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Research Article

Motivations and Mechanisms of End-Of-Life Issues: the Reflections on the Right to, and not to die among Yoruba, Nigeria

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ABSTRACT

The study examines end-of-life issues: the right to, and not to die among Yoruba. End-of-life decision which could also be described as advance directive on euthanasia has assumed new dimensions due to the advancements in medical sciences. Euthanasia is a death that results from the intention of one person to kill another person, using the most gentle and painless means possible, for the presumed best interests of the person who dies. While progress has been made in this area, there is need for further, cultural, ethical and legal reflections into this topic especially in such areas as autonomous decision making, importance of advance directives, rationality of care in a supposedly futile treatments and costs involved in providing end-of-life care. The narration was situated to interrogate the types of euthanasia among the Yoruba Nigeria and the nature of compliance to generally acceptable cultural/medical/ethical norms in Nigeria. It was discovered that the concept of*ikuyajesin*- it is better for one to die than to face opprobrium or wallowing in anintractable suffering in Yoruba is borne out of central-petal-force –like- association of people which places the premium on the universal good of the society than the good of individuals. In conclusion it was suggested that euthanasia must be viewed critically in society by society context to bring about policy with national outlook

Keywords: Euthanasia, Central-petal-force, End-of-life decision, Yoruba, Competence

INTRODUCTION

End of life voluntarily or euthanasia is the practice of intentionally ending a life through physician assistance to relieve pain and/or suffering. The word euthanasia means a good death and it originated from Greek [1]. Euthanasia addresses a set of moral questions about the causation of death that are not particularly free of the concept of 'killing.' Thus, the question is 'under which conditions is it permissible for a patient and physician to arrange for assistance in intentionally ending the patient's life?. To the question, euthanasia is categorized in different ways, which include voluntary, non-voluntary, or involuntary. Voluntary euthanasia is legal in some countries. Non-voluntary euthanasia (patient's consent unavailable) is illegal in all countries. Involuntary euthanasia (without consent or against the patient's will) is also illegal in all countries and is usually considered murder [2]. There is a wide spectrum of issues on assisted suicide and misunderstandings of these also abound. Assisted dying involves either euthanasia or assisted suicide. It is illegal in Nigeria and many other countries. A widely accepted definition of euthanasia is killing on request and is described as a doctor intentionally killing a person by the administration of drugs at that person's voluntary and competent request. The competence of the one requesting for it should be absolute. Otherwise, the request can come from his legal representative acting on the sick person advance directive. In some countries, there is a divisive public controversy over the moral, ethical, and legal issues of euthanasia. Passive euthanasia (known as "pulling the plug") is legal under some circumstances in many countries. Active euthanasia however is legal or de facto legal in only a handful of countries (e.g. Belgium, Canada, Switzerland) and is limited to specific circumstances and the approval of councilors and doctors or other specialists. In some countries such as Nigeria, Saudi Arabia and Pakistan, support for active euthanasia is almost non-existent [3].

END OF LIFE: THE TERRI AND MICHAEL SCHIAVO CASE 1998

Globally and historically, human euthanasia or assisted suicide,

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as if other life and death issues such as abortion always engender virulent controversy and divergent perspectives; much of these differences rest squarely on legal, religious, ethical/moral, social and economic considerations. As at now, five countries have legalized euthanasia (ending the life of a patient faced with incurable illness) and assisted suicide (writing a patient a lethal drug prescription of choice) is legal in eight other countries [3]. Euthanasia laws varying in concept and practice in each country across the globe. In Nigeria particularly, as in many other African countries, all forms of death based on the end-of-life issues are considered homicide [4]. However, there may be palliative of double effect medicine to relieve the pain and bring about gradual death to the sufferer.

This is yet to be engrained in Nigeria medical laws and ethics. However, Nigerian health care system attracted palliative care (improving quality of life by relieving pain for people in life-threatening illness) in 1991. Only 17 palliative care services are available thus far [4].

Request for premature ending of life has contributed to the debate about the role of physicians of such practices in contemporary health care. The debate also cuts across legal, ethical, human rights, health, religious, economic, spiritual, social and cultural aspects of many societies. Here, I argue this complex issue from both the supporters and opponents' perspectives, and also attempt to present the plight of the sufferers and their caregivers. However, what is death [5] posits that, until the late twentieth century, death was defined in terms of loss of heart and lung functions, both of which are easily observable criteria. However, recent researches in neuroscience and bioethics have indicated that death can be said to take place when human brain stops to function. The term brain death is defined as irreversible unconsciousness with complete loss of brain function, including brain stem, although the heart beat may continue. Demonstration of brain death is accepted criteria for establishing the fact and time of death. Factors in diagnosing brain death include irreversible cessation of brain function as demonstrated by fixed and dilated pupils, lack of eye movement, absence of respiratory reflexes (apnea), and unresponsiveness to painful stimuli [5] From the foregoing description of the meaning of life and death, it seems fundamental to observe that two defining natures of life-death analysis emanate. That is, death is either seen as annihilation of consciousness or breath, or death is taken to be the passage of the soul. While the body is a physical and ephemeral entity, the soul is believed to be spiritual and immortal.

Generally, somebody will prefer to live rather than to die. Even those who commit suicide prefer to live than to die; they choose death as a last option, but not their will. Death can either be natural or not natural. The natural one is without assistance of any kind. Natural death is therefore not a complete annihilation of man's life. On the other hand, unnatural deaths are those taken to obstruct the life of man, which does not allow people to live to a fulfilled age. On death by obstruction beyond natural occurrence one may frown at euthanasia as being unnatural. However, the Yoruba agree that when one is going through excruciating pain it is better for him to die to end the misfortune: *Ejekokukinkantorunkotan*. Again, what are the implication(s) of this among the Yoruba? We shall come to this very shortly. How long one wait for natural death would depends on the situation or the cause, length, and dimension of the sickness

A case in point elucidates this poignantly- The Terri and Michael Schiavo case 1998-2005 in the United States of America- Terri experienced cardiac arrest and collapsed in her home sometime in February 25, 1990 and suffered massive and irreversible brain damage. She was in coma for ten days. Thereafter, she was diagnosed to be in a persistent vegetable state (PVS) with little chance of recovery. PVS indicates that she would be unconscious to take voluntary and competent action and unable to interact with people and environment purposively [6]. After she was revived, it was found that she was unconscious and a quadriplegic, and she required artificial nutrition and hydration (AN&H) through a tube - Gastric Feeding Tube (GFT) -to keep her alive. According to [7] for a period of thirteen years she was in PVS, not uttered a comprehensible word, she keeps her arms drawn tightly up to her neck, her fingers curled tightly into her palms, into gnarled fists, rigid and locks up in awkward positions. Years of inactivity and her liquid diet have made her plump, her features soft and less distinct. Her legs are stick thin.

"Starting from 1998, Schiavo's husband and guardian Michael Schiavo petitioned the courts to remove the gastric feeding tube keeping her alive Schiavo's parents, Robert and Mary Schindler, fought a series of legal battles opposing Michael. The courts consistently found that Schiavo was PVS and had made credible statements (advance directive-emphasis mine) that she would not want to be kept alive on a machine. By March 2005, the legal history around the Schiavo case included fourteen appeals and innumerable motions, petitions, and hearings in the Florida courts; five suits in Federal District Court; Florida legislation (Terri's Law) struck down by the Florida Supreme Court; a subpoena by a congressional committee in an attempt to qualify Schiavo for "witness protection"; federal legislation (Palm Sunday Compromise); and four denials from the United States Supreme Court, among others came to end" (Wikipedia,the free encyclopedia.htm. Https://Www.Ajol.Info/Index.Php/Naujilj/Article/Viewfile/136296/125786)

The court directed that the GTF should be removed. Thereafter Terri gave up the ghost after thirteen years of excruciating pain, incapacitation and huge lot of public opprobrium coupled with Terri lost of autonomy and privacy. Terri's medical treatment drew divergent opinions across the world among population groups and intellectuals. Some opined that she should be kept *ad infinitum* though not sure of her recovery. And the other school was in the support of the husband to remove the GTF.

In any case before the Supreme Court intervention the woman went through intractable pain and loss of dignity-*ikuyajesin* in the Yoruba mythology of disease, care and eventuality. To the Yoruba, Terri Schiavo should have been helped to get her will fulfilled without the pain and loss of dignity she went through and the attendance of social and economic costs to her husband

The Yoruba belief in euthanasia and that, it is more dignifying for one to die when ovation is louder than to be wallowing in opprobrium and intractable suffering –*ikuyajesin* - The question that should come to mind is: what is it the submit of this narrative? The Yoruba, as it is conceived in this study are homogeneous borne out of centripetal- force- like- association of people which places premium on the universal good of the society than the good of individuals. On the other hand, the good of individual is a sub-set of the good of society. They are highly cosmopolitan and with particular understanding of collective living and avoid anything that embarrasses the family, the community and society at large. This conceptual collectivity is partly due to the fact that there is an existing compendium of mythology (Ifa Corpus) that cogitates the philosophical understanding of the people to live in perpetual

unity – *de ori* – one only strikes his chest with clenched fist and a lonely hand cannot carry load to the head. The preeminence of culture and its putative role are sacrosanct

CULTURE AND END OF LIFE EVENTS

The relevance of culture among other things can be understood in the way it points to social origin of disease /illness (beyond its biological causation) and the central role society plays in disease diagnosis, treatment, prevention and/or prognosis[7]. Emphasis, therefore, on culture in all ramifications and particularly on ill-health cannot be overemphasized because it helps to shape the understanding and focus of individuals who are unhealthy by making them to recognizese the implication of their state of health on their household, family, lineage and community. On the other hand, society is not unsympathetic to its members who are in need as it does not leave its sick members to seek for intervention or cure alone but renders collective and composite support in finding solution to the problem [7] indicate societal influence in the types of healthcare consumption available to individuals:

society is unlikely to leave the individual decision makers to their own imaginative devices. Instead, cultural pressures designed to standardize perception and behaviour will be brought to bear on private decision making with respect to health related preferences [8]

Stressing the above otherwise, the cultural pressures or prescription can be brought to bear on the type of existing health care method and end of life issue.

African image as described above reveals a pyramidal characterization of the society as being structured together in a two frontal principles: the vertical authority and horizontal family/ communal support system. [9] in agreement with the above notion of generally observable peculiarity identified African family or kinship setting as a vertical power structure or an overwhelming social apparatus where individuals derive their existence, belief system in total submission to what the society dictates and outside of which one is regarded as an outcast. Individuals have little latitude to manoeuvre or courage for self-determination outside what is considered as purview of traditional African family, community or kinship setting. [10] alluded much to this:

"...what happens to the individual happens to the whole group and whatever happens to the whole group happens to the individual. The individual can only say 'I am, because we are, and since we are, therefore I am?" [9].

This is one of the cardinal principles in the understanding of the African view of human societies including health care and end of life issue. But if an individual or a group of individuals chose to be contrarian(s) and remains passive or uncompromising to collective norms, the relationship between such individual(s) and the collective group is often cast in tension [11]. The question to be asked is how can "maximum" individual(s) liberty be assuaged and reconciled with the dictate(s) of society/collective group cultural norm and for such individual(s) to get along together with the society/group in the interest of "social harmony".

To succeed among the Yoruba therefore, entails the coming together of several others for one to realize his destiny or goal in life. One can therefore ill afford to rupture this collectivity. This is in conformity with long standing practice of communitarianism. It is a collection of interactions and alignment of culture, social and history among a community of people in a given geographical location, or among a community who share an interest or who share a common history and/or background.

Communitarianism is a strand of philosophy that alludes to the suzerainty of individual and the community. It is based upon the belief that a person's social identity and personality are largely molded by community relationships, with a smaller degree of development being placed on individualism. It is usually understood, in the wider,

philosophical sense. Communitarianism usually opposes extreme individualism and disagrees with extreme laissez-faire policies that neglect the stability of the overall community [12]. The understanding was due to past experiences such as external influences like war and slave trade which decimated the populace and economic prosperity when individual settlements were prosecuting war haphazardly in fragmentations. Until when they came together were they able to ward off the intruders. Therefore, to the Yoruba, anything that does not go in agreement with this collectiveness including vices, sickness or terminal diseases must be promptly dealt with. And when one is sick, especially terminal types for instance create an issue of involving several people in terms of care, role play and economic costs. This thus creates an infraction on the collectivity. Therefore, if the "culprit" in this case the sick is helped to die his position can be filled up by another able person for the essence and survival of the collectivity.

This indeed partly justifies the concept of *ikuyajesin*coupled with the belief that death is a passage to eternality and must rather be in dignifying manner. It means that man has two specific and distinct entities in him, namely: body and soul. This belief in life after death goes on to further entail that at the separation of the body from the soul at death (absolute death), the human soul moves into a new world or return to this world, where it continues its existence again. By this, it means that life is first lived in this physical world, followed by eternal life in the hereafter or a return to life in the old or a new body [13]. While this is a fact among Yoruba, however, association with Western world and other cultures is impinging on this fact and eroding on its utility. Now, more emphasis on euthanasia is located within orthodox medical armpit than social and to be strictly conducted within the hospital confinement with physicians, health workers, relative or significant others/legal representative present. Euthanasia therefore means that the physician would act directly, for instance by giving a lethal injection or double effect palliative to end the patient's life, all things being equal.

This is not withstanding euthanasia is nuanced within certain legal and ethical issues such as problematic influence of significant others, competence as an existential state, consent and capacity, good will to implement advance directive, withdrawing / withholding life-sustaining medical treatment.

END OF LIFE DECISION AND SUPREME COURT CASE IN NIGERIA

Although euthanasia is not used in the penal laws in Nigeria, but an inference to that effect is provided for. Consent of a person either competently or otherwise given by anybody to an act causing death is not a defense by the accused even in the hospital setting. The killing of a human being by another is a crime under homicide, amounting to murder or manslaughter, depending on the intent with which the killing is done. The penal laws do not distinguish between a killing that is carried out with the assistance of a physician or a request emanating from a patient or the state

of the patient's health. The effect is that euthanasia is murder. Unlike in the USA where a 'mercy killing' or euthanasia is generally considered to be homicide and is normally used as a synonym of homicide committed at a request made by the patient[5]. This is not the case in Nigeria as there was no outright permission of euthanasia with the only precedent set by the Supreme Court of Nigeria as recalled by [14].

"The history of euthanasia in Nigeria cannot be without mentioning the Supreme Court decision in Medical and Dental Practitioners Disciplinary Tribunal vr John Nicholas Okonkwo In that case, the Supreme Court per Ayoola JSC held among other things that, 'if a competent adult patient exercising his right to reject life saving treatment on a religious grounds, thereby chooses a path that may ultimately lead to his death, in the absence of judicial intervention overriding the patient's decision, what meaningful option is the practitioner left with, other, perhaps than to give the patient the comfort?'It was also the Supreme Court decision in this case that a patient has a constitutional right to object to medical treatment on religious grounds. In that decision, the Court held that "the right to freedom of thought, conscience or religion implies a right not to be prevented, without lawful justification, from choosing the course of One's life, fashioned on what one believes in, and a right not to be coerced into acting contrary to one's religious belief. The court also stated that the physician can awfully withdraw any form of treatment on a patient who by refusal of blood transfusion consented to die on ground of religion" [3] .

By implication if one peruses critical this judgment by the Supreme Court it shows that Nigeria has subtlety approved passive euthanasia in Nigeria. The use of pain medication to relieve suffering, even if it hastens death, has been held as legal in several court decisions across the world. Some governments in different societies have legalized voluntary euthanasia but most commonly it is still considered to be criminal homicide. The judicial sense of the term homicide includes any intervention undertaken with the express intention of ending a life, even to relieve intractable suffering. In a judgment in India, the Supreme Court legalized passive euthanasia. The apex court remarked in the judgment that the Constitution of India values liberty, dignity, autonomy, and privacy. Withholding or withdrawing treatment will hasten death only for those individuals who could be or are being sustained by a technology. Many other individuals, including some patients with cancer, face a protracted period of dying when respirators and other life-preserving technology are not being utilized. Great improvement in and extensions of palliative care adequately address the needs of many, perhaps most of these patients. However, for some, palliative care and the refusal of particular treatments do not adequately address all their concerns. During their prolonged period of dying, they may endure a loss of functional capacity, unremitting pain and suffering, an inability to experience the simplest of pleasures, and long hours aware of the hopelessness of their condition. Some patients find this prospect unbearable and desirable and desire a painless means to hasten their deaths.

CONCLUSION

Euthanasia encompasses various dimensions, from active (introducing something to cause death) to passive (withholding treatment or supportive measures); voluntary (consent) to involuntary (consent from guardian) and physician assisted (where physician's prescribe the medicine and patient or the third party administers the medication to cause death thus it can be said that euthanasia and or assisted suicide is illegal in Nigeria. This illegal status is however not as a result of any special legislation, but as based on existing laws which do not specifically provide for euthanasia and assisted suicide. One last point requires emphasis: Contrary to widespread belief, competence is not an existential state, a state of being. It is not people who are competent but decisions. So the same person may be competent to make one decision but not another. This is the case with young children, those with dementia, the confused old, mental health patients, and individuals temporarily or permanently unconscious. There are many instances in health care where the patient's consent is appealed to and used, where her actual consent is unobtainable. These are circumstances in which the patient is either unconscious or unable to process the information required to give a valid consent, or is temporarily or permanently lacking the relevant capacity to consent. Again, children are an obvious case in point.

NOTES

The Yoruba are taken to be the people who live in the southwest region of Nigeria with early contacts with Western culture, formal education, modernization, urbanization and civilization. The Yoruba constitute one of the major ethnic groups of Nigeria. They occupy the whole of Oyo, Osun, Ogun, Ondo, Ekiti, Lagos and a substantial part of Kwara and Kogi States. Today, the Yoruba live in three distinct regions: at home in Western Nigeria; in other West African countries, such as the southeastern Benin Republic and Togo; and outside of Africa, especially in South America, the West Indies, and Cuba (Diaspora).

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