Consultant in nephrology	1
4.	Medical oncologist	4
5.	Specialist in internal medicine	2
6.	Specialist in critical care and anaesthetics	9
7.	Pathologist	2
8.	Specialist in family medicine	1
9.	Cardiologist	1
10	Consultant psychiatrist	1
11	Ophthalmologist	1
12	Urologist	1
13	Paediatrician	2
14	Endocrinologist	1
15	Gynaecologist	1
	Total	36

Table 4.5 Specialization of the medical practitioner

Regrettably, only 36 medical practitioners indicated their specialization. It is illustrative that only 1 practitioner is a resident medical doctor while the others are specialists in diverse fields.

4.3. SECTION II: INCIDENCES

In Section II of the questionnaire, medical practitioners were requested to answer questions relating to the occurrence of euthanasia. This section is titled "Incidences".

Question 1: Administration of euthanasia

The 1st question sought to establish if, in the experience of the medical practitioner, voluntary euthanasia takes place in Kenya. The medical practitioners' response to this question is summarized hereunder;

Item	Response	Number of medical Practitioners
1.	Yes	45
2.	No	10
3.	Total	55

Table 4.6 Administration of euthanasia

It is surprising that approximately 82% of medical practitioners answered the question in the affirmative, namely that voluntary euthanasia takes place in Kenya. This is a remarkable response given that notwithstanding the penal law in Kenya, the incidence of voluntary euthanasia is significantly high.

Question 2: Rate of incidence of "active euthanasia".
This question required the medical practitioner to rate the incidence of active euthanasia. The data collected is as hereunder;

Item	Rate of administration of Active Euthanasia	Number of Medical Practitioners
1.	High	0
2.	Occasional	5
3.	Rare	40
	Total	45

Table 4.7 Rate of administration of active euthanasia

It is a significant fact that 5 medical practitioners rate the incidence of active euthanasia as occasional. Since the other 40 medical practitioners rate the incidence of active

euthanasia as rare, the startling fact is the realization that active euthanasia is indeed administered notwithstanding the penal sanctions that exist. It is also illustrative that 45 medical practitioners indicated the rate of active euthanasia as between occasional and rare which is the identical number that answered the first question in the affirmative.

Question 3: Rate of incidence of "passive euthanasia".

This question required the medical practitioners to rate the incidence of passive euthanasia. The data obtained is summarised as hereunder;

Item	Rate of administration of passive euthanasia	Number of medical practitioners
1.	High	5
2.	Occasional	29
3.	Rare	21
	Total	55

Table 4.8 Rate of administration of passive euthanasia

It is significant that all 55 medical practitioners were in agreement that passive euthanasia takes place and only differed on whether the rate of incidence is high, occasional or rare. It is instructive that 34 medical practitioners show the rate of passive euthanasia as ranging between high to occasional. This shows an extremely high rate of prevalence of passive euthanasia in a country where the practice is illegal. Significantly, all the 55 practitioners were in agreement that passive euthanasia takes place and only differed on whether the occurrence was rare, occasional or high. Without doubt, this was a most significant revelation.

Question 4: Requested to administer euthanasia.

This question required the medical practitioners to indicate whether the practitioner had been requested to administer active voluntary euthanasia. The data that was received from the practitioners is as hereunder;

Item	Requested to administer "Active Euthanasia"	Number of Medical Practitioners
1.	Yes	12
2.	No	43
	Total	55

Table 4.9 Requested to administer active euthanasia

It is remarkable to note that whereas 12 medical practitioners had been requested to administer active euthanasia, 43 practitioners had not been requested. In keeping with sound ethical requirement, no follow up question was asked as to whether the medical practitioner acceded to the request. Such a question would, in view of our penal sanctions, be self-incriminating and unethical.

Question 5: The person who made the request for euthanasia.

In this question, the medical practitioner was requested to indicate the person who made the request. The data that was received is as hereunder.

Item	Person who made the request	Number of Medical Practitioners
1.	Patient	4
2.	Patient's next of kin	7
3.	Relatives	1
	Total	12

Table 4.10 Person who made the request

In total, 12 practitioners indicate that a request for active euthanasia had been made, albeit by different persons. In the previous question, 12 medical practitioners indicated that a request had been made to them to administer active euthanasia. The data generated for the 4th and 5th question were consistent.

Since 4 medical practitioners had been requested to administer euthanasia by a patient, this reveals a request by a competent patient. The requests by the patient's next of kin may relate to both competent and incompetent patients. The fact that 12 medical practitioners in a sample size of 55 medical practitioners had received a request for active euthanasia is startling in a country where euthanasia is an indictable offence.

Question 6: Whether the medical practitioner has administered "Passive Euthanasia"

In this question, the medical practitioner was requested to indicate whether the practitioner had occasion to withdraw medication or life support to a patient who was terminally ill i.e. administer passive euthanasia. The data that was received is as hereunder;

Item	Whether request has been made	Number of Medical Practitioner
1.	Yes	31
2.	No	24
	Total	55

Table 4.11 Whether medical practitioner has been requested to withdraw life support

It is significant that 31 out of 55 medical practitioners had been requested, in essence, to administer passive euthanasia. This is an extremely high incident rate in a country where the practice is illegal.

Question 7: How the decision to administer euthanasia was arrived at.

The follow up question required the medical practitioners to indicate how the decision to administer passive euthanasia was arrived at. The data collected is summarised as hereunder;

Item	How the decision was arrived at	Number of medical practitioners
1.	Evaluation of patients' condition	11
2.	Request by the patient's next of win	17
3.	Request by the next of kin and evaluation of patient's medical condition	3
	Total	31

Table 4.12 How medical practitioner arrived at the decision to administer passive euthanasia

In all, 31 medical practitioners indicated how the decision to administer passive was arrived at. The number of practitioners who responded corresponds with the number. It is illustrative that the majority of decisions for withdrawal of medication and/ or life support are consequent to requests from the patient's next of kin. This indicates that withdrawal of medication and/ or life support could largely be in respect to incompetent patients.

The data establishes that both active as well as passive euthanasia are indeed administered in Nairobi. This is a significant finding that warrants further in-depth research.

Although the medical practitioners are all based in Nairobi, their patients are from all over the country and the answers are derived from their clinical experiences. Hence, whereas the practice may primarily be attributable to Nairobi, it is probable that this is replicated in the entire country. Section III considers the basis upon which the right to request euthanasia is based and the reasons that would compel a medical practitioner to accede to a patient's request for euthanasia.

4.4. SECTION III: PATIENT'S "RIGHTS"

In this Section, the medical practitioners were requested to answer questions to establish the basis upon which a medical practitioner may accede to the patient's "right" to request for euthanasia.

Question 1: Patient's "right".

In this question, the medical practitioners were requested to indicate whether a patient or a patient's next of kin have a right to request for euthanasia. The data that was obtained is as hereunder;

Item	Patient or patient's next of kin has a right to request for euthanasia	Number of medical practitioners
1.	Yes	38
2.	No	17
	Total	55

Table 4.13 Patient or patient's next of kin has a right to request for euthanasia

As regards whether a patient or the patient's next of kin have a right to request euthanasia, 38 medical practitioners answered in the affirmative. This is a shocking answer. 17 practitioners answered in the negative.

Question 2: The basis of the right to request for Euthanasia

The next question sought to establish the basis of the right upon which a patient or the patient's next of kin could request for euthanasia. The data that was received is as hereunder;

Item	Basis of the right	Number of medical practitioners
4.	Freedom and Autonomy	12
5.	Compassion	13
6.	To reduce medical costs	6
7.	Freedom, autonomy rights and compassion	3
8.	Compassion and reduction of costs	4
	Total	38

Table 4.14 Basis of the right

The dominant grounds that are discernible are compassion as well as freedom and autonomy.

Question 3: Competence of medical practitioner to decide on euthanasia.

In this question, the medical practitioners were requested to indicate whether a medical practitioner is competent to decide whether euthanasia can be administered. The data that was received is as hereunder;

Item	Is the medical practitioner is qualified to decide when euthanasia can be administered	Number of medical practitioners
1.	Yes	34
2.	No	21
	Total	55

Table 4.15 Competence of medical practitioner to decide on euthanasia

The foregoing responses elevated to the fore whether an evaluation by a medical practitioner is a sufficient ground for the administration of euthanasia. This is further compounded by the fact that in absence of any guidelines, the evaluation would be subjective.

Question 4: Instances when euthanasia could be administered.

In this question, the medical practitioners were requested to indicate the instances when euthanasia can be administered. The data that was collected is as hereunder;

Item	Instances when euthanasia could be administered	Number of medical practitioners
1.	Intractable pain	3
2.	Terminal illness	10
3.	Intractable pain and terminal illness	4
4.	Death with dignity	5
5.	Tired of living	2
6.	Reduction of medical costs	4
	Total	28

Table 4.16 Instances when euthanasia could be administered

The instances that were presented to be grounds for administration of euthanasia were varied and this was in accord with the literature for the western world. The primary grounds upon which euthanasia could be administered were indicated as terminal illness and death with dignity.

It is illustrative that the majority of the medical practitioners i.e 10 out of 34 considered terminal illness as a sufficient ground for euthanasia whereas i.e 5 out of 34 considered death with dignity as a valid ground to euthanize a patient.

Question 5: Practice of euthanasia in society.

In this question, medical practitioners were requested to indicate whether there are communities who practice the equivalent of euthanasia. The data obtained is as hereunder;

Item	Practice of euthanasia in communities in Kenya	Number of Medical Practitioners
1.	Yes	25
2.	No	30
	Total	55

Table 4.17 Practice of euthanasia in society

Most of the practitioners i.e 14 out of 25 indicated that the community which practices the equivalent of euthanasia is the Somali community. 30 medical practitioners answered in the negative, namely that no community practices the equivalent of euthanasia.

Question 6: The rate of euthanasia in communities.

In this question, the medical practitioners were required to indicate the rate of practices of euthanasia in the communities. The data received is as hereunder;

Item	Rate of practice of euthanasia in the communities	Number of medical practitioners
1.	High	2
2.	Occasional	18
3.	Rare	5
	Total	25

Table 4.18 Rate of practice of euthanasia in the communities

In response to the last question under Section III established that, 20 out of the 25 medical practitioners who affirmed that some communities in Kenya practice euthanasia rated the occurrence of practice between high and occasional. This is still shocking data in view of the fact that euthanasia is an illicit act and has a penal sanction.

Question 7: The communities that practice equivalent of euthanasia.

This question required the medical practitioners to indicate whether the practitioner has knowledge of any community that practices the equivalent of euthanasia. The data collected in this regard is as hereunder;

Item	Community	Number of medical practitioners
1.	Somalis	13
2.	Maasai	3
3.	Muslims	3
4.	Europeans	2
5.	Turkana	1
6.	Asians	1
7.	Pokots	1
		24

Table 4.19 communities that practice equivalent of euthanasia

Predominantly, the Somalis were considered to practice the equivalent of euthanasia by a large number of practitioners.

Question 8: Ownership of life.

This is an open ended question which required medical practitioners to indicate how they consider human life i.e. is life a possession which the person owns or is it beyond ownership of the person. The data received is as hereunder;

Item	Views on human life	Number of medical practitioners
1.	Life is sacred, God Given and beyond human control.	43
2.	Life is owned by a person.	3
3.	Life is owned by a person though God given	2
	Total	48

Table 4.20 Views on human life

Significantly, the greatest number of medical practitioners indicated that life is given to the person by God thus appreciating the transcendental nature of the person.

Question 9: Comment on euthanasia.

The last question was also open ended. It requested the medical practitioner to comment on any issue relating to euthanasia. The data received is as hereunder;

Item	Comments on Euthanasia	Number of Medical Practitioners
1.	Euthanasia is justifiable in some circumstances.	7
2.	A patient and the patient's next of kin have the right to request for euthanasia	6
3.	Euthanasia is illegal.	12
4.	Medical practice should focus on providing palliative care	2
5.	Guidelines should be provided on administration of euthanasia	17
6.	Euthanasia is an emotive topic and there is need for more discussions to be held about it.	6
7.	Euthanasia should be legalised	1
8.	Passive euthanasia should be permitted in certain circumstances	1
	Total	52

Table 4.21 Comments on Euthanasia

The data reveals the divergent views on euthanasia ranging from 1 practitioner who considered that it should be legalised to 12 practitioners who were emphatic that the practice is illegal. It is illustrative that 17 medical practitioners consider that guidelines should now be provided on administration of euthanasia. Hence, despite the 12 medical practitioners who consider that euthanasia is illegal, a trend showing acceptance of euthanasia is evident.

4.5. CONCLUSION

From the responses received from medical practitioners, it is evident that euthanasia is carried out in Nairobi and the moral justification is not dissimilar to the justifications advanced in the Western world.

It is discernible that voluntary passive euthanasia is more prevalent than voluntary active euthanasia. As regards passive euthanasia, the predominant view is that the incidence is occasional. In discussions with medical practitioners, it was apparent that in the event of terminal illness, a practice has evoked whereby the medical practitioner after consultation with family members may decide that no resuscitation should be carried out. Such incidences of "no resuscitation" notice are common

As regards active euthanasia, the predominant view is that the practice is rare. Although it is reported as rare, the fact that active euthanasia takes place justifies a further in-depth research.

Perhaps in a bid to satisfy a growing need regarding incompetent patients, one hospital in Nairobi has published what is similar to an Advance Medical Directives whereby the patient's next of kin expressly directs the hospital not to engage in various life prolonging procedures. Whereas this may be considered a laudable effort, its legal efficacy is doubtful since no enabling legislation is in existence. A copy of the Advance Medical Directive is attached. "See Appendix C".

A troubling issue is the medical practitioners near unanimity that life is sacred yet from the answers on euthanasia, there is a widespread acceptance of the practice. Those who truly hold that life is sacred would be loath to countenance acts and/ or omissions intended to terminate life.

The penal law in Kenya is clear that even in circumstances where suffering is immeasurable, termination of life whether by active or passive means is illegal. The data that was received reveals that the penal sanction is no barrier to administration of both active and passive euthanasia.

In the next Chapter, a discussion of the parameters of the debate about voluntary euthanasia is undertaken. The Chapter identifies the principal ethical issues and arguments that drive the debate forward i.e. reasons that patient may cite to request for euthanasia (terminal illness and death with dignity) as well as the moral reason that a medical practitioner may give for acceding to a patient's request for euthanasia (patient autonomy and compassion). These reasons are contrasted to the personalist view on euthanasia. The chapter invites a conclusion that the reasons advanced by the patients as

well as the moral views advanced by medical practitioners to accede to the patient's request for euthanasia are morally illicit.

CHAPTER FIVE

DISCUSSION

5.1. INTRODUCTION

Human life is a basic, intrinsic good which is sacred and inviolable (Keown, 2002 p. 5). In the perspective of natural law philosophy, the divinity in human life is not subordinate to any condition be it quantitative, economic or ideological (Pope John Paul, 1995). The value of human life is interchangeably addressed by many words for instance "equality of life", "purity of life" e.t.c. However, the word sanctity has its own as it enhances the inviolability of life beyond municipal law enactments.

St. Thomas Aquinas considered that natural law expressed a "universal sanctity for human life" (Harigovind, 2013 p.1). Thomist view of natural law gave recognition of man-made law only to the extent that such laws were in accord with natural law. A secularization of natural law was not permissible. Accordingly, an intrinsically evil act was incapable of being anything other than evil (Harigovind, supra p.2). Hence, seeking one's death by means of premature termination of life or procuring the death of a patient are intrinsically evil acts. Being intrinsically evil acts, secular reasons cannot make them morally licit.

Philosophers such as Hume tried to downplay the significance of natural law edicts by seeking to posit a prominence of individual liberty. According to Hume;

> "......I owe my birth to a long chain of causes, of which many depended upon voluntary actions of men. But providence guided all these causes, and nothing happens in the universe without its consent and co-operation. If so, then neither my death, however voluntary, happen without its consent; and whatever pain or sorrow so far overcome my patience, as to make me tired of life, I may conclude that I am recalled from my station in the clearest and most express terms" (Harigovind, supra p. 3).

Hume seeks to elevate individual liberty to a high pedestal and further show that whatever action that the individual initiates can only succeed due to the will of

providence. The weak link in this analysis is the fact that one cannot ascertain that it is providence which has permitted the individual action to succeed.

From the research questionnaire, it was established that patients seek euthanasia due to what patients perceive as terminal illness. 10 out of the 34 medical practitioners expressed that terminal illness was a reason for patients to seek euthanasia. Another reason that was expressed as a ground to seek euthanasia is death with dignity. The latter reason was expressed by 5 of the medical practitioners. In both instances, patients consider that one is entitled to seek termination of life due to the discomfort brought about by illness. That illusion will be the subject of a discussion in this Chapter.

As regards medical practitioners, justification for administering euthanasia was indicated to be patient autonomy (12 out of 38 medical practitioner). In this view, a patient has a ''right" to seek euthanasia. The philosophical basis of that "right" is not discernible unless one invokes Hume's "providence" worldview. The other reason that was advanced by 13 out of 38 medical practitioners is compassion. Compassion as an act of mercy should direct one to seek ways to alleviate the pain and suffering. It is a contradiction in terms to terminate the patient's life and claim that the illicit act was driven by compassion. To ease the patient of the pain is radically different from terminating the patient's life. (Harigovind, supra p. 3)

Sequentially, the reasons advanced by the patients are discussed in a bid to ascertain whether the reasons are morally valid. Thereafter, the reasons advanced by the medical practitioners shall be reviewed to establish whether moral and ethical grounds exist to justify administration of euthanasia. The reasons advanced by the medical practitioners are evaluated further against personalist philosophy.

Any notion that may have hitherto existed that euthanasia is not administered in Nairobi has been found to be grossly incorrect. The correct situation is that both passive and active euthanasia are administered. The incidence of passive euthanasia is markedly higher than active voluntary euthanasia. It is therefore a matter of great significance to establish whether the new practice has any morally justifiable basis.

5.2. REASONS ADVANCED BY PATIENTS

5.2.1. Terminal illness

From the data received from the questionnaire, 10 out of 34 medical practitioners indicated that terminal illness is a ground upon which patients would seek voluntary euthanasia. Due that high incidence, it is necessary to review that ground in entirety.

Terminal illness is perceived to be an illness which is irreversible. Since the illness is beyond recovery, euthanasia is considered to be a mode of relieving the patient from the malady. The patient's "marathon of torture" is thus relieved by euthanasia.

Human life is sacred. Termination of life therefore should be weighed against sound philosophical basis. The pain and suffering a patient experiences due to illness does not diminish the sacredness of "life" since life cannot be subordinated to quantitative test. A patient's recourse is not termination of life but endurance of the condition with the assistance of palliative care (Dimmock, 2017).

St. Thomas Aquinas considers all forms of termination of life to be morally illicit. His explanation of sanctity of human life is based on the principle of totality. Thomist principle of totality considers that man is not ordained in himself as a totality but for something that is outside himself, including the spiritual aspect (Colbert 1978, p. 5). Since natural law frowns upon termination of life, terminal illness cannot be a proper basis for a patient to request euthanasia because the consequence is the unacceptable termination of life.

The governing principle in the stance taken by St. Aquinas is that since life is inviolable and given that everyone has the desire to conserve that which he values, a patient cannot seek termination of his life. A patient who requests euthanasia is not only engaging in self-destruction but also arrogates to himself a divine prerogative and sins against God. As one respects life, so should one also accept death in the knowledge that one is morally obligated to preserve his life (Colbert, supra p. 6).

From a natural law viewpoint, a patient's request for euthanasia "when all usefulness is over, when one is assured of an imminent and unavoidable death" is devoid of any sound philosophical basis (Rachels, 2007).

From the data gathered from the research questionnaire, it is manifest that patients cite terminal illness as a reason to justify euthanasia. The question that postulates itself is whether terminal illness can be a morally sound reason for a patient to seek euthanasia. Subsumed in that question is the further issue of what constitutes terminal illness i.e. at what point can illness be termed as irreversible.

Illness could be assumed to be terminal while in reality it is not. The misapprehension could be an error in judgment or a mistake in the diagnostic process. In addition, the prevailing knowledge may be inadequate to address the illness at that time but after some lapse of time, new knowledge may competently deal with the illness.

It could therefore be a misstatement to consider that a patient who is suffering from an illness has no prospects of recovery. An example of a conclusion that the patient was terminally ill which subsequently became incorrect is the case of Terri Wallis. On 13th July 1984, Terri Wallis who was then 20 years old, was involved in a motor vehicle accident which left him a quadriplegic and, in a coma, (Carey, 2006). After about a year, the coma stabilized into a minimally conscious state. The medical practitioners were unanimous that the patient would never recover. In 2003, nearly 19 years after the accident, Terri regained consciousness (Carey, supra). Tests carried out revealed that Terri's brain's neurons which had remained intact after the accident formed new connections bypassing the damaged areas. That ability of the neurons to make new connections was unknown to the medical practitioners at the time the conclusion was made that the illness was terminal. (Carey, supra).

Similarly, Mr. Jan Grzebski, a Polish citizen, received severe head injuries while trying to reconnect two railroad cars. He was in a coma for 19 years before he regained consciousness; though mute and paralysed, he was completely aware of his surroundings (The Guardian, 2007).

Numerous other examples exist, each manifesting man's ability to recover from what was initially considered terminal. What is perceived as a terminal condition may prove incorrect with the lapse of time. What may appear terminal may be illusory or dependent on present knowledge. In addition, the "opinion'' that the condition is terminal is subjective and may be as a consequence to a mistaken evaluation.

The concept of sanctity of life is not dependent on an individual having robust health. To the contrary, life is considered sacred notwithstanding the illness which may have invaded the individual. Accordingly, there should not be a tension between sanctity of life and suffering ill health. All life, whether of an individual who is experiencing robust health or who is mastered by illness is sacred. In essence, both are persons in being.

The administration of euthanasia to a patient due to a perception that the illness is beyond recovery violates the principle of sanctity of life as illustrated by the case of Regina-vs-Inglis. (Regina-vs- Inglis, 2011. 1 WLR 1110). In that case, Thomas, a 12-year-old boy, had suffered severe brain injury from an automobile accident. To save his life, doctors conducted surgery and decompression of his skull. The doctors opined that without a second surgery, Thomas would not survive. However, Thomas' mother regarded him to be in a "cabbage state'' and believed that another surgery would "subject her son to further and unnecessary suffering and no recovery." She therefore asked a neighbour to procure heroine for her so that she could end her son's life. She considered that she should terminate her son's life so as to "take him out of his misery and end his pain." On 4th September 2010, she administered a lethal dose of heroine to her son which the son succumbed to(Regina-vs- Inglis, 2011. 1 WLR 1110). . Although the mother may have considered the son's life as irreversible, the court was emphatic that the son was a person in being who was "alive". The Court held;

> "We must also emphasise that the law does not recognise the concept implicit in the defence statement that Thomas Inglis was "already dead but a small physical degree". The fact is that he was alive, a person in being. However brief the time left for him, that life could not lawfully be extinguished. Similarly, however disabled Thomas might have been, a disabled life, even a life lived at the extremes of disability, is not one jot less precious than the life of an able-bodied man" (Regina-vs- Inglis, Supra).

Similarly, in Airedale NHS Trust-vs-Bland, the House of Lords a terminally ill patient was a human being whose life was sacred. The court held;

> "Our belief in the sanctity of life explains why it is almost always wrong to cause the death of another human being, even one who is terminally ill or so disabled that we think that if we were in his position we would rather be dead. Still less do we tolerate laws such as existed in Nazi Germany, by which handicapped people or inferior races could be put to death because someone else thought that their lives were useless" (Airedale NHS Trust-vs-Bland, supra).

Contrary to the well-articulated position that life is sacred, utilitarianism posits that mankind is governed by pain and pleasure. Bentham's theory can be construed to mean that a terminally ill patient is suffering and administration of euthanasia would contribute to his happiness. How death can contribute to the happiness of the deceased is difficult to comprehend. One cannot, by a process of logic, conclude that a patient shall enjoy happiness after death.

Even if the patient requests euthanasia, it ought to be appreciated that the request may be as a consequence to defect in the patient's reasoning; defect in the information available or defect in the stability of the patient's desires (Hariss, 1994).

The troubling concern that is presented by the data gathered in the research questionnaire is that there is a near unanimity amongst medical practitioners that life is sacred and should be preserved; yet there is evident practice of euthanasia to terminate the life of a patient who is perceived to be suffering from a perceived terminal illness.

As regards patients suffering from terminal illness, the focus by the medical practitioner should not be a search for cure but to provide care for the patient because the quest for cure is a "dangerous myth that serves the patient and practitioner poorly" (Kleinman, 1988, p.229). The lived reality is that since death is the ultimate fate of all mankind, a medical practitioner and his patient should work towards care and not cure of the patient. To care for the patient suffering from terminal illness is directed towards the patient's existential predicament, namely restoring the integrity of the patient from the attack by the illness.

A single minded quest for cure will be equated with failure if the cure is not found. If cure is not found this "will easily become the motive for being abandoned" (Zaner, 1985, p.240). Those who are terminally ill "stand outside medicine as beyond its

apparent powers but also are living affront to it". To be incurable is therefore perceived as being "beyond help and this too easily becomes the motive for being abandoned" (Zaner, supra p.240). Abandonment triggers the need for euthanasia.

In contrast thereof, if the approach is to care for the patient, this will entail attentiveness to the patient's lived experience of suffering the terminal illness which is the main focus of phenomenological personalism. Suffering takes place at the reflective level and is experienced by the patient. Thus, suffering is intimately related to the perception which the patient has and the meaning which the patient attaches to his construct of the terminal illness (Toombs, 1992 p.109).

The need for a medical practitioner to provide care rather than cure to a patient can deepen the medical practitioner's appreciation of the terminal patient's experience of the condition by temporarily shifting from biomedical preoccupation to a lifeworld interpretation of the patient's disorder. By doing so, the medical practitioner will not only gain insight into the human experience of illness but may also be able to address the patient's suffering more effectively (Toombs, supra p. 98).

A patient who is terminally ill retains an element of mystery. Medical practitioners are well trained to tackle problems medically but are poor at reacting to the mystery of the terminally ill patient (Marcel, 1978). Gabriel Marcel distinguishes between a problem and a mystery in the following terms;

> "A problem is something which I meet, which I find complete before me, but which I can therefore lay siege to and reduce. But a mystery is something in which I myself am involved, and it can therefore only be thought of as a sphere where the distinction between what is in me and what is before me loses its meaning and its initial validity. A genuine problem is subject to an appropriate technique by the exercise of which it is defined; whereas a mystery, by definition transcends every conceivable technique" (Marcel, supra p.212).

A mystery demands a temporary suspension of a scientific approach and the presence of a personalistic approach as the medical practitioner is in truth involved in an issue which transcends every imaginable technique.

Determining the stage at which an illness could be regarded as terminal and irreversible thus justifying euthanasia is a complicated undertaking, as the experience of being terminally ill differs from one patient to another. At one end of the spectrum is the patient whose illness may not have advanced but passively welcomes death; on the other end of the continuum is the patient who may be undergoing excruciating pain yet frowns upon assisted death. In Belgium, before a physician can euthanize a patient, he has to be satisfied that the patient is "in a medically futile condition of unbearable condition and untreatable physical or psychological suffering" (Section 3 of the Belgian Act on Euthanasia, 2002). Equally in Holland, a physician is required to ascertain that the patient's suffering is without prospects of survival (Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002). These conditions are hollow as they permit a subjective review by a medical practitioner oblivious of any other aspect of the wholeness of the human person.

Terminal illness as a reason for seeking euthanasia is largely abstract because what constitutes suffering is indefinite, cannot be quantified scientifically and largely varies between different moral agents. Thus, a medical practitioner who responds to patient's pain by euthanizing the patient in order to rescue the patient from his suffering overlooks the fact that the roots of suffering are more than physical and reaches beyond a physician's responsibility and competence. (Hughes, 2008).

A medical practitioner commits a monstrous error of judgment by considering that death relieves a patient from the distress occasioned by illness. Euthanasia violates the moral law against murder and suicide. That law is immutable as its origin is natural law. Fernandez Ashley presents a graphic scene of a medical practitioner administering euthanasia to his patient:

> "The room seemed filled with the patient's desperate effort to survive...It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were; "Let's get this over with" I retreated with my thoughts to the nurse's station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20

> milligrams of morphine sulphate into a syringe. Enough, I thought, to do the job. I took the syringe into the room and told the two women I was going to give Debbie something that would let her rest and to say good bye. Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world...With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved. It's over" (Anonymous, 1988).

Although the morphine injection "rested" the patient, it cannot be said that death does liberate the patient who is in distress. The fact is that death terminates the life of the patient but the aspect of it "liberating" cannot be abstracted for the physical act.

In this regard, Leon Kass emphatically states;

> "One who calls for death in the service of personhood is like a tree seeking to cut its roots for the sake of growing its highest fruit. No physician, devoted to the benefit of the sick, can serve the patient as person by denying and thwarting his personal embodiment" (Kass, 1991).

Aristotle criticises euthanasia in his writings. He states that "to seek death in order to escape from poverty, or the pangs of love or from pain or sorrow is not the act of a courageous man, but rather of a coward" (Papadimitriou, 2007). Thus, to take away one's life is to commit an injustice against one's self.

Karol Wojtlyla criticizes the view that suffering arising from terminal illness can be a justification for euthanasia. On the contrary, it is such practice that can easily create the "culture of death" (Evangelium Vitae, 1995). In societies where there is the culture of death, the terminally ill and elderly are not tolerated and are considered burdensome. The Pope states;

> "With regard to the last moments of life too, it would be anachronistic to expect biblical revelation to make express reference to present-day issues concerning respect for elderly and sick persons, or to condemn explicitly attempts to hasten their end by force. The cultural and religious context of

> the Bible is in no way touched by such temptations; indeed, in that context the wisdom and experience of the elderly are recognized as a unique source of enrichment for the family and for society. Old age is characterized by dignity and surrounded with reverence (cf. 2 Mac 6:23). The just man does not seek to be delivered from old age and its burden; on the contrary his prayer is this: "You, O Lord, are my hope, my trust, O Lord, from my youth ... so even to old age and grey hairs, O God, do not forsake me, till I proclaim your might to all the generations to come" (Ps 71:5, 18). The ideal of the Messianic age is presented as a time when "no more shall there be ... an old man who does not fill out his days (Is 65:20)" (Evangelium Vitae, supra p 15).

Karol Wojtyla acknowledges that it is important for people who practice Christian faith to understand that suffering is a necessary experience. It is during the period of man's suffering, that man begins to question his existence. Similar circumstances of God using suffering to test their Christian faith has been well documented in the Bible. (Wojtyla, 1979). In the book of Job, it is recorded that;

> "Job had been lying in unrelieved misery for months with open sores all over his body. During this time he bore the grief of seven dead sons and three dead daughters. All of his wealth had vanished in one afternoon. He had become repulsive to his wife, loathsome to his brothers, and even little children despised him as he lay on the ash heap outside of town" (King James Holy Bible, 2010).

Suffering, Wojtyla explains, is an experience that man is called upon to endure. Consequently, euthanasia does not advance any good as it is plainly an intrinsic evil act. Further, the practice of euthanasia spurns the gift of life and embraces the curse (Pope John Paul II, 1998, p 16). Thus, from a biblical viewpoint, it is only through suffering and perseverance that God's purposes can be known to man.

A personalistic presence in the clinical procedures encourages the patient to appreciate the situation presented by the illness. As David Bakan states; "There are two major points in life which are beyond the scope of the individual will. One is conception; the

other is death. Between these, but not including them, the will of the individual has its proper sphere" (Bakan 1968, p. 128).

It is thus not within the will of the individual to seek termination of life. Phenomenological personalism acknowledges that, "health is not the all-encompassing good of the human person; it is utopian and unrealistic to conceive health in this matter" (Seifert, 2002, p.138). In this approach, the focus is not the cure but the care of the patient. Personalism therefore recognizes other goods apart from the biological and as asserted by Seifert, human goods such as love, community, virtue, transcendence, knowledge, friendship and beauty surpass the realm of biological health. Hence although the illness may be terminal from a biological view, the discovery of meaning in unavoidable suffering will orient the patient to the higher goods which would include seeking the Truth, the Beautiful and the Good (Seifert, supra).

A personalistic approach to voluntary euthanasia demonstrates that although the patient may be suffering from terminal illness coupled with unremitting pain, the patient is nonetheless capable of many other goods. In fact some of these goods may surpass health.

A medical practitioner can seek to be attuned to these goods by being sensitive and approach the illness from a personalistic viewpoint. Since it is the patient who participates in those goods, the medical practitioner should appreciate that certain priorities of the patient may override medical recommendations. This approach does not exclude biomedical attention but expands the lifeworld of the medical practitioner so that he is able to appreciate the patient's suffering with terminal illness. In that context, the patient can no longer be a candidate for euthanasia. To the contrary, the patient will be attuned to the higher goods which surpass health.

From the data collected for this dissertation, the second reason cited for a patient's request for euthanasia is death with dignity. The perception that a patient's autonomy is breached when one is compelled to endure the indignities that the dying process may involve has largely formed basis of the pro-euthanasia debate. The next subsection of this chapter examines whether death with dignity is a sufficient reason for a patient to

request for euthanasia. A conclusion is reached that there is no fluidity in the concept of death with dignity as the phrase "death with dignity" is amorphous i.e. for some patients, death with dignity means having an assisted death while for others it implies a natural death which is free from pain due to palliative care.

5.2.2. Death with Dignity

Dignity is defined as "the quality or state of being worthy, honoured or esteemed." It is something one may perceive in another, or in oneself. Dignity therefore has both an inherent and a perpetual aspect (Sulmacy, 1994).

Dignity is a right which inheres in men. Illness may interfere with various aspects of man's dignity such as inability to attend to one's private needs. In those circumstances, the patient may be constrained to seek assistance from other persons. It is the reliance on others that may tempt a patient to consider euthanasia so that termination of life is attained while the patient is still in control of his private needs.

5 out of 34 medical practitioners who confirmed that voluntary euthanasia is practiced in Nairobi cited death with dignity as a justification for seeking euthanasia. The concept of death with dignity is a request by a patient to be relieved from the indignity of having to rely upon other persons for his private and personal body functions. A patient may consider it a burden and discomfort to rely on assistance of others in his private needs.

In the natural law set up, all human beings have an inherent dignity that is not variable because all humanity is created in the image of God. The purpose of human dignity is communion with God and it is through the freedom that God has given man to dominate other creatures that man can choose goodness. Thus, euthanasia is an assault to human dignity (Harigovind, supra p. 2).

The contemporary concept of human dignity can be traced to the philosophy of Immanuel Kant in his Groundwork of Metaphysics of Morals where he asserts that there is an inherent "inner worth" in the human person that cannot be valued. This human worth is based on the rational nature of human beings that cannot be weighed against another value. Applying the Kantian philosophy to the euthanasia debate, it is

discernible that human dignity is of unquantifiable worth and cannot be compromised to relieve a person from any unpleasantries of life (McMahan, 2002 p. 508).

Whereas a patient's extent of terminal illness may possibly be assessed scientifically by medical evaluation, dignity as a schemata for euthanizing a patient is nonconcrete as it attaches to personal qualities of a patient.

Death with dignity connotes two claims- first that a life without dignity should be ended. This might be effected by withdrawing or withholding treatment or administration of life-ending treatment. The second claim is that people should be allowed to make choices necessary to secure a dignified death. The second limb is derived from the notion that certain conditions surpass palliative treatment to ensure death with dignity, hence, euthanasia should be administered (Allmark, 2002).

The proponents of death with dignity portray natural death as a slow, undignified process which is horrifying. A graphic scenario simulated in graphic details as follows;

> "Death is dreadful to watch. The skin and mucosa dry out, the blood thickens, the kidneys no longer produce urine and gradually die. The eyes become damaged for the lack of tears; the mouth is infested by fungal infections because the natural cleaning by saliva is lost. The body is gradually poisoned by the breakdown of products which can no longer be excreted. In the airways crusts of dried mucus develop which makes breathing steadily more difficult and so the unconscious patient fades away under the eyes of doctors, nurses and family. It can well take ten days or more before death arrives and in dying the patient becomes a monument to medical and judicial cowardice and hypocrisy" (Tur, 2002).

To consider the process of death in such exaggerated manner would easily justify one to consider that a patient should have a right to seek euthanasia so as to terminate life in dignity. A basis is created for invocation of a need to end one's life so as to avoid indignity that one may experience during the prolonged period prior to death (Allmark, supra).

The proposition that death with dignity is merited is founded on the principle that dignity is inherent in every individual by virtue of being human. The principle is

illustrated in the case of R (on the application of A, B, X and Y) V East Sussex CC and the Disability Rights Commission [2003] EWHC 157 (Admin), by Munby J. as follows;

> "[T]he recognition and protection of human dignity is one of the core values … in truth the core value of our society and indeed of all societies which are part of the European family of nations and which have embraced the principles of the Convention. It is a core value of the common law, long pre-dating the convention…the invocation of the dignity of the patient in the form of a declaration habitually used when the court is exercising its inherent declaratory jurisdiction in relation to the gravely ill or dying is not some meaningless incantation designed to comfort the living or to assuage the consciences of those involved in making life and death decisions: it is a solemn affirmation of the laws and society's recognition of our humanity and of human dignity as something fundamental."

Despite the fact that dignity is attached to every person's life, the reality is that it is rather far-fetched to seek termination of life simply because one is apprehensive of some indignity during the process of illness. Given the advances made in health care, the contemplated indignity can be suitably handled to the reasonable satisfaction of the patient. This aspect can be illustrated by consideration of the Aristotelian idea that human beings are distinct and unique from other animals because of their rationality, ability to reason and act upon reason. A person's rationality enables him to reach a rational decision regarding the fundamental and sacred right to life vis a vis discomfort which can be mitigated (Vanleare & Gastmans, 2011, p. 170).

The prohibition placed against a medical practitioner from assisting his patient to terminate his life is not only rooted in the Hippocratic Oath but is also drawn from the reality that a patient is a 'person' who possesses an intrinsic and irreducible value by virtue of being human. Thus, a "medical practitioner who ignores the person of the patient and instead reduces the patient to a clinical picture essentially violates the very dignity that is inherent in a patient" (Vanleare & Gastmans, supra p. 170). The patient should be cared for instead of being assisted to terminate his life. Dignity cannot be invoked to justify euthanasia as euthanasia violates human dignity.

Louvain's anthropological approach of personalism in care slightly contrasts with the Aristotelian view that a human being is a rational being distinct from other animals and can dictate the course of his life. Louvain's personalistic approach holds that a person is more than his rational capacities and powers. Rather, his being is evidenced in his corporeality. As a corporeal, a person is not just an objective body that belongs to the material world, but one that is subject to physical laws. Therefore, even a person who is unconscious and in a diminished state of mental and physical health is 'a person' because of his corporality (Vanleare & Gastmans, supra p. 169)

Herman De Dijn's approach to care contrasts with Louvain's. Herman gives care a sentimental value. (Herman, 2002) In his approach, the purpose of providing care is to ensure that the patient does not experience pain or suffering. Care travels beyond sentimental and emotional attachment of a medical practitioner to the patient's suffering; it is founded on the dignity of the person. By giving care, a medical practitioner is able to affirm the patient's dignity. Kittay agrees with Herman's views and writes that:

> "Dignity is a feature that must be perceived in order to be. For dignity is a call upon another to recognise our intrinsic worth. That call requires a response, a witnessing, even, as in cases of extreme oppression, the only witness is the internal witness that we have developed in ourselves as a consequence of the care we have had to have received in order to survive and thrive as best we might. In our relationships of care, we witness, recognise-and so confer- that dignity in another." (Kittay, 2005).

Paul Valadier, a theologian, argues that the purpose of providing care is to create dignity. (Paul, 2003) Dignity in this instance arises out of the relationship between the patient and the medical practitioner. He demonstrates this by analogizing the parable of the Good Samaritan. An interpersonal interaction between the Good Samaritan (a medical practitioner) and the injured traveller (the patient) enabled the Good Samaritan to identify himself with the illnesses and suffering of the injured traveller. This invoked him to provide care to the injured traveller in order to preserve his dignity (Vanlaere & Gastmans, 2011).

Similarly, in providing care to a patient, a medical practitioner is able to identify himself with the patient's suffering and appreciate that the patient is more than 'just a body.' In the process of providing care, the medical practitioner is able to acknowledge the person of the patient. In this sense, dignity is dual and is created by the one who provides it as well as by the one who receives it. Kittay confirms Valadier's perspective on dignity when she states that "Our dignity…is bound both to our capacity to care for another and in our being cared for by another who is herself worthy" (Vanlaere & Gastmans, supra p. 170). Dignity is respected when the medical practitioner preserves the life of his patient.

A personalistic view of a human being reveals that although all human beings are fundamentally equal, each person is an originality. Therefore, every person has dignity that is not dependent on his achievements but is derived from the fact that each one of us is a distinct and unique subject who should be treated with respect (Vanlaeare & Gastmans, supra p. 166).

Personalism suggests that true care towards a dying, vulnerable patient who is in a distorted and undignified state should arouse a medical practitioner to identify with the suffering of the person and convey respect and care to the distorted person, rather than to take away the life of the patient (Vanlaeare & Gastmans, supra p. 171).

Personalism makes it clear that the true purpose of care is to preserve the life of the patient. Respect for the patient's dignity and sanctity of a person's life is truly manifested by preserving a patient's life, even where he is unconscious and not by honouring the patient's request to end his life (Vanlaeare & Gastmans, supra p. 171).This call is ethical, moral and obligatory in character. Instead of upholding the patient's request that his life be terminated, a medical practitioner should exercise more pragmatic approaches such as adopting palliative-inspired strategy of accepting death when it is inevitable, providing the best human support to ease suffering and using every reasonable measure to control the pain (Harriss, 2005).

The intrinsic dignity of the human person ought to be imposed in an objective sense and ought to act as a moral limits to the autonomous subject which may sometime be unstable. In all, a patient cannot morally or ethically justify a request for euthanasia upon a supposed right that the patient has a right to die with dignity. Euthanasia does not

lead to a death with dignity because any process of dissolution of human life entails some measure of indignity.

Patient autonomy is central to the euthanasia debate. The subsequent subsection of this chapter examines whether patient autonomy is a sound moral ground upon which a medical practitioner may accede a patient's request for euthanasia. A conclusion is drawn that although a competent patient is capable of making rational decisions, a medical practitioner's acceptance of a request for euthanasia removes the patient's possibility of making all other choices. Ultimately, there cannot be an autonomy-based right to terminate one's life since death means total loss of future freedom. Autonomy is a value to protect and promote but cannot be a right to terminate the individual's existence.

5.3. REASONS ADVANCED BY MEDICAL PRACTITIONERS

5.3.1. Patient autonomy

Autonomy is founded on a proposition that an individual has a right to do determine the course of his life. This right was expressed by Justice Kennedy in the United States Supreme Court in Planned Parenthood – V – Cassey (Supra) in the following terms;

> "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."

The deeply ingrained fear of state encroachment upon individual rights is used to leverage the legal preservation of supposedly very private, and essentially individual rights which men should exercise freely. Man should have a territory where he exercises self-rule.

Moral theologian, Richard Gula, states that patient autonomy does not morally justify a medical practitioner's acceptance of a patient's request for euthanasia as it runs counter to the principle of common good which promotes those actions and policies which would contribute to the total wellbeing of the society while respecting and serving the interests of the person. Patient autonomy is a fallacy that cannot justify the medical practitioner's decision to terminate the patient's life (Stimpson, 2010 p. 7).

Patient autonomy has been defined as "self-rule or the capacity to think, decide and act on the basis of such thought and decision freely and independently without hindrance" (Gillon, 1985).

Patient autonomy is founded on the doctrine of informed consent which instructs that an individual has the right to shape his life through his choices, and this right extends to the right to determine the time and manner of his death. When interpreted in a loose sense, patient autonomy is constituted of ideas as diverse as "privacy, voluntariness, self-mastery, choosing freely, the freedom to choose, choosing one's moral position and accepting responsibility for one's choices." (Faden & Beauchamp, 1986).

Patient autonomy has been regarded in two respects- as right to self-determination and side-constraint. Patient autonomy underlies in the Kantian principle that "individuals are ends and not merely means; they may not be sacrificed or used for achieving ends without their consent."

Comarc Burke comments on the self-rule as follows;

> "It follows that every individual is his own project: also in the sense that in designing himself there are no given norms to follow. He builds from scratch, as he chooses, freely using the materials and situations of life so as to achieve his project" (Burke, supra).

The neo-liberal concept of autonomy can be drawn from the practice of Greek philosophers who did not wholly condemn death but rather judged death on the moral nuances of the circumstance, and at times permitted death. Thus, when Socrates was condemned to death by an Athenian Court in 399 BC for the offence of corrupting the minds of the youths of Athens, he opted for the death sentence in place of seeking an escape from Athens.

Karol Wojtyla states that it is through self-determination that other antecedent properties of true autonomy which are self-possession and self-governance are revealed. Karol Wojtyla states:

> "A complete description of the will cannot refer to the moment of willing alone, neither to the exercise nor the experience of will. Every action confirms and at the same time makes more concrete this relation, in which the will manifests

> itself as a feature of the person and the person manifests himself as a reality with regard to this dynamism that is properly constituted by the will" (Wojtyla, 1979).

Man is transcendental in nature (Cottingham, 2012). This means that man is attracted to Truth and Good and chooses it freely. In the "Acting Person" Karol Wojtyla recognizes that intrapersonal transcendence through self-determination is exercised through the will. Wojtyla defines transcendence as the "reflective element of consciousness. "(Wojtyla, Supra) Conscience has a cognitive and a normative element. The cognitive element measures the goodness or badness of an action and reveals efficacy whereas normative elements make claims about how things should or ought to be and how to value them.

Woznicki Andrew states that:

> "A person communicates his very self to another through an act of free will. One cannot act as another. He can only act as himself, recognizing his action as originating from within and literally revealing his being in the process. Human action is truly "an act of existence" (Woznicki, 1980).

The contention that a patient is the expert of his wellbeing is advanced not because of its factual accuracy but as a basis for the justification that the patient is entitled to seek euthanasia as an attribute of his liberty. Veatchs justifies respect for patient's right to self-determination on the basis that patients have special expertise regarding their wellbeing, especially when they have access to information (Veatchs, 2009). It is difficult to comprehend how a patient who is tormented by illness and likely undergoing emotional turmoil could be regarded as an "expert" over his wellbeing.

Natural law adherents challenge patient autonomy on the ground that life is a gift from God which human beings only hold in trust. Man, therefore, does not enjoy control over his life which can entitle him to decide when to live or die. Hence, termination of life is a grave violation of natural law (Stimpson, 2010). A juridical exposition of this philosophical inclination is discernible in the case of Airedale NHS Trust-vs-Bland (Supra). It was held:

> "We have a strong feeling that there is an intrinsic value in human life, irrespective of whether it is valuable to the person concerned or indeed to anyone else, those who adhere to religious faiths which believe in sanctity of all God's creation and in particular that human life was created in the image of God himself will have no difficulty with the concept of intrinsic value of human life. But even those without any religious belief think in the same way. In a case like this we should not try to analyse the rationality of such feelings. What matters is that, in one form or another, they form part of almost everyone's intuitive values. No law which ignores them can possible hope to be acceptable."

The concept of life having an "intrinsic value" sets life apart from the other rights which inhere in man. Life is not akin to a right in property such as chattels which man can acquire or dispose at will. Life has a uniqueness distinct from other rights created by municipal laws.

Patient autonomy is predicated on a supposition that a patient can fully comprehend the nature and implications of his choices. A patient's inability to competently reach a sensible decision especially when undergoing intractable pain undermines the concept of patient autonomy.

Given the reality that a patient is undergoing a myriad of activities including pain and discomfort, it is not realistic to expect the patient to make a competent decision regarding an issue of such profound finality as euthanasia. The discomforts arising from illness and the possible inability to fully understand the full impact of the disease render the patient ill-suited to make a rational decision. Indeed, a medical practitioner who justifies administration of euthanasia on the basis that a terminally ill patient makes the request for euthanasia is indulging in deceit. John Keown expounds;

> "Doctors are not automata who simply execute the patient's wishes, however autonomous. They are professionals who form their own judgment about the merits of any request for medical intervention.. The doctor, if acting professionally would decide each case whether the intervention was truly in the

patient's best interest. Consequently, the alleged justification of voluntary euthanasia rests fundamentally not on the patient's autonomous request but on the doctor's judgment that the patient no longer has a life 'worth' living" (Keown, 1995).

Inherent in autonomy is the right of self-determination. The right of self-determination enables one to make decisions in all areas where man can regulate his life and actions. In that area of "self-rule" a tension arises between the principle of sanctity of life and self-determination. The House of Lords acknowledged this conflict in the case of Airedale NHS Trust-vs-Bland (Supra) and held that although the patient's right of self-determination is a deeply rooted principle in medical practice, it cannot co-exist with the principle of sanctity of life. For example, whereas a patient can competently decline medical treatment as an attribute of self-determination, the patient cannot demand termination of life as an attribute of self-determination. No such right exists.

A patient's autonomy has two notions- the right of a patient to refuse medication and a converse right to seek medical treatment. The tragic consequence of a patient's right to decline medical treatment was graphically illustrated in a Daily Nation newspaper article on 14th January (Daily Nation, 2019). It was reported that a patient, Samuel Maina, declined lifesaving blood transfusion at Nyeri General Hospital because as an adherent of Jehovah Witness, he could not receive or donate blood (Leviticus 17:10). The hospital had to discharge him after warning him of the dire consequences of his refusal for the vital procedure. The patient succumbed to the illness shortly after discharge from hospital. The article revealed the divisive nature of the patient's autonomous decision. While certain members of his family supported the decision on religious grounds, other close family members stated that the patient should have received the blood transfusion (Daily Nation, 2019).

The case of State of Georgia –vs- McAfee, 1989 259 Ga. 579) further demonstrates the centrality of a patient's right to refuse medical treatment. McAffee, a competent adult, suffered severe injury to his spinal cord in a motorcycle accident. He was incapable of spontaneous respiration and was thus dependent on a ventilator. He filed a petition in the

Fulton Superior Court and sought a determination that he be allowed to turn off his ventilator, an action that would result in his death. Through the assistance of an engineer, he devised a means of turning off the ventilator himself. He sought to be provided with a sedative to alleviate the pain which he would experience once the ventilator is disconnected.

In allowing McAfee's Petition, the Georgian apex Court found that a competent adult has the right to refuse medical treatment. The court held;

> "McAfee's right to be free from pain at the time the ventilator is disconnected is inseparable from his right to refuse medical treatment....his right to have a sedative (a medication that in no way causes or accelerates death) administered before the ventilator is disconnected is a part of his right to control his medical treatment" (State of Georgia –vs- McAfee, Supra).

In the Bland case (supra), the House of Lords held that where there is a conflict between the sanctity of human life and patient autonomy, in the case of an incompetent patient such as a minor, a compromise must be reached, and this compromise may require the adoption of paternalist view which would deny the patient his autonomy and uphold the sanctity of life. However, the Court was clear that English law upholds the autonomy of an adult. Thus, a person of full age may exercise this right and refuse treatment 'for any reason or no reason at all'. Who is a "competent person" is a troubling issue given that one may appear seemingly in control of his senses but is in real truth hostage to unfounded flaws and apprehensions. To consider that since one is an adult and seemingly competent, the person can legitimately initiate acts intended to terminate his life cannot be morally correct.

Although Immanuel Kant is of the view that man is the sole arbiter of his will, he strongly disagrees with the views of medical practitioners who seek to justify administration of euthanasia. Kant believes that euthanasia violates universal law. Kant presupposes that universal laws bound one to recognise moral law. As a result, by

administering euthanasia on a terminally ill patient, a medical practitioner violates moral laws that prohibit murder (Gregor, 1996).

Karol Wojtyla contends that autonomy is selfish as it is divorced from truth and constitutes false freedom. Wojtyla states that when freedom is made absolute in an individualistic way, it is emptied of its original content and its meaning and dignity are contradicted. Therefore, freedom negates and destroys itself and becomes a factor leading to the destruction of others when it no longer recognizes and respects its essential link with the truth (Pope John Paul II, 1998).

The concept of freedom by Karol Wojtyla in his book, The Acting Person (1979) begins with evaluating ontological freedom. Wojtyla concludes that the concept of man, by being human, constitutes freedom itself. Thus, man can only be referred to as a free person because "every moral claim is an expression of the agent's moral autonomy: the person is in himself or herself by nature, but becomes for himself or herself though exercise of freedom" (Dell 'Oro, 2010).

Although Janssens' personalistic view on autonomy and freedom is in consonance with the Aristotelian idea that a human being as a subject who is able to think and act freely, she opines that from this freedom attaches great responsibility placed upon man to account and justify to himself and other people that he interacts with that the actions he undertakes are morally right (Vanlaere & Gastmans, supra p. 165). Consequently, autonomy is a fallacy because a human being does not belong to himself but he is rather a subject directed towards other persons. It is through interaction that a person learns that the other is a subject and must be treated as a fellow human being. This, in turn, implies that the medical practitioner must reciprocate and view the patient not as a means or an object but as an original being that must be treated as such (Vanlaere & Gastmans, supra p. 165). Given the originality of each individual, the medical practitioner cannot take away the life of a person, even when requested by a patient who appears competent.

To contrast the view held by personalist on autonomy Johansen, S. conducted a study in United States of America to establish reasons that motivate terminally ill patients to ask for voluntary euthanasia (Johansen Hollen, Kaasa & Materstvedt, 2005). He concluded that patients had the desire to control their life due to the loss of sense of self. The patients were concerned about losing their personality, source of identity or essence. Without the ability to maintain aspects of their life that defined them as individuals, life loses its meaning and personal dignity was jeopardized. Euthanasia was therefore driven by a sense of fear and the perceived neglect which was to occur as illness progressed.

Since the relationship between a terminally ill patient and the physician is usually asymmetric, with safety and information on the power of the physician, a medical practitioner who is confronted with a patient's request for euthanasia should not accede to the patient's request. Instead, he should remind himself that his "constitutive professional role is to attend to those who are sick and debilitated, seeking to preserve the measure of health that can be preserved, and to help them bear pain and progressive loss of autonomy and bodily function that illness often brings" (O'Rourke, O'Rouke & Hudson, 2017).

Personalism shows that autonomy as a ground for euthanasia is beset by its lack of the necessary objectivity of human action, rooted in truth. The argument also lacks unity of an ethical act which is derived through true freedom and acting according to one's will. Therefore, autonomy does not represent true freedom.

Compassion was also cited by medical practitioners as a moral ground to accede to a patient's request for euthanasia. It is an accepted, yet controversial fact that doctors may sometimes terminate a patient's life on the basis of the compassion they may have towards the patient's pain and suffering. The next subsection of this Chapter explores the moral and ethical issues surrounding compassion as a moral reason for terminating a patient's life. The analysis invites the conclusion that a physician's involvement in euthanasia is the antithesis of what doctors are trained to do. On the other hand, the provision of care and attention to avoid "loneliness in dying" is the true manifestation of compassion towards a dying patient.

5.3.2. Compassion

13 out of 38 medical practitioners who participated in the questionnaire indicated that compassion is a moral basis upon which a medical practitioner could accede to a request for euthanasia. Compassion evokes human feelings of sympathy towards those who are suffering and calls upon us to alleviate the suffering if within our power.

Suffering is irremediably a part of the life of human beings and the fight against suffering is an endless task. The notion that is impossible to make room for life alongside suffering, which is expressed in the demand for euthanasia, negates the fact that both can co-exist. By euthanizing a patient in order to alleviate his pain is in effect only the institutionalization of despair.

Karol Wojtyla states that suffering is a "universal theme that accompanies man at every point on earth" (Pope John Paul II, 1998). Suffering then is "almost inseparable from man's earthly existence". Thus, administration of euthanasia to a patient is not manifestation of compassion but an expression of failure. True compassion requires a medical practitioner to recognize that human life has been given to man in trust, and can only be respected through preservation, not elimination. By providing care to the patient, the medical practitioner is able to preserve both the individual integrity and the common good (Stewart, 2010).

A theological understanding of compassion is found in the parable of the Good Samaritan. The Good Samaritan sacrificially carried the injured man and his burdens to a place where the man could find peace and restoration. This act enabled the Samaritan to identify with the suffering of a stranger which he acted upon by placing the burden of care upon himself.

From a utilitarian point of view, we should strive to maximize happiness and pleasure. Applying Bentham's principle that only pain and pleasure govern human existence, one could argue that killing someone who is belabouring unbearable pain and thereby eliminating the physical and existential pain is a means of expressing compassion for the person by relieving the patient from his pain.

An expression of the utilitarian view is illustrated by Jose Granados as follows;

> "Compassion is the adequate answer to the call of suffering, an identification with the suffering person that awakens suffering in us. "Compassion allows us to see the intrinsic dignity of the person who is suffering. "This is because our suffering with our neighbour, flesh of our flesh, means the reawakening in us, through our own compassionate suffering, the question of the origin, of the need to look for the good that precedes all evil" (Granados, 2006, p.556).

Hence the suffering by the patient is a privation of a good as explained by John Paul II. The privation prompts one to search for the good and compassion "a call to love in return and by doing so to give one's own suffering the form of love" (Evangelium Vitae, 1995) Compassion therefore becomes an explicit manifestation of fraternal communion in the suffering of the patient. The foregoing experience can occur when the patient is recognized as a unique and irreplaceable person.

Karol Wojtyla criticizes the false notion that euthanasia is motivated by compassion towards the terminally ill (Wojtyla, 1995). Wojtyla considers that euthanasia may in reality be motivated by our selfish desire not to be burdened by the terminally ill. Karol Wojtyla states that "even when not motivated by a selfish refusal to be burdened with the life of someone who is suffering, euthanasia must be called a false mercy, and indeed a disturbing "perversion" of mercy" (Wojtyla, 1995).

Indeed, a patient who we feel compassion for should provoke in us the desire to express our solidarity. The society should also be able to support families that take care of terminally ill patients. Appropriate palliative care should be provided to alleviate the heavy burden borne by patients and family members. Karol Wojtyla in his visit to Renweg Hospice in Vienna said;

> "From this standpoint, the decision actively to kill a human being is always an arbitrary act, even when it is meant as an expression of solidarity and com- passion. The sick person expects his neighbour to help him live his life to the very last and to end it, when God wills, with dignity. Both the

artificial extension of human life and the hastening of death, although they stem from different principles, conceal the same assumption: the conviction that life and death are realities entrusted to human beings to be disposed of at will. This false vision must be overcome" (Pope John Paul II, 1998).

Karol Wojtyla, in Evangelium Vitae, criticizes this view that suffering by patients can be a justification for euthanasia. Such justification can easily create the "culture of death". In societies where there is the culture of death, the terminally ill and elderly are not tolerated and are considered burdensome. He states;

> "With regard to the last moments of life too, it would be anachronistic to expect biblical revelation to make express reference to present-day issues concerning respect for elderly and sick persons, or to condemn explicitly attempts to hasten their end by force. The cultural and religious context of the Bible is in no way touched by such temptations; indeed, in that context the wisdom and experience of the elderly are recognized as a unique source of enrichment for the family and for society. Old age is characterized by dignity and surrounded with reverence (cf. 2 Mac 6:23). The just man does not seek to be delivered from old age and its burden; on the contrary his prayer is this: "You, O Lord, are my hope, my trust, O Lord, from my youth ... so even to old age and grey hairs, O God, do not forsake me, till I proclaim your might to all the generations to come" (Ps 71:5, 18). The ideal of the Messianic age is presented as a time when "no more shall there be ... an old man who does not fill out his days" (Is 65:20) (Evangelium Vitae, 1998, p 15).

Karol Wojtyla acknowledges that it is important for people who practice Christian faith to understand that suffering is a necessary experience. It is during the period of man's suffering, that man begins to question his existence. Similar circumstances of God using suffering to test their Christian faith has been well documented in the Holy Bible. In the book of Job, it is recorded that;

> "Job had been lying in unrelieved misery for months with open sores all over his body. During this time he bore the grief of seven dead sons and

> three dead daughters. All of his wealth had vanished in one afternoon. He had become repulsive to his wife, loathsome to his brothers, and even little children despised him as he lay on the ash heap outside of town" (King James Holy Bible, 2010).

Moral justification of euthanasia on the ground of compassion is beset by the blurred distinction that is exists between relieving a patient of his pain and eliminating the patient altogether. In this regard, Prescot associates himself with the writings of Dr. Ira Byock that "there is a distinction between alleviating suffering and eliminating the sufferer- between enabling someone to die gently of their disease and ending that person's life with a lethal pill or injection. (Prescot, 2015).

The shortcoming of compassion as a moral justification for voluntary euthanasia is that it appeals to emotion and ignores the fact that reason plays an important role in the process of reaching a decision to euthanize. Circumstances that compel a person to act compassionately differs between different moral agents. Pallegrino states that compassion may lead some physicians to relieve a patient of their anguish by accelerating the death of a disabled patient, yet this will conflict with those who, also out of compassion, seek to cherish the disabled as valuable members of the society. (Pellegrino, 2002).

The ethical value of care commands a medical practitioner to extend care to the patient. However, since compassion is not obligatory, whether it can be extended or expressed to the other person depends on one's feelings towards the other person. Thus, care and compassion can be "an impulse, a whim or a caprice, springing from short-sightedness, bias or prejudice" (Vanleare & Gastman, 2011 p. 3). The medical practitioner may thus end a patient's life out of prejudice or bias and not sympathy for the patient.

Aquinas argued that it is our nature to preserve ourselves, to love and recognise the rights and duties of community membership. Therefore to respect each other is to help each other not to have to choose against life. We do not show people respect by facilitating their choices of death. Rather, respect for the sick patient involves fully

acknowledging the difficulties in being ill and encouraging them to choose well (Ramsey, 1997 p. 2).

Compassion and care, unlike curing, is appreciating and dealing with the unique experience of the illness as lived by the patient. As stated by Arthur Frank, "caring has nothing to do with categories; it shows the person that her life is valued because it recognizes what makes her experience particular" (Frank, 2017, p. 48). A medical practitioner who has a full understanding and commitment to phenomenological personalism is more likely offer care and compassion to the unique and irreplaceable patient and definitely not administer euthanasia to the patient.

5.4. CONCLUSION

The moral reasons that medical practitioners use to justify administration of euthanasia render support to the oft cited claim by David Hume that morality is based more on people's emotions and feelings than on a logical analysis of a given situation (Bucciarelli, Khemlani, & Johnson-Laird, 2008). No doubt that assertion is incorrect.

Man has the capacity to engage in moral reasoning i.e. forming judgments about what one ought, morally to do. It is necessary to understand what is right or wrong. A patient who is suffering from a terminal illness may seek euthanasia under the mistaken belief that euthanasia will relieve his pain and suffering. Such a request is not a product of practical reason as it is neither based on right nor virtue. Equally, a medical practitioner cannot claim that terminal illness or the ensuing pain can be a moral ground upon which euthanasia can be justified. Such a view is devoid of moral reasoning. In all, no justification can be advanced for the illicit act whether based on moral reasoning or a well-founded philosophical view point.

Personalism asserts the nature of man as a virtuous and ethical being. It will be a contradiction for man seeks to justify euthanasia by reference to autonomy or compassion. Therefore, just like other debates such as abortion and murder,

administration of voluntary euthanasia is an intrinsic evil; which might lead to a breakdown of human existence and also disintegration of moral law.

Euthanasia is an intrinsic evil and cannot therefore be justified by any moral reason. Indeed, it is a contradiction to seek to justify an illicit act by a moral justification. Having ascertained that euthanasia is widely practised, it is imperative that urgent remedial measures are taken to prevent an unregulated practice acquiring acceptance in the society.

A true view of man shows that man is driven to other goods which may surpass health. The ultimate good transcend health and comfort.

The Kenyan Penal Code is unequivocal in its prohibition of euthanasia. Euthanasia is an illicit act incapable of justification. In the next Chapter, conclusions drawn from the research are discussed as well as various recommendations.

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1. INTRODUCTION

True compassion for those who are suffering is by showing care, not terminating their lives. Through care, life is affirmed, nurtured and protected in all of its mystery and transcendence. Euthanasia is an act of abandonment and despair. Euthanasia represents a palliative care failure and violates the societal role of the medical practitioner to care for the patient. The message to the patient is that medical practice has not invested enough in him to alleviate the suffering that he is undergoing.

Natural law considers life to be a divine gift that cannot be terminated at the whim of man. Suffering is part of human life. Once a patient accepts that suffering as part of life then suffering gains acceptance and does not justify termination of life. Natural law proponents support the view expressed by Cyril of Alexandria namely that suffering is divine in nature. Suicide and euthanasia are properly seen not as forms of death but as the outcome of certain attitudes toward life. For the Christian, the reasons for living begin with the understanding that life is a "gift".

In utilitarian theory as expressed by John Stuart Mill, an individual is regarded as the best judge and ultimately the sole guardian of his own interest. Autonomy would therefore entitle an individual to decide refrain from seeking medical treatment or even seek voluntary euthanasia and the decision should be upheld. In a famous example, it is said that if you see people about to cross a bridge you know to be unsafe; you may forcibly stop them in order to inform them of the risk that the bridge may collapse under them. But if they decide to continue, you must stand aside and let them cross, for only they know the importance to themselves of the need to cross, and only they know how to balance that against the possible loss of their lives. This utilitarian view of man is not in accord with the view of personhood as it elevates one right against the more fundamental right i.e. the right to life.

Life is not simply to be terminated at the option of the recipient, for it "is a gift that is not property to possess" but rather "a task to live out, a task where freedom follows

upon responsibility". Knowing that life does not belong to man exclusively, man "should not live as if survival is an end in itself, but rather because we know that life allows us the time and space to live in the service of God"

In this chapter, conclusions are drawn from the data that was obtained from the research questionnaire. In addition, various recommendations are made.

6.2. PREVALENCE OF VOLUNTARY EUTHANASIA IN NAIROBI

The research ascertains that indeed voluntary euthanasia is practiced in Nairobi. Both passive and active voluntary euthanasia are administered in Nairobi in spite of the existing penal sanctions. Although the practice is quite prevalent, it is done on the quiet. This could be due to the penal sanctions that exist in the municipal statutes.

Some of the medical practitioners recommended that Parliament should consider formulating guidelines for Advance Medical Directives. In the Western world, a number of countries have legalized Advance Medical Directives. Advance Medical Directive is a legal document in which a patient can limit long term therapies and/or prolongation of life (Negri, 2011, p. 295).

For instance, in Netherlands, a competent patient may write a request limiting the life sustaining procedures. A physician is obliged to act on the directive even if the patient subsequently is incompetent subject only to compliance with prescribed medical protocols (Moratti & Vezzoni, 2012).

6.3. MORAL REASONS THAT MEDICAL PRACTITIONERS USE TO JUSTIFY ADMINISTRATION OF VOLUNTARY EUTHANASIA

This dissertation sought to ascertain the moral reasons that medical practitioners in Nairobi use to justify administration of voluntary euthanasia. Majority of the medical practitioners stated that the basis of undertaking voluntary euthanasia were compassion and freedom and autonomy.

Medical practitioners in Nairobi consider freedom and autonomy of the patient as creating a right which the patient could utilise to seek euthanasia. This is similar to the

views expressed by Hume who placed the individual liberty at a high pedestal. The concept of patient autonomy is the supposition that a patient is able to comprehend the nature and implication of his/her choices. It is not realistic to expect patients suffering to terminal illness and in great much pain and discomfort to make a rational decision.

Voluntary active euthanasia has implicit moral repulsion. Although a majority of the medical practitioners in the sample group indicated that they had not been requested to undertake voluntary active euthanasia, the fact that a minority had been requested is indicative of a felt desire for voluntary active euthanasia.

6.4. PERSONALISTIC PHILOSOPHICAL EVALUATION FROM RESPONSES GIVEN BY MEDICAL PRACTITIONERS ON EUTHANAISIA

This dissertation sought to find out the personalistic philosophical underpinning that medical practitioners relied on to justify voluntary euthanasia. From a critical evaluation of the moral reasons and critique from a personalistic philosophical view, it is clear that neither autonomy nor compassion can justify administration of euthanasia.

From a personalism viewpoint, a decision by a medical practitioner to administer active voluntary euthanasia is erroneous because personalism embraces all people, all men regardless of their development, illness or usefulness in society. One cannot exclude a man in his prenatal period such as terminal illness, or coma. Equally in the Catechism of the Catholic Church, the right of every human being to the gift of life is absolute in that every human being, from the moment of his conception until the moment of his natural death, possesses an invaluable right to life and merits all the respect owed to the human person.

6.5. RECOMMENDATION

This dissertation ascertains that indeed medical practitioners in Nairobi practice voluntary euthanasia. The sole object of euthanasia is termination of life. Death is not an indirect result but is the intended outcome. Euthanasia is an illicit act. Since euthanasia terminates life it unbalances the laws of nature. Suffering or bodily discomfort may

reveal "a richer understanding for the suffering of others, and away from the superficialities that too often characterise daily existence". Once the medical practitioner has instilled in the patient that he may grow from pain and suffering to temporal greatness, euthanasia becomes an unnecessary act.

The dissertation also ascertained that the main moral reasons that medical practitioners justify euthanasia are: autonomy of the person, compassion for the terminally ill and reducing medical costs for the terminally ill patient. The greatest fear for the terminally ill patient is not physical pain but the fear of being abandoned by family and/or society. To alleviate this fear, medical practitioners should focus on providing loving, competent care to a terminally ill patient and consider what improvement medical science can do to prevent and relive distress for those approaching death. A proper palliative care not only relieves the patient of the fear of pain but also makes the practice of euthanasia unnecessary.

Modern day medicine should strive to provide hospice care and palliative care to the terminally ill. Hospice care focuses on a patient's twilight period and includes palliative care. The World Health Organization regards the role of hospice care as to improve the quality of the patient's last days by offering comfort and dignity. Palliative care is an approach that improves the quality of life of patients and their families who are faced by threatening medical conditions.

Palliative sedation is an appropriate alternative to euthanasia in the case of patients suffering from unremitting pain. Broeckaert defines palliative sedation as "the intentional administration of sedative drugs and combinations required to reduce the consciousness of a terminal patient as much as necessary to adequately relieve one or more refractory symptoms. The intent of palliative sedation is not to end life but relieve a terminally ill patient of pain (Broeckaert, 2002a).

There is need for a quantitative research into the moral reasons in a larger population size. Due to limitations highlighted in chapter 3, the research was limited geographically to Nairobi City. Whereas euthanasia is widely practiced by the Somali community who are pre-dominantly in North-Eastern Kenya, further research can confirm whether the

moral views which have been ascertained to exist in Nairobi are similar to the views that would trigger practice of euthanasia in that community.

This dissertation also sought to evaluate the personalistic philosophy that underpins the moral views offered by medical practitioners on euthanasia. There should be a public debate on whether the current laws support the actions of medical practitioners in practicing euthanasia in Nairobi. It will also be prudent if medical practitioners sought advisory opinion Kenya's court on the legality of the Advanced Medical Directive currently in use.

The Penal Code espouses a philosophy which seeks to outlaw any form of euthanasia or physician assisted suicide. That philosophy is founded on natural moral law. The natural moral law predates the State. Neither the State nor its organs has the moral authority to legalize a moral wrong. Thus, voluntary euthanasia should retain the place it rightfully occupies in the penal structure of our criminal justice jurisprudence.

6.6. CONCLUSION

This dissertation has laid bare the practice of euthanasia by medical practitioners in Nairobi. Indeed, the practice continues unabated. The moral views expounded by medical practitioners in Nairobi sought to justify voluntary euthanasia as necessary for a terminally ill patient. Euthanasia proponent assumes that when a patient is empowered to decide when life should be terminated such empowerment is an expression of civil liberty. Euthanasia is thus viewed as self-deliverance.

Personalist philosophy regards such a claim as gibberish and unfounded in reason. Man has a dimension beyond the physical body. The personalistic philosophy proposed by many philosophers do not support the "moral" views offered by the medical practitioners.

Euthanasia is a morally illicit act which neither human law nor practice can uplift to a licit act. The condemnation excludes extraordinary treatment whose sole object is prolongation of life with no prospects of recovery. In those circumstances, exclusion of

extraordinary treatment in essence means a rejection of machines taking over the functions of body organs.

Such a rejection is morally illicit since life ought to be sustained by the body and its organs. To allow machines to take over the functions may lend to a situation where the patient is maintained in a state in an "animated suspension" for an indefinite period notwithstanding that essentially life has ceased.

Whereas this dissertation was undeniably limited in terms of geography, time and sample size, nonetheless the data that was obtained is indicative of a practice, which now calls for an in-depth research of a practice that could possibly be prevalent in the entire country and the region.

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APPENDICES

APPENDIX A-QUESTIONNAIRE

QUESTIONNAIRE TO MEDICAL PRACTITIONERS ON EUTHANASIA IN KENYA

(Your identity and the answers that you will provide will be kept in the strictest confidence. Your answers will be used exclusively for this research)

Section I- Personal Information

(Please tick as appropriate)

1. Gender

   Male ☐

   Female ☐

2. Age

   21- 30 yrs ☐

   31-40 yrs ☐

   41-50 yrs ☐

   51-60 yrs ☐

   61-70 yrs ☐

   Over 71 yrs ☐

3. Period you have been a medical practitioner

   5 - 10 yrs ☐

   11 - 20 yrs ☐

   21 - 30 yrs ☐

   Over 31 yrs ☐

4. Current Place of work

   Public Institution ☐

   Private Practice ☐

5. Are you a specialist? If so, please specify your area of specialization

....

Section II: Incidences

1. How would you rate the incidence of "active euthanasia" in Kenya? i.e lethal injection or such similar termination of life carried out by a medical provider?

   High ☐

   Occasional ☐

   Rare ☐

2. How would you rate the incidence of "passive euthanasia" in Kenya? i.e. withdrawal of life support or fluids etc, to patients who are considered to be terminally ill?

   High ☐

   Occasional ☐

   Rare ☐

3. As between "active euthanasia" and "passive euthanasia" which would you consider to be more prevalent in Kenya?

   Active Euthanasia ☐

   Passive Euthanasia ☐

4. Have you had occasion(s) to be requested to administer "active euthanasia"?

   Yes ☐

   No ☐

5. If "YES" to question no. 4, who made the request?

   Patient ☐

   ☐

Patient's Next of Kin

Other

(Please specify)……………….

6. Have you had occasion(s) to withdraw medication and/or life support to a patient who was terminally ill i.e. "passive euthanasia"?

   Yes

   No

7. If "YES" to question 6, how did you arrive at the decision?

   Personal evaluation of the patient's condition

   Request by patient

   Request by Next of Kin

   Other

   (Please specify)……….……………………….

8. How would you rate the incidence of "passive euthanasia"

   High

   Occasional

   Rare

Section III- Patient's "Rights"

1. Do you consider that a patient or a patient's next of kin have a "right" to request for euthanasia in instances where the patient is considered to be terminally ill or suffering from intractable pain?

Yes

No

2. If "YES" to question no. 1, what would be the basis of that "right"?

   Freedom and Autonomy rights

   Compassion

   To reduce medical costs

   Other

   (Please specify)

   ………………..……………

3. Do you consider that a medical practitioner is suitably qualified to decide when euthanasia can be administered?

   Yes

   No

4. If "YES" to question 3, in which instances would you consider administering euthanasia?

   Intractable pain

   Terminal illness

   Death with dignity

   Tired of living

   To reduce medical cost

   Other

   (Please specify)…………………..

5. To your knowledge, are there communities who practice the equivalent of euthanasia within those communities?

   Yes

   No

6. If "YES" to question 5, how would you rate the incidence of such practices?

   High ☐

   Occasional ☐

   Rare ☐

7. Please indicate the communities who practice the equivalent of euthanasia.

   ....
   ....
   ....
   ....
   ....
   ....

8. How do you consider human life? Is life a possession which a human person owns or is it beyond ownership by the human being? Please provide a brief response.

   ....
   ....
   ....
   ....
   ....
   ....
   ....

9. Please comment on any issue relating to euthanasia.

   ....
   ....
   ....
   ....
   ....
   ....
   ....

Asante Sana,

Fredrick Ngatia
Strathmore University

APPENDIX B

Strathmore
UNIVERSITY

TO WHOM IT MAY CONCERN

15th February 2018

Dear Sir/Madam,

RE: REQUEST TO CONDUCT RESEARCH

This is to certify that Fredrick Ngatia is a final term Master of Applied Philosophy and Ethics student at Strathmore University. To complete his Masters he is required to write a dissertation applying the knowledge and skills he has acquired.

His dissertation on "*A Personalist Anthropology Review of Euthanasia in Kenya: The Moral and Legal Issues among Medical Practitioners*" requires him to interview some people under your care. We shall be grateful for any assistance you can give him.

He and the university commit to follow all confidentiality regulations and submit the findings to your institution's management before publishing or disseminating them.

We hope that his research will benefit your institution, management and staff.

We shall appreciate any assistance given to him.

Yours truly,

Yours Sincerely,

John Branya Ph.D
Course Director
Master of Art in Applied Philosophy and Ethics

Ole Sangale Rd, Madaraka Estate. P.O Box 59857-00200, Nairobi, Kenya. Tel +254 (0)703 034106
Email jbranya@strathmore.edu www.strathmore.edu

APPENDIX C

The Aga Khan University Hospital
P. O. Box 30270 - 00100 GPO, Nairobi
Tel: +254 20 366 2000 / 374 0000

Addressograph

CHANGE OF GOALS OF CARE ORDERS

This form is to be signed by a person acting on behalf of a patient who is incompetent or otherwise unable to make his or her wishes known. To be witnessed by 2 other independent individuals. These orders must be re-affirmed every 14 days.

Patient's date of birth ____________________ Admission date ____________________

Diagnosis ____

Date of diagnosis: ______________ Brief notes on irreversible nature of disease: ________

____

____

____

____

Attending consultant ____

Medical power of attorney / next of kin / guardian / surrogate ____________________

Length of care at AKUH at the time of issuing this order ____________________

Summary of discussion between family & medical team

____

____

____

____

____

List all Persons Present: (family& medical team)

____

____

____

____

____

I am the patient's: Please tick as appropriate

- ☐ 1. Legal agent under Medical Power of Attorney
- ☐ 2. Next of kin, specify: ____________________
- ☐ 3. Legal guardian
- ☐ 4. Surrogate

Two independent doctors have appraised and explained to me the patient's present condition and likely outcomes. They are of the expert opinion that the patient has no realistic chance of cure and no medical interventions will reverse the situation and therefore the patient is unlikely to recover from illness or impairment involving severe distress or incapacity for rational existence.

Therefore I state that:
A. I have been fully explained to the meaning of change of goals of care and my role and therefore:

I direct that the said patient should **NOT** be subjected to medical or treatment interventions ticked below

1. Cardiopulmonary Resuscitation (CPR)
2. Transcutaneous Cardiac Pacing
3. Defibrillation
4. Advanced Airway Management
5. Artificial Ventilation
6. Care in the Intensive care unit
7. Care in High dependence unit
8. Artificial Total Parenteral Nutrition
9. Haemodialysis
10. Hydration
11. Antibiotic therapy
12. Blood and blood products
13. Laboratory and Radiological investigations
14. Other interventions (Specify): ______________________________

Further I direct that any distressing symptoms including pain are to be fully controlled by appropriate analgesics. Any medications are to be given if they, in the opinion of the medical team, will contribute to the patients comfort. All measures to maintain comfort, dignity and quality of life should be instituted.

I consent to anything proposed to be done or omitted in compliance with the directions expressed above and absolve the medical team from any civil or criminal liability arising out of such acts or omissions.

Name: ______________________________ Signature: ____________________

Relationship to patient: ______________________ Date: ____________________

We testify that this directive was signed in our presence, and that the signatory made it clear to us that he/she understood what it meant. Further he/she understood that she/he **RESERVES** the right to revoke this **DIRECTIVE** at any time, but unless he/she does so it should be taken to represent continuing directions.

Witnessed by:

Name: ______________________________ Designation: ____________________

Signature: ___________________________ Date: ____________________

Name: ______________________________ Designation: ____________________

Signature: ___________________________ Date: ____________________

DOCTOR ASSESSMENT FOR CHANGE OF CARE GOALS.

Attending consultant: ____________________

Diagnosis: ____________________

Other co-morbidities: ____________________

Previous treatment: ____________________

Current clinical condition: ____________________

Expected disease trajectory: ____________________

____

In your professional opinion will this patient benefit from the following interventions?

		YES	NO
1	Cardiopulmonary Resuscitation (CPR)		
2	Transcutaneous Cardiac Pacing		
3	Defibrillation		
4	Advanced Airway Management		
5	Artificial Ventilation		
6	Care in the Intensive care unit		
7	Care in High dependence unit		
8	Artificial Total Parenteral Nutrition		
9	Haemodialysis		
10	Hydration		
11	Aggressive Antibiotic therapy		
12	Blood and blood products		
13	Laboratory and Radiological investigations		
14	Any Other interventions Specify:		

Consultant's Name: ____________________ Designation: ____________________

Date: ____________________ Signature: ____________________

TABLE OF RE-AFFIRMATION

Date	Signature (Medical Power of Attorney/ Next of kin/Guardian/ Surrogate)	Signature (Consultant)

Notes

1. These orders must be reviewed if a patient is discharged from ICU to HDU to ward or condition/ prognosis changes drastically as defined using Palliative Performance Score or other valid assesment tool
2. These orders must be fully signed, dated, signatories identified by names and accompanied by notes in the patient's medical file to be valid
3. Original copy to patient's file page 1 and a copy to the Medical Power of Attorney/ Next of kin/ Guardian/ Surrogate

TABLE OF RE-AFFIRMATION

Date	Signature (Medical Power of Attorney/ Next of kin/Guardian/ Surrogate)	Signature (Consultant)

Notes

1. These orders must be reviewed if a patient is discharged from ICU to HDU to ward or condition/ prognosis changes drastically as defined using Palliative Performance Score or other valid assesment tool
2. These orders must be fully signed, dated, signatories identified by names and accompanied by notes in the patient's medical file to be valid
3. Original copy to patient's file page 1 and a copy to the Medical Power of Attorney/ Next of kin/ Guardian/ Surrogate

APPENDIX D

FREDRICK NGATIA

ADVOCATE

BISHOPS GARDEN TOWERS
2ND FLOOR
BISHOPS ROAD
P.O. BOX 56688-00200
NAIROBI
KENYA
TEL: 2733652/2733653
FAX: 2733656
email: fngatia@gmail.com

Date: 16/05/2019

Chief Executive Officer
Medical Practitioners & Dentist Board
NAIROBI

Attn: Mr. John Kariuki

Dear Sir,

RE: RESEARCH PAPER

I am pursuing a Masters in Applied Philosophy at Strathmore University and in partial fulfillment of the degree, I am required to write a dissertation. The topic that I identified for the dissertation is Moral Perceptions of Euthanasia Amongst Medical Practitioners in Nairobi, Kenya.

I have concluded the field survey which entailed identifying a sample group of 55 medical practitioners whom I requested to complete a questionnaire on Euthanasia. A copy of the questionnaire is attached hereto for your information.

I write to request you to provide me with the following data;

a) Number of medical oncologists in Nairobi

b) Number of physicians who are specialists in critical care in Nairobi

c) In addition to the foregoing, please inform us whether there are other medical practitioners who routinely attend to terminally ill patients and how many such practitioners are in Nairobi.

I attach hereto copies of letters from Strathmore University and National Commission for Science, Technology & Innovation authorizing me to undertake the research.

I will be most grateful for your expeditious response.

Yours faithfully,

FREDRICK NGATIA

REPUBLIC OF KENYA

Telephone: +254 020 2724994/2711478/2728752
0720 771478/0738 504112
Fax: + 254 020 2724938
Email Address: info@kenyamedicalboard.org
Email Address: ceo@kenyamedicalboard.org
Website: www.medicalboard.co.ke
When replying please quote:

MEDICAL PRACTITIONERS
AND DENTISTS BOARD
MP & DB HOUSE,
WOODLANDS RD, OFF LENANA RD
P.O BOX 44839 - 00100
NAIROBI

Ref No:MPDB/BF/Vol.II/87

Date: 16th May, 2019

Fredrick Ngatia Advocate
Bishops Garden Towers
2nd Floor Bishops Road
P O Box 56688-00200
Nairobi
Email: fngatia@gmail.com

RE: STATISTICS REQUESTED FROM THE MEDICAL PRACTITIONERS AND DENTISTS BOARD

Reference is made to your letter on the above.

Do note that we have the following specialists in Nairobi: -

1. Medical Oncologists in various speciliaties =20
2. Critical Care Physicians =2
3. Anaesthetists, Critical Care Sub Speciality =2

However, we do not have doctors in palliative care.

Enclosed please find a list of the specialists indicated above.

DANIEL M. YUMBYA, MBS
CHIEF EXECUTIVE OFFICER
MEDICAL PRACTITIONERS AND DENTISTS BOARD
Encl.
/rw

APPENDIX E

15th April 2019

NGATIA, FREDRICK HARRISON
P.O. BOX 56688-00200
Nairobi.
ngatiaassociates@gmail.com

Dear Fredrick,

REF **Protocol ID:** SU-IERC0373/19 **Student Number:** 090737

MORAL PERCEPTIONS OF EUTHANASIA ANONGST MEDICAL PRACTITIONERS IN NAIROBI, KENYA

We acknowledge receipt of your application documents to the Strathmore University Institutional Ethics Review Committee (SU-IERC) which includes:

1. Study Protocol submitted 13 April 2019
2. Cover letter listing all submitted documents 14 April 2019
3. Proposal declaration page signed by supervisors 4 April 2019

The committee has reviewed your application, and your study "*Moral perceptions of Euthanasia Anongst medical practitioners in Nairobi, Kenya*" has been granted approval.

This approval is valid for one year beginning ***15th April 2019*** until ***15th April 2020***

In case the study extends beyond one year, you are required to seek an extension of the Ethics approval prior to its expiry. You are required to submit any proposed changes to this proposal to SU-IERC for review and approval prior to implementation of any change.

SU-IERC should be notified when your study is complete.

Thank you

Sincerely,

Prof. Florence Oloo
Secretary
Strathmore University Institutional Ethics Review Committee

Ole Sangale Rd, Madaraka Estate. PO Box 59857-00200, Nairobi, Kenya. Tel +254 (0)703 034000
Email admissions@strathmore.edu www.strathmore.edu

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/19/41320/29650**

Date: **25th April, 2019**

Fredrick Harrison Ngatia
Strathmore University
P.O. Box 59857-00200
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Moral perceptions of euthanasia amongst medical practitioners in Nairobi Kenya"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **25th April, 2020.**

You are advised to report to **the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.