EUTHANASIA IN ZAMBIA: AN ETHICAL ASSESSMENT

By

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(a) Represents my own work;

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APPROVAL

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ABSTRACT

The debate on whether euthanasia is morally permissible or not has become one of the most controversial issues in the world. Despite the fact that there is not much discussion in Zambia on the practice, Zambia is not spared from moral consequences of both euthanasia being practiced without comprehensive legislation and ignorance on key issues relating to euthanasia.

Although euthanasia has been discussed from many moral points of views like utilitarianism, Kantian ethics, and even virtue ethics, it has not been discussed from the point of view of a "claimed" common morality that is inherent in the Hebrew-Christian tradition.

This study is divided into two parts. The first part describes euthanasia, distinguishes the different types of euthanasia, offers a short history of euthanasia, gives some moral arguments for and against the practice, and states the fact that in Zambia, there are no adequate guidelines or legislation on euthanasia.

The second part discusses whether some kinds of euthanasia should be morally permissible or not. This is done through an ethical assessment of euthanasia using Alan Donagan's ethical theory, namely the fundamental principle of common morality described in his book *The Theory of Morality*. By applying Donagan's fundamental principle to the different types of euthanasia, I argue that voluntary euthanasia is morally permissible if the patient seeking it is competent. Non-voluntary euthanasia can only be morally permissible if the wishes of a patient in a written will are followed. Involuntary euthanasia and non-voluntary euthanasia where a surrogate makes a decision on behalf of those who are dying, are morally impermissible.

If human beings are to be respected as rational creatures in Zambia, the moral basis for accepting or denying euthanasia should be established. This respect of human beings as rational should result in law or guidelines on euthanasia. More discussion on the issue and establishing a medical ethics curriculum in medical schools are necessary to help in establishing that much needed moral basis on the practice.

To my parents, Timilile Elizabeth Nkhoma and Wilson Stefano Liche

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INTRODUCTION

With the improved health care system in Zambia, many more Zambians are dying in clinics, hospitals, hospices, or some other form of health care facility. The improvement in the health care service delivery has meant that life can be prolonged for a longer time when about 50 years ago, it would not have been possible. Before the early 1900s, medical care often just meant offering as much comfort and alleviating the pain of patients (often referred to as palliative care). Now with improved machinery like dialysis machines, X-rays, oxygen masks, insulin treatments, anti-retroviral treatments, artificial pacemakers, artificial feeding devices, etc., end-of-life decisions and the manner of ending one's life, have become even more difficult. Given the autonomy[1] of human persons, and the duty of medical professionals to save life and not to do harm, finding the moral basis for such decisions is necessary.

In the Zambian health care system, with the improved health care service delivery system, there will be an increase in the number of Zambians facing end-of-life decisions. These decisions are two-fold: from the side of the medical professional and from the side of the patient and/or the patient's guardians. These decisions include problems of withholding and withdrawing treatment and problems that arise when patients ask healthcare professionals to end their lives. Although such decisions need to be made, finding a moral basis for them has not been extensively discussed in Zambia. This has been mainly due to ignorance, misconceptions as to what constitutes euthanasia, and lack of appreciation that euthanasia can involve the respect of rights to self-determination of persons.

Given the autonomy of a person, it would not be an ethical way of proceeding to simply do nothing without exploring the ethical basis for medical decisions concerning death and dying. This is because the way a person suffers and dies has a lot to do with how meaningful one finds their life. Given a person's autonomy and the meaning one attaches to life, it is vital to consult patients in medical decision

[1] Autonomy in this dissertation will be taken to refer to the patient's right to make free decisions about his or her health care. Autonomy, literally meaning self-rule, has been defined as the capacity to think, decide, and act on the basis of such thought and decision, freely and independently (Chalmers, 2008:17). In certain cases the right of a patient to choose what is best for them can conflict with what the doctor feels is in the best interest of the patient. It is still debatable what course of action ought to be taken in such a situation.

making which might lead to a patient's death. It is therefore necessary to find the moral basis for regarding certain types of euthanasia permissible or impermissible.

Given this background, this dissertation is divided into two parts: Part I discusses in general issues of euthanasia and gives a brief outline of the situation with respect to medical practice on euthanasia in Zambia. This part also gives an overview of some arguments against euthanasia and some arguments for euthanasia setting the ground for the ethical assessment part. Part II is an ethical assessment of euthanasia using Alan Donagan's ethical theory, namely the fundamental principle of common morality described in his book *The Theory of Morality*.

Objectives

The research objectives are:

- to explain in detail the different kinds of euthanasia and their ethical implications;
- to give a brief overview of the context within which euthanasia can be discussed in Zambia and consider what guidelines physicians could use when faced with a case that qualifies as a euthanasia case;
- to investigate whether there are some types of euthanasia that are morally permissible and whether there are some other types that are not morally permissible;
- to make recommendations on having clear ethical and legal guidelines on euthanasia.

Research Questions

a) What is euthanasia and what are its ethical implications?
b) What is the context within which euthanasia could be discussed in Zambia?
c) What kinds of euthanasia could be morally permissible and which ones would be morally impermissible, using Alan Donagan's moral theory?

Significance of the Study

The emergence and increase of incurable and fatal diseases like AIDS, cancers, and some genetic disorders means that decisions on ending lives, at least through withholding and withdrawing treatment, will have to be made inevitably. The

modern technologies that enable healthcare professionals to diagnose, treat, and prolong the lives of people, make the question of ending lives even more difficult. This makes finding a moral basis for dealing with different cases of euthanasia important.

Scarce medical resources (funds, drugs, personnel etc.) and unequal distribution of available scarce resources between the rich and the poor, urban and rural, mean that some people die in intolerable pain or in a deplorable state without any reasonable relief. In Zambia, life-saving and life-sustaining technological advances like dialysis machines, heart-lung devices, X-rays, chemotherapy, and expensive drugs are not widely available in health centres. In most cases, there are more patients in need of such life-supporting equipment than are available. Discussing the basis of making a decision on who benefits and who does not benefit and who should be left to die, is important to study. In some circumstances, such decisions relate to cases of euthanasia especially involuntary euthanasia.

The rights of patients, when taken seriously, might make some patients to explicitly ask to be relieved of the pain by actively being put to death, or by being allowed to die through withdrawing or withholding life-supporting treatment. It is therefore necessary to find the moral basis for allowing or not allowing certain kinds of euthanasia to provide the background on which to base such decisions.

It is hoped that this research will add to the body of knowledge on medical ethics and bioethics in the Zambian context. Such knowledge on euthanasia in Zambia could provide a basis for arguing for legislation or written guidelines on euthanasia. Further, it is hoped that this type of research can lead to discussions on euthanasia that would even clarify the legal situation in Zambia that healthcare professionals and Zambians can refer to when met with a problem in the area.

Methodology

This was a mixed research[2] consisting of an empirical part and an ethical assessment part. In the empirical part, descriptive research was used to find out what euthanasia means and whether there are any guidelines (oral or written) in Zambia on

[2] Although mixed research normally applies to a research consisting quantitative and qualitative research, in this dissertation "mixed research" is used as consisting an empirical part and a philosophical ethical assessment part. This research is primarily qualitative in nature using philosophical arguments.

euthanasia. Data collection was done through documentary research and informal interviews. Both primary sources (informal interviews) and secondary sources (documentary research) were used. Informal interviews were conducted with some physicians, students at the School of Medicine of the University of Zambia, clinicians at the University Teaching Hospital, and officials at the Ministry of Health. Documents from the Medical Council of Zambia and the Laws of Zambia were reviewed.

Purposive sampling was used where persons who were chosen in the study were chosen based on the purpose of this dissertation. This non-probability sampling method was chosen because, the research wanted to establish specific objectives that relate to certain institutions like the Ministry of Health, School of Medicine of University of Zambia, the University Teaching Hospital (UTH), Zambia Medical Association, some persons with traditional knowledge, and students studying medicine. This was done to achieve the objective on the establishment of the context within which euthanasia could be discussed in Zambia and to find out guidelines on euthanasia in the country. The informal interview guide (see Appendix) employed six cases, corresponding to the six different types of euthanasia, for analysis that was presented to the interviewees and some general questions on what is the current situation of euthanasia in Zambia. Consent was obtained from all interviewed persons whose names appear in this dissertation. This information was used as background for the ethical assessment part. Secondary sources included books from the University library and the Philosophy Department, journal articles from the internet (mainly from JSTOR and Blackwell Synergy databases), and some personal books.

In the ethical assessment part, philosophical research was used where analysis was based on logical arguments using primarily Alan Donagan's fundamental principle from his book, *The Theory of Morality.* Donagan's approach to morality was used as the framework within which the ethical assessment was conducted. Donagan's theory uses Immanuel Kant's 'End-in-itself' formulation of the Categorical Imperative to describe common morality that is inherent in the Hebrew-Christian moral tradition. A straightforward application model was used where after describing the problem of euthanasia, Donagan's ethical theory was used to investigate the problem. Donagan stresses that a theory of morality is one based on

rationality[3] and since human beings have reason, they ought to be treated as ends in themselves (Donagan, 1977; Wertheimer, 1983). According to the Hebrew-Christian tradition, morality only applies to rational creatures – human beings (Donagan, 1977: 32). The theory was used to critically assess the six different types of euthanasia to see which types could be morally permissible and which ones could be morally impermissible.

Since euthanasia involves ending the lives of human beings in one way or the other, a theory that deals essentially with how human beings relate to one another is desirable. Donagan's theory deals with how we ought to treat other human beings given their rationality. The basic moral principle of his theory is a slight modification of Immanuel Kant's Categorical Imperative, "*Act so that you treat humanity, whether in your own person, or in that of another, always as an end and never as a means only"* (quoted from Rachels, 2007: 131). Kant is one of the greatest eighteenth century philosophers and his theories are renowned and have been discussed over the centuries all over the world. Donagan's theory is also consistent with Hebrew-Christian (Judeo-Christian) thinking in that it claims to express the essence of Hebrew-Christian view of morality, specifically that human beings are not just objects for our use but due to their human reason, they are ends in themselves. Since Zambia claims to be a "Christian Nation" and since Christianity and its dictates play a major role in the lives of many Zambians, such a theory can relevantly be applied to moral issues in Zambia.

Donagan's theory of morality has so far not been comprehensively applied to the problem of euthanasia. However, it has been applied to problems of abortion[4] and the general ending of a life of an innocent human being[5].

Limitations of the Study

This dissertation is not intended to be a study in law on euthanasia. It is limited to a philosophical work that assesses from an ethical point of view certain kinds of euthanasia and against some other kinds of euthanasia. It is hoped, though, that this

[3] Rationality in this dissertation will be used to mean acting according to good reason. One accepts only that which they have good reason to believe. Logic is used to weed out any contradictions.
[4] For more details on Donagan's use of his theory of abortion, see Reynolds' paper on "Moral Absolutism and Abortion: Alan Donagan on the Hysterectomy and Craniotomy Cases."
[5] For more information of Donagan's use of his theory on murder and ending of the life of an innocent person, see Dan W. Brock's paper on "Taking Human Life."

type of discussion would provide an ethical background for further discussion and possible legislation and guidelines on the practice of euthanasia.

Further, this is not a quantitative research on attitudes or feelings of Zambians on euthanasia, neither is it intended to be a detailed investigation on the wide range cases that happen in health care facilities in Zambia but a qualitative research from a philosophical point of view. Despite the fact that empirical data were collected to establish the current situation in Zambia as regards euthanasia, data were only used to ascertain whether there is any legislation and as background for ethical assessment. The empirical data that was collected is by no means exhaustive but discussed with reference to an adequate basis for ethical discussion on euthanasia. Even though data were only collected in Lusaka district, the current situation applies to the whole of Zambia because of the centralization of health policy in Zambia at the Ministry of Health. The principle aim of the dissertation is to focus on the existence or non-existence of ethical guidelines or policies when cases relating to euthanasia arise.

The study on euthanasia is wide dealing with general issues of how person B ends the life of person A for the sake of person A. In this research, I will only deal with euthanasia that happens or could happen in a health care facility like a clinic, or hospital.

PART I: BACKGROUND ON EUTHANASIA

CHAPTER 1: EUTHANASIA AND ITS ETHICAL IMPLICATIONS

In this chapter, I discuss the definition of euthanasia, explain its different types and its history, and give an overview of some arguments for and against euthanasia. I do not discuss physician-assisted suicide even though it is often discussed alongside euthanasia in existing literature. What is discussed in this chapter provides a clear problem for assessment in Part II of this dissertation.

1.1 What is Euthanasia?

The word "Euthanasia" refers to the deliberate hastening death of a person by commission or omission for the sole benefit of that person in relieving suffering (Dickens et al., 2008: 72). "Euthanasia" - derived from Greek words *eu* (well) and *thanatos* (death) - means literally a "good death." It has been defined as "an action in which a person is intentionally killed or allowed to die because it is believed that the individual would be better off dead than alive, or else, as in the case of irreversible coma, at least no worse off" (Tooley, 2003: 326). Euthanasia is not limited to human beings but can also be performed on animals. I will limit my discussion to euthanasia performed on human beings. A good death should be understood as one that is peaceful, with as little pain as possible. For a case, in which a patient dies, to qualify as euthanasia, there must have been a deliberate intention to take the person's life or to let the person die. For example, the case where a patient dies because of an overdose of *chloroquine* because the physician did not know that the patient took some *chloroquine* at home before going to the clinic, would not qualify as euthanasia because the physician's intention was not to end this person's life. Also, cases of patients dying from negligence or lack of necessary medicines in the clinic would not be euthanasia. More importantly, the action or decision to let a patient die or cause a patient to die should be for the good or benefit of the patient such as to relieve the suffering of the patient because he is suffering painfully from an incurable or fatal

disease. For example, the case where a patient who is not suffering but is just bored with his life and finds a physician to give him a lethal injection of potassium chloride, would not qualify as euthanasia but merely assisted suicide. Euthanasia is performed for the good of the patient. Thus, a case where a guardian asks a physician to end the life of a comatose patient suffering from a fatal disease in order to inherit a large sum of money would not qualify as euthanasia because the intention is not the interests of the patient but the guardian's. These cases distinguish euthanasia from other forms of killing or the manner in which patients die. To summarise what has been said above on the definition of euthanasia and using Wreen's definition of euthanasia, all of the following conditions have to be fulfilled for a case to qualify as euthanasia:

- A kills B or lets B die;
- A intends to kill B or let B die (cases where B is killed or allowed to die accidentally or through negligence, or because of lack of the needed medications, or even killing knowingly do not qualify as euthanasia);
- In A's intention to kill B or let B die, a proper course of action is taken (e.g., injecting lethal substance or pulling the feeding tubes - this excludes cases where there is an intention to kill B but then A accidentally kills B);
- the act in which A kills B or lets B die should always be voluntary (this would exclude cases where a physician is compelled by pressure from the family, or due to scarce medical resources to kill a patient);
- the ending of B's life by A is for the benefit/good of B (this excludes cases where a person is killed because of any other motives like inheritance, a patient being a burden, jealousy, saving the life of another like in hysterectomy). B could be terminally ill and near death and not terminally ill (like those in PVS or those suffering from an incurable and very painful chronic disease, e.g., multiple sclerosis) making life difficult to live;
- the good seen in ending B's life should include avoidance of evil or more harm.

It has to be shown that the killing of a person in euthanasia is because of benefits she enjoys and not to further the suffering that they are going through. Euthanasia should always be seen as a good act other than an evil one (Wreen, 1988: 652).

The way euthanasia has been defined here in detail would rule out many cases in literature that are referred to as euthanasia. Some examples of this are the Nazi killings of those thought not helpful to society (the disabled, very old, sick and even the Jews) and the acceptance of some forms of withdrawing and withholding treatments for other reasons other than ending a person's life. These are not cases of euthanasia.

In this dissertation, only euthanasia performed in health care facilities by healthcare professionals is discussed. So a case where a patient suffering from a fatal disease dies because she asked the husband to give her cleaning fluid that is lethal, will not be discussed in this dissertation despite the fact that in some circumstances it could qualify as a case of euthanasia.

The questions surrounding the moral and legal status of the different kinds of euthanasia have continued to be the focus of philosophical, medical, legal and public discussion in recent times. It is now possible to keep a person alive on machines (respirators, heart-lung machines, intravenous feeding devices, artificial kidneys) for a long time (Campbell et al., 2005: 205-206; Rachels, 1996: 134). Before the Twentieth century, with little medical help and diagnosing power, these questions were not that much of a problem because a patient would just die with little or no help for pain relief or prolonging life.

Before going any further on the different kinds of euthanasia, let's examine briefly what physician-assisted suicide is and its difference from the types of euthanasia that will be considered at length in this dissertation. In broad terms, euthanasia can be self-administered and other-administered (Munson, 2008: 683). In self-administered euthanasia, the patient himself performs the final action that results in death whilst in other-administered euthanasia, another person other than the patient himself commits the action that results in death. Self-administered euthanasia is usually referred to as assisted suicide and physician-assisted suicide. "Assisted suicide ... is the act of taking one's own life purposely, but with the assistance of another person.... In many cases, the person assisting is a layperson, such as a relative or friend who is sympathetic to the other person's wish to end his or her own life" (McDougall and Gorman, 2008: 1). Physician-assisted suicide is when the person who assists is a doctor. What is important here is to recognise that it is actually the person who has chosen to die who performs the final act that leads to

death. A layperson (in assisted suicide) or a physician (in physician-assisted suicide) only provides the means through which a person ends their own life. A further distinction has to be made here to differentiate traditional suicide (where a person takes their own life for emotional or psychological reasons) and assisted suicide where a person makes a rational choice to end their lives. The rational choice is based on the desire to end or avoid unnecessary pain and suffering and the desire to exercise one's autonomy (McDougall and Gorman, 2008: 32-34). In this dissertation, only euthanasia that is administered by another person is discussed. This is because physician-assisted suicide brings additional issues relating to suicide that are generally not discussed in other-administered euthanasia. Although it can be argued that physician-assisted suicide is not any different from voluntary euthanasia, the distinguishing factor is who performs the act that leads to death even though both acts are voluntary and both are done for the good of the patient. It is worth stressing that there could be many more types of euthanasia in literature but I have limited myself to only six types for a good discussion on the issue.

For a fuller understanding of what euthanasia[6] is and what it is not, two distinctions have to be made, (i) between voluntary, non-voluntary and involuntary euthanasia, and (ii) between active and passive euthanasia.

1.1.1 Voluntary, Non-voluntary, and Involuntary Euthanasia

The first distinction is between voluntary, non-voluntary, and involuntary euthanasia. Euthanasia can be said to be **voluntary** when it is requested, autonomously, by a competent person who undergoes it (Campbell et al., 2005: 213).

Non-voluntary euthanasia is euthanasia that is performed on a person who is not in a position to request or make a competent decision in her interest without her consent like in the case of infants or persons who are in Persistent Vegetative State (Campbell et al., 2005: 213; Tooley, 2003: 326). The case where a patient is incompetent, but where directives contained in a *living will* stating that if he becomes incompetent his life should be taken or treatments withdrawn or withheld, will still fall under this category because, in such a situation, at the time of euthanasia being done to them, no explicit request is given. It is dependent on family members to bring this to the attention of the physician or the witness/lawyer at the signing of

[6] In this dissertation the term “euthanasia” is used to mean other-administered euthanasia only.

such a will. The *durable power of the attorney,* where a surrogate is appointed and given powers to make decisions on behalf of a patient, will also be regarded as non-voluntary euthanasia. This is differing significantly from the views of Garret and Brock who have classified euthanasia on the basis of a living will or a durable power of the attorney as voluntary euthanasia (Garrett et al., 2001: 186-187; Brock, 2004: 1411-1412). I have decided only to categorise these cases in terms of competence[7] at the time when a request or no request is made. I restrict cases of voluntary euthanasia only to those where the competent patient at the time euthanasia is performed on him, explicitly asks for his life to be ended. This is to avoid confusion on how reliable a living will or a durable power of the attorney is in ascertaining the wishes and intentions of the patient.

Involuntary euthanasia is performed on a competent patient without his consent without asking the patient of his preference even when he would have preferred to go on living (Campbell et al., 2005: 213; Tooley, 2003: 326). In all these cases, it is in the interest of the patient that an act is performed or treatments withdrawn or withheld. Whilst involuntary euthanasia might *prima facie* be morally forbidden, Tooley gives a case of involuntary passive euthanasia that might be open to discussion and might even be considered morally permissible. Take a case "… in which the continued existence of the person is very much contrary to his or her best interests" (Tooley, 2003: 329). In such a case, it would seem morally permissible to allow such a person to die because the person is suffering from a fatal disease that makes him live a very dehumanised life. If assessing his existence leads to conclusions that he is better off dead than continue living (his quality-of-life is bad or receiving futile treatments), it can be argued that such an action could be morally permissible.

Some thinkers have contended that this distinction between voluntary, involuntary and non-voluntary is nonexistent. Some will strongly rule out involuntary euthanasia as euthanasia at all. They hold that since it is done against the will of the patient who is competent enough to make a decision on her fate, involuntary euthanasia should be strictly considered murder (Garrard and Wilkinson,

[7] Competence refers to having functional abilities needed to make a decision. The abilities include having enough information, understanding the information, and understanding the consequences of the decision.

2005: 64). This also applies to non-voluntary euthanasia since it would be difficult to know the intentions of the incompetent person who is undergoing euthanasia at the point when euthanasia is being performed, the act should also be considered murder. The task force of European Association of Palliative Care (EAPC) asserts very strongly that the "medicalised killing of a person without the person's consent … is not euthanasia … [but] murder" (Garrard and Wilkinson, 2005: 64).

Without getting misled by such arguments on the different explanations of the kinds of euthanasia, it is good to keep in mind the general definition of euthanasia as as provided earlier in Section 1.1.

1.1.2 Active and Passive Euthanasia

The second distinction is between active and passive euthanasia. **Active euthanasia** occurs in those instances in which someone takes deliberate active means (direct intervention) for the benefit of the person who dies, such as administering a lethal injection to a terminally ill person, to bring about that patient's death. The primary cause of death is human action, normally the action of a physician (Tooley, 2003: 326-327). An example of active euthanasia would be: Patient A is suffering from fatal incurable prostate cancer and according to the attending physician, he will die in a month or two. Patient A, after discussing his preferences of death with his wife and children asks the physician to give him a lethal injection of morphine. The physician gives Patient A the lethal injection. Patient A dies after 2 minutes. This case qualifies as a case of active euthanasia because direct act of the physician, namely injecting Patient A with a lethal injection, is what causes death. The act is done in the interest of the patient who is in intolerable suffering.

Passive euthanasia occurs in those instances in which someone simply refuses to intervene in order to prevent someone's death. Specifically it is (i) when a physician does not deliberately do something necessary to keep the patient alive like when a physician does not resuscitate a patient who has gone into a temporal coma; or (ii) when a physician intentionally stops doing something that is necessary for the patient to stay alive like in discontinuing ventilation and providing nutrition to a person who cannot breathe unaided and is in a Persistent Vegetative State. Unlike in active euthanasia, the primary cause of death is here some injury or disease as is the case in a patient who dies of kidney failure due to withdrawal of a dialysis machine. In

passive euthanasia, the physician's direct action (stopping treatment or not providing treatment) does not immediately lead to a patient's death. Not providing an oxygen mask or removing the dialysis machine to persons who need them for their continued living do not directly cause the patient to die. Death comes indirectly even when it is foreseen that these actions will bring about a patient's death. It is worth noting that when a physician does not do something that would have otherwise preserved a patient's life, the action should be intentional and done for the benefit of the patient to qualify as a case of passive euthanasia. Here is an example of passive euthanasia. Patient B suffers from severe kidney failure coupled with fatal kidney cancer. He is in intolerable suffering and his condition is hopeless. He depends on a dialysis machine to keep on living. He asks his physician to remove the dialysis machine. The physician removes the machine and Patient B dies five days later of kidney failure.

Two points have to be stressed: (i) not every act of withdrawing or withholding treatment qualifies as a case of euthanasia. For example, stopping treatments that are not helpful to the patient, and when this leads to death, does not qualify as a case of euthanasia. Also when a dialysis machine is not provided because there is none available, this does not make the act one of euthanasia. Also not all forms of direct actions that lead to a patient's death qualify as euthanasia. As stated above, actions out of mistakes, incompetence, lack of necessary treatments, expired treatments, misinformation will not be considered as euthanasia. (ii) For any case to qualify as euthanasia, there has to be the intention to end a person's life and this act has to be for the benefit of the patient.

In short, active euthanasia is when a medical professional knowingly does something that directly causes a patient's death and passive euthanasia is when a medical professional knowingly allows a patient to die without doing anything that would sustain his life. Sometimes passive euthanasia is referred to withdrawing or withholding treatments with the sole intention of letting a patient to die.

Despite the fact that the passive-active distinction seems straightforward, some philosophers have (i) argued that the active-passive distinction is morally irrelevant. What is relevant in both cases is the fact that a healthcare professional intends to cause a death, only that the ways such a death is arrived at differs (Munson, 2008: 682). (ii) Others claim that the active-passive distinction is not always clear. For

example if a doctor removes a dialysis machine from a patient with the intention of killing the patient, should this clearly be a case of passive euthanasia or active? (Munson, 2008: 682). For in this case, it can be claimed that the doctor's deliberate action, namely removing the dialysis machine, directly causes death. Or should it be regarded as a case of euthanasia at all considering that it is just removal of a machine and there can never be a guarantee that when such a machine is removed, the patient will certainly die?

(iii) Further, some thinkers have restricted euthanasia to mean only active euthanasia. Some have considered traditional Catholic thinking on euthanasia, for example, to mean only active euthanasia. Therefore, these thinkers when rejecting all kinds of passive euthanasia as cases of euthanasia, would consider some forms of withdrawing and withholding treatment as morally not problematic especially when they use the principle of ordinary and extraordinary treatments. The ethics task force of the European Association of Palliative Care (EAPC) asserts that euthanasia is active by definition and that there cannot be such thing as passive euthanasia (Garrard and Wilkinson, 2005: 64). Since acts that are generally classified as passive euthanasia are mostly those of withdrawing and withholding treatments, these acts in themselves cannot cause death. By withdrawing or withholding treatments, it does not directly lead to someone dying. As such, these acts cannot be labelled as euthanasia because death is not really caused by these acts (Garrard and Wilkinson, 2005: 65-66).

Although the debate of whether there is any euthanasia that can be classified as passive due to the fact that acts in passive euthanasia do not necessarily cause death even when death is foreseen, since the intention is to let a patient to die, we will treat it as a case of euthanasia. Despite the fact that the distinction between active and passive euthanasia can at times be difficult to establish, it is important to keep in mind that, generally seen, active euthanasia employs doing something that directly causes death and passive euthanasia is doing something that indirectly causes death (Rachels, 1996: 134). In this view, withdrawing and withholding treatment will fall under passive euthanasia whilst injecting lethal substances or taking lethal medicines will be classified under active euthanasia. David Callahan argues that to say that there is no moral distinction between active and passive euthanasia is very wrong. The problem lies in "confusing causality and culpability, and in failing to note the

way in which human societies have overlaid natural causes with moral rules and interpretations" (Callahan, 2008: 708). Callahan asserts that there is a clear distinction between one's actions *causing* death (as in administering a lethal injection) and one's actions that just allow the disease kill the patient. In the case where one's actions directly cause death, one ought to be directly responsible for the actions. Whilst in the case where actions just let nature (disease or illness) take its course, even when the intention is to let die, it is the disease or some other condition that finally kills the patient. Note that even after withdrawing or withholding treatments, a patient can still go on living without dying as intended. This study recognises that there is a clear distinction between active and passive euthanasia as explained above and that this distinction has a bearing in considering certain types of euthanasia as morally permissible or morally impermissible.

Whilst generally, many people think that passive euthanasia is less problematic than active euthanasia, morally seen, others, especially philosophers, think that active euthanasia is morally better than passive euthanasia. These who argue for active euthanasia assert that active euthanasia is morally better because it is quicker and very precise in its intention of helping a person to die. Withdrawing and withholding treatments has been known not to be precise, painless or even inducing the intended outcome, death. For example, in the case of Karen Ann Quinlan, even after artificial nutrition and hydration, and ventilation were stopped in 1976, Quinlan remained alive for many years after withdrawing treatment before she actually died in 1985 (Beauchamp, 2005). Given a situation where a person continues to suffer without dying, active euthanasia would seem morally better. Consider another situation where feeding tubes are withdrawn with the intention of helping that person to die, the patient will of course die of hunger. It cannot be said that such a person died in a gentle and painless way because he died of starvation. Starvation is painful and not gentle. In some cases, people who would choose passive euthanasia are competent and not in a Persistent Vegetative State or unconscious (e.g., persons with diabetes refusing insulin treatment). They feel and know the consequences of not continuing treatment, or continuing treatment. Withdrawing treatment and withholding treatments, given this scenario, will not be the best possible kind of euthanasia, especially when one considers that euthanasia is intended to be gentle and painless. Some scenarios of passive euthanasia can even increase the pain, discomfort, and

suffering of patients for the few hours or days they live without treatments. Caution must be taken in ethical assessment so that simplistic assessments that portray passive euthanasia as morally better than active euthanasia are avoided. Such assessments can be misleading, especially when one considers that euthanasia is supposed to be done for the good of the patient to relieve the suffering of the patient undergoing it.

1.1.3 Six Different Types of Euthanasia

From the two distinctions of euthanasia as active and passive, and also as voluntary, non-voluntary, and involuntary, we can come up with six different types of euthanasia, as shown in Table 1: Voluntary Active Euthanasia, Voluntary Passive Euthanasia, Non-voluntary Active Euthanasia, Non-voluntary Passive Euthanasia, Involuntary Active Euthanasia, and Involuntary Passive Euthanasia. I will not discuss physician-assisted suicide that is often discussed alongside discussions on euthanasia, mainly because it is not strictly speaking a form of euthanasia. It is a suicide (the deliberate taking of one's own life), only that in this case, it is done with the help of a healthcare provider.

	Active	**Passive**
Voluntary	Voluntary Active	Voluntary Passive
Non-voluntary	Non-voluntary Active	Non-voluntary Passive
Involuntary	Involuntary Active	Involuntary Passive

Table 1: Six different types of euthanasia

1.1.3.1 Voluntary Active Euthanasia

In Voluntary Active Euthanasia, the actions of a healthcare provider directly cause the death of a competent patient who requests such a death (Brock, 2004: 1490; Gert, 2006: 456). Two points are important here. First, the patient must request to be killed, and second the patient must be competent. Competence in this case is the ability to make rational decisions after being adequately informed about the implications of making such a decision. Incompetent persons include infants, those with mental disorders, those who are depressed or under stress, patients who are under coercion, or those who cannot make a rational decision. Consider this example of Voluntary Active Euthanasia: Mary F. was dying from a progressively debilitating disease, she was almost totally paralyzed and, periodically, needed a respirator to

keep her alive. She was suffering considerable distress. Despite her suffering and distress, Mary was competent to make her own decisions about what was good for her. Knowing that there was no hope and that things would get worse, Mary F. wanted to die. She asked her doctor to give her a lethal injection to end her life. After consultation with her family and the members of the healthcare team, Dr. H. administered the asked-for lethal injection and Mary F. died.[8]

This case qualifies as a case of Voluntary Active Euthanasia because it has all the defining attributes of Voluntary Active Euthanasia. Mary F. was in terminally ill and suffering considerable distress. She competently asked Dr. H. to end her life. Dr. H. gave her a lethal injection that directly caused Mary F's death. Dr. H's action was intentional and deemed for the good of Mary F.

1.1.3.2 Voluntary Passive Euthanasia

In Voluntary Passive Euthanasia, a healthcare provider accepts the wishes of a competent patient for treatment to be withheld or withdrawn, knowing that doing so will result in the death of the patient (Gert, 2006: 456; Munson, 2008: 682). The patient must be competent, or wishes signed in a living will are followed, or the durable power of attorney allows another person to make a decision on behalf of the patient. The decision must also be rational. Consider this example of Voluntary Passive Euthanasia: Following an accident in which Donald Herbert, a member of a fire rescue squad, was trying to rescue potential victims in a burning building, Donald suffered severe burns and head injury after the building collapsed on him. This severely damaged his lungs and heart systems. He was unable to feed unaided and his heart was weakening needing a pacemaker. The attending physician said despite the head injuries, they were not severe enough to make him incompetent. Donald had always desired that should he be dependent on pacemakers or artificial nutrition, he would not want to prolong his life by accepting these. He preferred that nature takes its course without using artificial devices to unnecessarily prolong his life. Since he was competent, he asked his physician not to even begin the artificial provision of nutrition and hydration and the use of a pacemaker. The physician complied knowing his intention and competence. The doctors, after consultation,

[8] Case modified from one given in Kuhse (1997: 295).

granted his wishes and the pacemakers and feeding tubes were not provided. Donald died later due to lung and heart failure.[9]

All the defining attributes of Voluntary Passive Euthanasia are included in this case. Donald Herbert is competent enough to ask for or refuse that treatment be withdrawn. Donald freely and competently chooses that nature takes its course since it has been explained to him by the physician that without these devices, he would die. The doctors granted his wishes and the treatments are not provided leading to his death. The physician's intention is to let Donald die.

1.1.3.3 Non-voluntary Active Euthanasia

In Non-voluntary Active Euthanasia, the actions of a healthcare provider directly cause the death of a patient who is not in a position to request or make a decision, without her consent. Non-voluntary Active Euthanasia is performed on infants or persons who are in Persistent Vegetative State and, in some cases, on adults who are mentally ill or just incapable of making competent decisions. Consider this example: A six-month old baby was suffering from severe anencephaly.[10] The physician's assessment was that the baby could live for another 6 to 7 months but would certainly die because babies born with anencephaly normally do not grow up to adulthood. Seeing the suffering of the baby and after consulting with the parents of the child, the physician gave a lethal injection to the baby who died after a few minutes.

The case contains all defining aspects of Non-voluntary Active Euthanasia. The baby is suffering from a fatal condition with no prospects of recovery. The baby's consent is not acquired since the baby is not competent to give such consent. But the judgement of the physician after consulting with the parents is justification for the action. The physician gives her a lethal injection causing death.

1.1.3.4 Non-voluntary Passive Euthanasia

Non-voluntary Passive Euthanasia is bringing about the death of a patient by not performing a life-sustaining act (like resuscitating a person in a coma) or withdrawing treatment without the consent of a patient who cannot competently

[9] Case modified from one given in Munson (2008: 700-701).
[10] This is a brain condition where a baby is born with defects in brain development resulting in all or a part of the brain and part of the skull missing.

make decisions. It is passive in that the death of a patient is brought about indirectly by actions or inactions of a healthcare provider. Consider this example of Non-voluntary Euthanasia: Mr. A was riding his bike home from a friend's house when a truck hit him. Taken immediately to a hospital emergency room, he was put on life-support and treated aggressively for a severe head trauma. The neurologist who was called in to assist said that he would have been killed instantly except for the helmet he was wearing. Three months later, Mr. A was in a deep coma, with minimal response to sharp and intense pain. There were no prospects of recovery and he was on a ventilator and receiving artificial nutrition and hydration plus doses of antibiotics. Having failed to identify Mr. A or any of his relatives, the attending physician decided to discontinue treatment. Mr. A died a few days later.[11]

This is a case of Non-voluntary Passive Euthanasia. It is non-voluntary because the consent of the patient is not obtained (the patient has not asked for (or been asked for) treatment to be stopped). The patient is not in a position to give consent. It is passive in that death is brought about indirectly by withdrawing life-sustaining treatments. The action is intentional and is performed in the interest of the patient.

1.1.3.5 Involuntary Active Euthanasia

In Involuntary Active Euthanasia a healthcare provider kills a patient without a request from the patient who could otherwise have meaningfully made decisions to go on living but did not before his or her life was ended (Campbell et al., 2005: 213; Gert, 2006: 456). This should be understood as being done for the wellbeing of the patient as in the case of relieving the suffering of the patient. Consider this example of Involuntary Active Euthanasia: Trevor was HIV positive. He had been living with HIV for about 20 years. In the past two years, his HIV condition progressed to full-blown AIDS disease. Despite the efforts of giving him antiretroviral treatments, he was not responding to the drugs any more. His body was emaciated, he could not move or feed himself but he was still very sharp and competent. He was brave enough and planned to fight the disease to its bitter end. He knew he was going to die soon but he had not communicated anything to his attending physician, Dr. B or his wife on whether he wished to continue living or end his life. Dr. B considering Trevor's life as not having any quality since Trevor was in extreme pain and was

[11] Case modified from one given in Garret et al., (2001: 196).

going to die soon, decided to give Trevor a large dose of diamorphine that led to the death of Trevor a few minutes later.

This case is involuntary in that Trevor has not been consulted on his wishes or consent to be killed, despite him being competent. It is active in that Dr. B gives Trevor a lethal injection that directly causes death. But the action by Dr. B is in the interest of the patient to relieve the dehumanising suffering. The case therefore meets all the conditions necessary for it to be Non-voluntary Active Euthanasia.

1.1.3.6 Involuntary Passive Euthanasia

Involuntary Passive Euthanasia is "allowing a patient to die by ceasing treatment, in order to relieve the suffering, when the patient has neither refused treatment nor has an advance directive refusing that treatment" (Gert, 2006: 456). Consider this example of Involuntary Passive Euthanasia: Chucks was on life support needing artificial feeding and breathing devices to aid in feeding and breathing because he could not eat or breathe by himself. 7 years earlier, Chucks was involved in a motor vehicle accident that damaged most of his body, leading to amputation and several chest operations. His brain was untouched so he could still talk, think and process what was said to him. In short, he was still competent. But Chucks was in intolerable pain and had indicated nothing to his physician on his preference on having life-support terminated. The physician thinking that it would be best for Chucks to die, removed the life support. Chucks being a strong person lived without the life support for two weeks and died because of breathing failure.

This qualifies as a case of Involuntary Passive Euthanasia. It is involuntary in that Chucks is not consulted on the decision and has not given his consent although still competent. It is passive since treatments are withdrawn. The physician thinks he is acting in the best interest of Chucks relieving the intolerable suffering.

Generally speaking, euthanasia cannot be restricted to terminally ill patients (patients that have a fatal disease and would live for 6 months or less) since decisions about non-terminal patients should also be made as in the case of patients who have HIV and those in a Persistent Vegetative State. Acts of negligence by healthcare providers should not be considered as acts of euthanasia. In acts of negligence, it is not the deliberate intention of the physician to bring about death. Negligence also is not due to effort at acting in the best interest of the patient.

Euthanasia, as can be seen from discussions on the different types above, is a complex issue that touches on the rights of patients, role and duties of physicians, duties of family of patient and surrogates, legislation of a country, and the distribution and availability of scarce medical resources.

1.1.4 Euthanasia and the Definition of Death

In any type of euthanasia, one controversial issue has been the question of when should a person be considered dead. The major question on the definition of death is: at what point and what function (or part) signify the death of a person? It can be argued that depending on the definition of death, certain types of euthanasia would either be less controversial or not be considered as euthanasia at all. Several definitions of death have been discussed but I will only consider four: traditional, whole-brain, higher brain, and the personhood definitions of death.

The *traditional definition of death* defines death as the irreversible cessation of breathing and heartbeat (Zukowski, 2005: 355). A person is considered dead when he permanently stops breathing and the heart stops beating. The *whole-brain death* regards a person dead when the whole brain is dead. Death is the "irreversible cessation of all functions of the entire brain, including the brain stem" (ibid, 2005: 355). The cessation of electric activity in the brain is indicative of this conception of death. The *higher-brain concept of death* regards a person dead when the higher part of the brain permanently stops working even when the brain stem (the part that controls respiration and heartbeat) is still functional. The permanent loss of consciousness usually indicates that the higher brain has stopped functioning. Technically, it is when the part of the brain that keeps a person conscious permanently stops functioning even though a person can breathe and has a heartbeat. The *personhood criterion of death* views a person as dead when that person ceases to be a person. A person ceases to be a person if she loses features of personal identity, e.g., when she stops reasoning, remembering, feeling, planning, interacting with others.

Generally, the traditional criterion of death is used in Zambia and in many parts of the World. Also the whole brain criteria is desirable to be used but it demands adequate devices to ascertain that there is no brain activity and these devices are unavailable in most developing countries. Adopting the higher-brain death criteria

raises many ethical issues such as considering all persons in Permanent Vegetative State (irreversible coma) and children born with severe forms of anencephaly but breathing as dead. Similarly, adopting the personhood criterion of death is problematic. When can one be considered to have ceased to be a person? Many people that we consider to be alive now would be considered dead. People with mental retardation, unborn children, those in PVS, would be considered dead. Actively killing such people or letting them die by stopping treatments would not be a moral issue since these persons would have already died on ceasing to be persons or having their higher-brains dead. In any case killing or letting such persons die would not be considered as cases of euthanasia because it would have been a case of "killing" already dead persons. But when one uses the traditional or whole-brain criteria, euthanasia on persons in these conditions has moral implications since such persons would still be considered as persons and alive.

Generally, in this study I will work with the whole-brain concept of death. Although in most of Zambia, especially in rural areas, the traditional concept is applied, it is, however, much more problematic given the modern technological advances in measuring whether one is dead or not. Persons who temporarily cease to breathe or those whose heart temporarily stops beating could easily be declared dead.

1.2 A Brief History of Euthanasia

1.2.1 Ancient Times

Generally, in ancient times the Greeks and Romans did not believe that life needed to be preserved and protected at all costs. They were tolerant of suicide when life became not worth living or in cases where one was in extreme pain with no possible relief. Moreover, the Stoics and Epicureans could end their lives where one stopped caring for their lives (Young, 2007). It is sometimes believed that it is Judaism and the rise of Christianity, strongly believing in the sanctity of life and that life is given by God and that only God can take it away, that brought about the belief that euthanasia is never acceptable (Brock, 2004: 1410). Euthanasia in these traditions is seen as a violation of natural law (Kuhse, 1991: 294).

The Hippocratic Oath, written in 4th century BC clearly states that a medical professional should not deliberately cause the death of a patient. The Oath states, "To please no one will I prescribe a deadly drug nor give advice which may cause his

death" (quoted from Post, 2004: 2650). Despite this general thinking of people in ancient times forbidding euthanasia, the Greeks practiced and found acceptable euthanasia including infanticide and suicide on slaves, barbarians, and children born with extreme deformities (Berg, 2005: 483).

1.2.2 Before the 19th Century

The writings before the 19th century, such as the English Common Law (a law established by following earlier judicial decisions rather than statutory law), generally were not in support of euthanasia including suicide and assisted suicide. However, some writers of the time like Sir Thomas More in his book *Utopia* (1516) saw an ideal (utopian) community as one that would allow the ending of lives of those in extreme pain with no hope of much relief (Kuhse, 1991: 294). Notable British philosophers like David Hume, Jeremy Bentham and John Stuart Mill challenged the prohibition of euthanasia based on religious grounds. Still other philosophers, e.g., the German Immanuel Kant, maintained that when pure reason is basis for action, man cannot dispose of his or another's life.

1.2.3 Modern History since the 19th Century

Despite the general laws and thinking of the time that euthanasia was not acceptable, it was only in 1828 that the first anti-euthanasia law was passed in the United States of America in the State of New York. The English Common Law continued to be the basis of forbidding euthanasia in the United Kingdom. Notable in this period is the formation of Euthanasia societies in England in 1935 and in the USA in 1938. These societies advocated for the acceptance and passing of laws that would permit certain kinds of euthanasia especially those of the voluntary nature.

Much debate on euthanasia began again in the late 1930s and early 1940s with the so-called "euthanasia" by the Nazis in Germany on those that were socially unacceptable and unproductive. The so-called Nazi "euthanasia programme" was code-named Action T4[12]. Some hold that what the Nazis performed was a kind of

[12] The common designation for the adult euthanasia program, abbreviated from the Berlin address where the program was administered: Tiergartenstrasse 4. The T4+ programme was the intentional killing of the chronically sick, the extremely disabled, the old and was even extended to justify the killing of Jews in the concentration camps in the late 1930s and early 1940s. It is debatable whether this programme was technically euthanasia because it is not clear (at least in the killing of Jews in concentration camps) whether such killing was for the good of those killed.

involuntary euthanasia on children suffering from mental retardation or extreme deformities, older people, and the chronically ill. Later this programme was extended to killing thousands of Jews in concentration camps (Berg, 2005: 483; Chao et al., 2002: 129). Although it is debated as to whether this was euthanasia, some writers like Chao and Berg regard this as a form of euthanasia or at least as events that brought many controversies to the euthanasia debates. The killing of Jews by the Nazi's in concentration camps should be regarded as murder.

Despite the fact that these killings of the Nazis in Germany were met with a lot of opposition, in the same era, in the United States of America, a series of court trials were held involving people who were either critically ill and requested some form of euthanasia or those involving relatives that had put their patients to death claiming they did it for the good of the patients (Kuhse, 1991: 295). In most of these cases, it was generally recognised that euthanasia was not legal even when in some of the cases, those involved were given lenient sentences. Despite these developments, in 1937, Switzerland passed a law legalising physician-assisted euthanasia[13] only in cases where it was found out that the person being assisted to die had nothing to gain.

The approach that was mainly taken by those advocating euthanasia was that individuals, given their autonomy, had the right to die especially when their lives became unworthy of living. One case that highlighted arguments from both sides in the 1970s was that of Karen Ann Quinlan. In 1975 Karen at age 21, coming back home from a party where she had consumed alcohol and valium, fainted and was rushed and admitted to Newton Memorial Hospital. She stopped breathing and this led to a state known as Persistent Vegetative State (PVS) and had to be kept on a ventilator. After several months in this state the parents requested that the ventilator be removed but the Hospital (St. Clare's Hospital) in which she was admitted refused the parents' request. The parents sued the hospital (at New Jersey Supreme Court); the tribunal finally ruled in favour of the parents and the ventilator was removed in 1976. Although this was done, Karen lived on up to 1985 when she died of pneumonia. This very famous and important case in the history of euthanasia paved way for general acceptance of non-aggressive (passive) euthanasia and a law in 1977

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[13] Note that physician-assisted euthanasia is not dealt with in this dissertation for the sole purpose that it is a form of suicide where a patient voluntarily brings about his own death with the assistance of another person, in the medical setup, usually a physician.

in the State of California permitting or accepting a living will where a person, before becoming incapacitated, could sign that when she reaches such a state, she should be allowed to die or have life-supports unplugged legally (Beauchamp, 2005).

In the 1990s, a Michigan Physician Dr. Jack Kevorkian, famously known by anti-euthanasia groups as "Dr. Death," started to openly encourage and practice physician-assisted suicide in his clinic. This led to a 1992 law in the state of Michigan forbidding this practice. After Dr. Kevorkian performed an assisted suicide on television, he was tried for and convicted for murder in 1999 (Microsoft Encarta, 2006). During this same time, in 1993, in the Netherlands physician-assisted suicide was decriminalised. This meant that although it was illegal for a physician to assist a patient to commit suicide, the physician was not convicted or liable to any charges if the patient who was going through intolerable suffering requested to die, and the physician helped the patient after consulting with two other physicians. The State of Oregon in the United States of America voted for passing into law the acceptance of physician-assisted suicide in 1994 but it was only in 1997 that the Supreme Court allowed laws legalising the practice in the State through the Death with Dignity Act. In 1995, a euthanasia bill was enacted in Australia but was in 1997 overturned by the Australia's Federal Parliament. In 1999, voluntary non-aggressive (passive) euthanasia was permitted in the State of Texas of the USA.[14]

In the history of euthanasia, it was only in 2002 that euthanasia was legalised in many of its forms in the Netherlands, with very strict guidelines that included being performed in a recognised hospital, in consultation with one other medical professional and the competence of the patient on whom euthanasia is being performed.

1.2.4 The Current Practice of Euthanasia

On the international scene, many countries, especially those in the Americas, Asia, and Europe are discussing regulations and guidelines on euthanasia. As of 2008, several countries, especially in Europe, had legally permitted some forms of euthanasia with very strict guidelines. These included the Netherlands, Luxemburg, Belgium, Switzerland, Thailand, and the USA state of Oregon. In some countries,

[14] This acceptance of voluntary non-aggressive euthanasia strictly meant that the patient had the right to refuse treatment even when death is more likely and foreseeable if treatments are not provided.

euthanasia was legalised but then de-legalised after a few years as is the case of Australia (the Northern Territory of Australia approved a voluntary active euthanasia law in 1995 that was overturned in 1997). For other countries like the USA, common law built from earlier judicial decisions (like decisions in the Quinlan case) guides new cases on euthanasia.

The Netherlands, Belgium, and Switzerland are some of the countries in the world that have put in place comprehensive guidelines and laws guiding euthanasia in health care facilities. As far back as 1984, the Supreme Court in the Netherlands decriminalised some forms of voluntary euthanasia. A law on euthanasia was passed in 1993, decriminalising active euthanasia under specific regulations. Under this law, informal guidelines were established whereby a physician would not be prosecuted for participating in voluntary euthanasia (Smartt, 2006). But it was only in 2002 that a comprehensive law on euthanasia was passed, with the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* that took effect on 1 April 2002. Under this *Act*, active euthanasia and physician-assisted suicide are allowed in very specific cases and under very specific circumstances. A physician can terminate the life of a patient who is experiencing unbearable suffering and there are no prospects of improvement when the patient requests his or her life to be terminated. Such a request must be voluntary, well considered and one that persists over time. It must be approved by one other independent doctor and carried out in an approved hospital (Campbell et al., 2005: 217; De Haan, 2002: 155).

Belgium is another country that has legislation on euthanasia. Under the *Act Concerning Euthanasia* (Euthanasia Act) that was passed in 2002, Active and Passive Voluntary Euthanasia are allowed under very strict conditions. Physician-assisted suicide is not included in this Act (Adams and Nys, 2003).

Luxembourg has become the third country after The Netherlands and Belgium to pass comprehensive laws on euthanasia and assisted suicide. The country's parliament passed a law on 29 February 2008 legalising euthanasia. Although this piece of legislation did not immediately come in force, it was hoped to come in force later in 2008. The Luxembourg law mainly applies to elderly ill patients and would come in force in special clinics that will regularly be checked for compliance to

standards.[15] As in the Netherlands and Belgium, only those patients that are competent (or their guardians) and had repeatedly asked to be allowed to die would be accepted.

Although in the State of Oregon in the United States of America, physician-assisted suicide is allowed under strict regulations through the *Death with Dignity Act*[16] of 27 October 1997, euthanasia is technically still illegal.

In Switzerland, the Swiss law condones and legally allows physician-assisted suicide. But the law even allows non-physicians to participate in assisted suicide (Smartt, 2006).

In Britain, the British Medical Association (BMA) has some guidelines on euthanasia. Although active euthanasia and physician-assisted suicide are criminal offenses, there are some guidelines on withholding and withdrawing treatments (Campbell et al., 2005: 214).

1.2.5 Traditional Views of Euthanasia in Zambia

In most Zambian traditions, euthanasia was practiced and is still practiced on children born with extreme deformities, and on people who are extremely ill and would have been very ill for a prolonged period of time (Anya-Phiri, Personal Communication, 31 August 2008). The first form is where euthanasia was performed on babies born with extreme deformities. It was allowed for midwives to either actively kill that baby by suffocation or by just leaving the baby without feeding with the view of letting the baby die from natural causes.

The second form of euthanasia was on persons who had suffered prolonged illness with little hope for recovery. Such persons included those that had stopped talking for a long period, or those who were alive but showing few signs of recovery. Such persons would either be helped to die through active means of suffocation or by leaving them without feeding with the view of leaving them to die of starvation. This form of euthanasia was very rare compared to the one performed on babies born with extreme deformities because traditional societies still believed that killing was wrong (Anya-Phiri, Personal Communication, 31 August 2008).

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[15] Information available at: http://www.dailymail.co.uk/news/article-516819/Luxembourg-says-yes-euthanasia.html [accessed on 20 November 2008].
[16] Available at: http://www.oregon.gov/DHS/ph/pas/ [accessed on 4 January 2008].

In most of these traditional attitudes that still exist to date, the suffering and the burden that the patient poses to herself and to the community leads to the wish that such a person is better off dead than alive. One often hears such comments as, "it is better the patient just rests (dies) than go on living with the suffering that they are going through." In traditional Zambian societies, only those cases where patients were intentionally allowed to die or actively killed for the good of the patients could be considered as cases of euthanasia.

Table 2 below outlines a summary of the history of euthanasia from the discussions on euthanasia given above.

Era	Event on Euthanasia
400 BC	Hippocratic Oath – stressed that euthanasia is impermissible.
1300s	English Common Law in the UK that criminalized euthanasia.
1500s	Thomas Moore's Utopian society implied that people whose lives had become burdensome with no reasonable relief was allowed to die.
Zambian and traditional attitudes	Very old men, very ill persons, and non-viable children (children born with extreme defects) could be allowed to die or actively killed.
1800s (1828)	First anti-euthanasia law passed in New York, USA.
1937	Physician-assisted euthanasia was declared legal in Switzerland as long as the person ending the life had nothing to gain.
1935, 1938	Euthanasia Societies formed in UK and USA respectively
1939	Action T4 programme in Germany that terminated thousands of people for eugenics reasons and the argument that their lives were unworthy living.
1960s and 1970s	Rights to die approach – California legalized living wills. This referred mostly to the patient's right to refuse treatment even when the patient would probably die without the treatment.
1990	Dr. Jack Kevorkian from Michigan encouraged and assisted patients to end their lives – this resulted in a Michigan law against euthanasia in 1992 and his conviction for murder (euthanasia acts) in 1999.
1994-1997	Death with Dignity Act approved in the State of Oregon. US Supreme Court allows Assisted Suicide laws.
1995	Australia's Northern Territory approves a Euthanasia Bill; Federal Parliament overturns the approval of the Bill in 1997.
1999	Non-aggressive euthanasia permitted in Texas. This refers to the right of patients to refuse life-sustaining treatment.
2002	Some types of euthanasia and assisted suicide permitted in the Netherlands

Table 2: History of Euthanasia

1.3 Overview of Some Arguments For and Against Euthanasia

Traditional views and Christian views on euthanasia have brought many controversies on whether euthanasia is morally acceptable and whether court rulings in favour of euthanasia should be taken as morally binding. It is clear there is a distinction between something that is legally accepted and something that is morally accepted. An act can be legally acceptable but immoral. Also, an act can be morally acceptable but illegal. For example, slavery was legally acceptable for many centuries but it was immoral.

Generally, proponents of euthanasia argue that human beings, given their autonomy and human dignity, have the right to choose the kind of death they wish to have. Opponents of euthanasia argue that given the sanctity of human life, no one has the right to take one's or another's life in any circumstance. A few argue for euthanasia claiming that although life is sacred, there are certain situations where life loses its dignity and worth, making that life lose its sacredness and not be worth living.

1.3.1 Some Arguments Against Euthanasia

Of the many possible arguments against euthanasia, I will here present five major arguments. The basic argument is as follows: (i) human life has dignity and sanctity; (ii) taking away human life removes the dignity that makes persons distinctly human; (iii) therefore, taking away of any innocent life cannot be justified.

The **first argument** I will state is that accepting any form of euthanasia, e.g., voluntary euthanasia, will lead to a slippery slope that will lead to the killing of persons against their wish and even killing of those that are socially unacceptable, like the mentally ill, severely deformed newly born children and those suffering dementia. A slippery slope argument says that doing one act will lead to a sequence of actions, such that when the sequence begins, there is no stopping until eventually, a clearly horrible outcome comes about (Amini, 2005: 1382-1383). This outcome is the last event in the sequence. A typical slippery slope argument is:

- It seems to be permissible or acceptable to do A;

- Doing A will most certainly lead to C, which will in turn most certainly lead to D, and so forth, finally to Z;
- Z is a horrible, bad, disastrous, and morally impermissible outcome that is unacceptable;
- Therefore, one should not do A.

The basic idea of the slippery slope is that once you take a first step, it is like falling off from the top of a steep hill such that once you start rolling down, it becomes extremely hard to stop until you hit the bottom and break your neck. Since breaking your neck is an undesirable outcome, even if the first action of rolling off the top of the hill is not undesirable, considering the end (the last bad consequence in the sequence of consequences triggered by that one action), it is good not even to do that first step that has no direct bad consequence. To stop such future undesirable consequences provides adequate reasons not to take the first step. Let us now apply this line of reasoning to Euthanasia:

- Accepting voluntary euthanasia as morally permissible may seem to be acceptable;
- But accepting voluntary euthanasia would lead to non-voluntary euthanasia (since it can be debated that the patient is unable to make a decision and therefore making the decision of their behalf would become generally acceptable when one is incapable of making a decision);
- Accepting non-voluntary euthanasia would lead to involuntary euthanasia (since all decisions in the medical setup ought to be made on behalf of the patient even when the patient conceives his or her interest as being different from what others conceive);
- Involuntary euthanasia is undesirable and morally impermissible;
- Therefore, one should not even accept voluntary euthanasia as morally permissible even when at first it seems acceptable.

For this argument to be accepted as sound, it has to be shown, that if voluntary euthanasia is accepted, non-voluntary and/or involuntary euthanasia cases will increase. So far, it remains to be shown that acceptance of voluntary euthanasia has caused an increase in involuntary euthanasia cases. For example, studies conducted in the Netherlands show no such clear correlation. Studies done in 1990, 1995, and

2001 in the Netherlands showed a constant percentage of non-voluntary euthanasia cases, at 0.8 percent even after decriminalising euthanasia (Lewis, 2007: 199).

The **second argument** against euthanasia that I will state here is that palliative care makes euthanasia unnecessary. The World Health Organization (WHO) defines palliative care as:

> an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[17]

Since palliative care is holistic, dealing with relief of physical and psychological pain which also involves the family of the patient, it can be considered the most effective method, other than ending the life of a patient, to deal with terminally ill patients and those going through unbearable suffering. Using adequate palliative care can lead to a very peaceful death (that euthanasia proclaims to bring about) in a hospice, in a hospital and even at home, without facilitating such a death.

It has to be recognised here that whilst palliative care promises to be an effective way of not ending lives or hastening death, certain conditions of cancer, fatal burns, and other conditions make pain relief almost impossible, needing very high doses of painkillers that could hasten a patient's death. Euthanasia, at least voluntary active euthanasia, would in such cases seem to be the best way to bring about a peaceful death that ends suffering and pain quickly.

The **third argument** is that euthanasia is a violation of the sanctity of human life (human dignity). This is an argument that is mainly held by Christian ethicists like John Locke and St. Thomas Aquinas. "Locke argued for the right to life on theistic grounds, namely, that we are God's property, that we therefore lack the right to take life, our own or that of another person" (quoted from: McCloskey, 1975: 404). Aquinas, in his *Summa Theologica*, also asserted that life is a property of God (ibid., 1975: 405). If human life has sanctity and dignity no human person has the power to take away one's own or another's life because that is the prerogative of God. Only God has the right to give or take away life. Those holding this view prefer that a person dies from natural causes rather than from steps taken to hasten death. Valuing

[17] http://www.who.int/cancer/palliative/definition/en/ [accessed on 12 February 2009].

life and determining which life qualifies to be taken using "peaceful death" criteria is to judge that some people's lives are worthless. Life has value despite the circumstances one finds herself in. Ending a life using any kind of euthanasia would be similar to murder or suicide. Murder and suicide are morally unacceptable, therefore euthanasia is morally unacceptable.

This argument is problematic because it is double-edged. One can easily use it to argue for some forms of euthanasia by simply stating that in certain circumstances, one loses personhood and the dignity that comes therewith. Ending the life of such a person would be just letting the patient die with dignity. Also, not all forms of ending life qualify as murder. Examples of other types of ending lives include manslaughter, homicide, killing in self-defence. Euthanasia is distinctly different from murder because in murder the intention is not in the best interest of a patient to relieve him of suffering. Normally, the intention is to harm the other person.

The **fourth argument** is that the basic role of healthcare professionals is to save lives and not to end life. The Hippocratic Oath clearly states that, "I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect" (quoted from Post, 2004: 2650). Allowing medical professionals to perform euthanasia would therefore be a violation of their fundamental moral and professional duty as healers and carers (Brock, 2008: 441). Furthermore, allowing medical professionals perform euthanasia would make patients fear that they would not really be taken care of when in hopeless conditions, since there would be an option to end their lives. The fear that euthanasia might be performed on patients without their consent can lead to patients losing trust in their physicians.

But it can also be argued that ending life in a humane way, when a person is in extreme pain and no treatments can really save his life, it seems a good thing for a medical professional to end his life.

The **fifth argument** is that accepting any form of euthanasia can put pressure on a patient or surrogates to choose euthanasia. This pressure can come from family members who may feel that the patient is becoming a burden to take care of, from a hospital that has limited scarce medical resources, or from depression. This leads to the difficulty in determining whether a patient made a competent and independent

decision to end her life. The difficulty in proving whether there was pressure to make such a decision may be reason to forbid any form of euthanasia.

Despite the truth that in certain cases there can be pressure from others, even pain and suffering can be pressure on the patient to choose euthanasia. This is reason for putting enough safeguards to ensure that a patient is not receiving unreasonable pressure to end her life. For example, a physician noticing that there is some pressure, can refuse to help the patient end his life. Also, a condition, such as one that exists in the Netherlands, that a patient before being helped to end her life has to consistently ask for her life to be ended can be another safeguard.

1.3.2 Some Arguments For Euthanasia

The **first argument** for euthanasia is that since human beings have self-determination and autonomy, they should have the right to choose the time and manner in which they die. This sometimes is referred to as the right to die. Although this can be a broad argument covering suicide, I restrict myself here to euthanasia. This right to choose death, in cases of passive euthanasia, is supported by the patient's right to refuse treatment or certain medications. If a patient has the right to refuse treatment when death is approaching, then he could choose not to accept certain measures that can prolong life even when death is foreseen. In Christian circles, it can be argued that since human beings are endowed with free will, they should have the right to choose how their lives end. Such a decision to end one's life because of self-determination should be reached after a competent patient weighs the benefits of continued living against the pain, burdens, and suffering one is going through (Dworkin et. al., 1998: 110).

Surely, human autonomy and self-determination have limits. For example, despite the fact that person A has autonomy, he has to respect the good of person B and since euthanasia involves two other major parties (family and physician), their autonomy, self-determination ought to be taken seriously.

The **second argument** is that given that mercy and compassion for the suffering demands that physicians help patients, for certain patients, like those with terminal illnesses or in hopeless condition, such mercy could be helping such patients to have a good and peaceful death. This compassion is to relieve the suffering, burden and pain of those who are near death and those who have no hope of ever living a normal

healthy human life (like those in Persistent Vegetative State). It would be cruel to just watch the patient suffering when there is no other way of relieving pain rather than helping to die (ibid., 1998: 110-111).

The problem with this argument is it presupposes that the only effective and meaningful way to relieve suffering is through ending the life of patients. Palliative care and being around one's family can be very fulfilling ways a person can live their last days before dying. Also, some people, especially Christians, would view pain and suffering as participating in the pain and suffering of Jesus Christ and as a time to prepare for death, so that ending their lives might not really be the merciful thing to do (Paul II, 2005).

The **third argument** is that consideration for the quality of life asserts that when life is devoid of its human quality, it ceases to be worth living. Quality of life often includes the ability to communicate with others, being conscious, and responsive to surrounding environments. When there is suffering, pain and terminal illness or sickness that offers no real hope for full recovery, a person's quality of life is so low that she is better off dead than alive.

This argument tends to regard human beings as things that can have value or not. Human dignity asserts that every human being has supreme value despite the "quality of their life." Using the quality of life consideration in determining who should be allowed or helped to die would mean some persons in society who are not necessarily under excruciating pain, or terminally ill could involuntarily be killed. These would include those with dementia, extremely disabled persons (who depend on others for all help), children born with extreme deformities, and social invalids. It is generally unacceptable that such persons be helped to die simply due to their condition.

1.4 Christian Views on Euthanasia

Christians are generally against active euthanasia and involuntary euthanasia. Some forms of allowing death (sometimes mistakenly referred to as passive euthanasia) are acceptable especially in cases where continuing medication is futile or when medications known to hasten death (e.g., morphine) are given to patients to relieve pain and suffering. The reason why active euthanasia is generally regarded as unacceptable is the belief that life is God's gift to human beings. As such, only God

has the right to take away life. Christians prefer that death comes naturally with no efforts of quickening it or ending it (Childress, 2001). One difficulty about the Christian view on euthanasia is that most of the time when they talk about euthanasia, they take it to mean only active euthanasia and not passive euthanasia.

Catholics, for example, would accept death that is brought about by withdrawing or withholding treatments that are extraordinary and futile (further discussion is given in 1.4.2). The support for such withdrawing or withholding of treatments that could (even foreseeably) lead to death does not qualify as an instance of euthanasia because even though death is foreseen, the intention here (for Catholics) is not to end a person's life or to allow a person die.

There are four major reasons why Christians are against euthanasia. These can be summarized as, (i) that life is a gift from God, (ii) the intrinsic dignity and value of human life, (iii) dying is spiritually important, and (iv) all human life is equal in dignity and value. Since life is created by God and birth and death are part of that life, no human being, but only God has the authority to take away that life even when the patient requests it. If this were to happen, human beings would start playing God with powers that are reserved to God. The intrinsic dignity and value of human life stems from the fact that human beings are made in the image and likeness of God. This dignity and value does not depend on the circumstances that a person finds himself in (like the circumstances that persons who are terminally ill find themselves in). The circumstances one finds oneself in are not a sufficient reason for a person to be helped to die. In many Christian traditions, death is a time of passing on from this world to the next world to meet God, the Creator. If human beings, say physicians or patients themselves, are allowed to make decisions on ending life, this process of meeting God would be disrupted and its spiritual significance would lose meaning. To make decisions on what life is worth living and what life is not, is to say that human value and dignity is dependent on one's intelligence, mobility, achievements in life and health. Christian traditions insist that life has value in itself. People who are terminally ill, people suffering from intolerable pain, people in Persistent Vegetative State, people requiring life support machines, etc., are still human beings with full human dignity and value despite their ailing situation (BBC Team, 2004). In this section, I concentrate on the Catholic Church's view on euthanasia because it is the biggest Christian denomination worldwide, a prominent Church in Zambia, and

because the Catholics have a much clearer view on euthanasia and their view is well documented.

1.4.1 The Catholic Church's View on Euthanasia

The Catholic Church has a very clear position on euthanasia compared to other Christian denominations. The teaching on euthanasia can be found in four major documents of the Church, the 1965 Pastoral Constitution on the Church in the Modern World (*Gaudium et Spes),*[18] Pope John Paul II's 1995 encyclical, *The Gospel of Life,* the 1980 *Declaration on Euthanasia* by Vatican's Sacred Congregation for the Doctrine of the Faith, and the *Catechism of the Catholic Church.* In the 1960s, as the result of the revolutionary Second Vatican Council, the Catholic Church "condemned crimes against life such as any type of murder, genocide, abortion, euthanasia, or wilful suicide" (*Gaudium et Spes*, 1965: no. 27). Pope John Paul II, in the document, *The Gospel of Life* states that "man's life comes from God; it is his gift, his image and imprint, a sharing in his breath of life. God, therefore, is the sole Lord of this life: Man cannot do with it as he wills ... the sacredness of life has its foundation in God and in his creative activity" (Paul II, 2005: no. 39). In the *Declaration on Euthanasia,* euthanasia is prohibited as immoral and performing euthanasia is a "violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity." This prohibition is reiterated in the *Catechism of the Catholic Church* (paragraphs 2276-2279)[19] where "... an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator" (paragraph 2277). What is stressed in these documents is that the sick and those in conditions of extreme suffering deserve special respect, care, and attention but not to be helped to die.

Despite holding the view that euthanasia is forbidden, using the Principle of Double Effect, some forms of withdrawing and withholding treatments that may result in death are permissible. In these instances, death should only be brought about

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[18] Available at: http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_cons_19651207_gaudium-et-spes_en.html [accessed on 22 December 2008].
[19] Available at: http://www.vatican.va/archive/catechism/p3s2c2a5.htm [accessed on 22 December 2008].

when the intention of the physician is to relieve pain and not to kill. The Principle of Double Effect is used to explain the permissibility of an action that causes a serious harm, such as the death of a human being, as a side effect of promoting some good end. An action that can cause serious harm, such as death in this case, can be permissible if and only if all of the following conditions are met: (1) that the action in itself (withholding or withholding treatments or giving fatal painkillers) from its very object be good or at least indifferent; (2) that the intention is to cause the good effect (pain relief) and not the bad effect; (3) that the good effect be not produced by means of the bad effect; (4) the good effect is important enough and outweighs the bad one (Aulisio, 2004: 687). In defining euthanasia in this dissertation, it is stressed that for a case to qualify as euthanasia, the intention of the physician must be ending the patient's life for the sake and good of the patient. Strictly speaking, allowing death or hastening death using the principle or the doctrine of the Double Effect does not constitute euthanasia. The Catholics distinguish between ordinary (proportionate) and extraordinary (disproportionate) treatments. Ordinary treatments can be understood as all medicines, treatments, and operations, which offer a reasonable hope of benefit and do not involve excessive burden (Spielthenner, 2007). Such treatments should be easy to obtain and used without excessive pain, expense or inconvenience. Ordinary treatments are morally obligatory. Failure to administer these constitutes homicide if the failure leads to death. Extraordinary treatments, on the other hand, are those that involve medicines, treatments, and operations, which either involve excessive burden or do not offer a reasonable hope of benefit (Spielthenner, 2007). These treatments cannot easily be obtained or used without excessive expense, pain, or much inconvenience. Extraordinary treatments are morally optional. Withdrawing such extraordinary treatments even when it leads to death is permissible.

The Catechism of the Catholic Church clearly states that "discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate" (no. 2278). The intention in discontinuing such treatments is not to cause death even when such action actually leads to death.

The Catholic Bishops in Zambia in the pastoral letters have stressed similar views of opposing and condemning all forms of euthanasia. This is clear in their letters, *Choose to Live* (1988: no. 58), a pastoral letter addressing the HIV and AIDS

pandemic and in *Choose Life* (1997: nos. 1 and 2) a pastoral letter addressing abortion. In both documents, the Bishops stress that life is a gift from God and no human being has the right to take that life away, and that a culture of life should be promoted rather than the culture of death.

1.4.2 The Protestant Views on Euthanasia

Protestant denominations vary widely on their approach to euthanasia. Although the main Evangelicals oppose all forms of euthanasia without exception on the basis of sanctity of life, liberal Protestants are open to consider some forms of euthanasia like voluntary euthanasia. For example, Joseph Fletcher, one of the Protestants advocating for legalizing euthanasia, comes from this liberal group of Protestants. Some other Protestant clergy and laity were in the euthanasia societies offering some religious arguments and support for limited forms of euthanasia[20].

The Lutherans have generally maintained a hard-line view on euthanasia. Euthanasia is wrong for the sole reason that God only has the right to take a person's life[21].

The problem of defining what euthanasia really is and what it is not remains elusive and sometimes distinctions between active and passive, assisted suicide and voluntary euthanasia are so thin that it becomes difficult to simply discuss when euthanasia should be morally acceptable and when it should not. Having defined what euthanasia is and given its brief history, some arguments for and against euthanasia, and giving some Christian perspectives, we now turn to the context within which euthanasia can be discussed, and the kind of challenges that can be faced in discussing euthanasia in Zambia.

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[20] Available at: http://www.1lord1faith1baptism.com/TRACTS/EUTHANASIA.HTML [accessed on 17 March 2009].

[21] Available at: http://www.religionfacts.com/euthanasia/christianity.htm [accessed on 20 December 2008].

CHAPTER 2: OVERVIEW OF THE CURRENT SITUATION OF EUTHANASIA IN ZAMBIA

In this Chapter, I give a brief overview of the context within which euthanasia can be ethically discussed in Zambia. Whilst active euthanasia does not officially happen in Zambia, there are a number of clinical cases that are related to discussions on euthanasia and that demand physicians to make ethical decisions. I stress that the practice is difficult to avoid due to challenges of unavailability of life prolonging treatments and direct requests from patients to have their lives ended. Furthermore, I state that there is lack of extensive discussions or comprehensive policies or laws guiding medical practitioners on the issue of euthanasia in Zambia.

Despite the fact that the issues of withdrawing and withholding treatments and cases where a patient explicitly asks to be allowed to die do occur in Zambia, there are inadequate legislation or specific guidelines on euthanasia, and there has been very little discussion on this topic (Dr. S. Macha, Personal Communication, 30 June 2009). Consequently, given that there are patients who are brain dead but can live for two to three months or children born with extreme deformities like those with hydrocephaly or anencephaly with no prospects of survival, what should the physician do and what sort of guidelines should the physician look up to in the Zambian context? Talking to some professionals in the School of Medicine of the University of Zambia, clinicians in the University Teaching Hospital, Lusaka, students at Ridgeway Campus of the University of Zambia, some research and ethics experts in the School of Medicine, and an expert in the Ministry of Health, six issues became clear on the context of euthanasia in Zambia. These are: (i) physicians and clinicians in Zambia encounter cases relating to euthanasia (often passive euthanasia) that demand a decision from them; (ii) there are few organised debates or discussions on euthanasia either by the School of Medicine or by professional bodies like the Zambia Medical Association or the Medical Council of Zambia; (iii) Religion, especially Christianity, plays a major role in discussions on euthanasia because some physicians would make decisions based on their religious beliefs; (iv) the African conception of death where the family has a larger say on how a patient dies plays a

big role in either passively allowing death or patients explicitly asking for lives to be ended; (v) a systematic examinable course on medical ethics (in the medical curriculum) is not taught at the University of Zambia's School of Medicine;[22] and (vi) there are inadequate laws or explicit guidelines that guide the practice or instances of euthanasia in Zambia.

2.1 Do Physicians Encounter Euthanasia Cases in Zambia?

Even though it can be said that it is inevitable for medical professionals to encounter cases of euthanasia in Zambia, it can still be debated that these cases are not cases of euthanasia as defined in this dissertation. However, let us consider a few hypothetical cases, which I have discussed with some medical practitioners that raise concerns on euthanasia in Zambia:

Case 1: Baby F is born with extreme deformities caused by hydrocephaly. Due to these deformities, Baby F needs to be put in the paediatrics intensive care unit. But in the Unit, there is Baby Y who was born prematurely but with more prospects of survival than Baby F According to current practice at the University Teaching Hospital (UTH), the person with most prospects of survival is given precedence over the one who has less. So, Baby F is not put in the ICU and dies a few days later.

Case 2: The adult intensive care unit is full[23] and there is an 89-year old patient who is hypertensive and diabetic. But there are three other persons who need the facility. A decision has to be made about whether to keep the patient in the ICU or consider one of the three patients for treatment in the ICU. An immediate rapid assessment needs to be done to determine who would benefit most from ICU treatment and who has the most chances of survival. It is found that a 16-year old boy (one of the three outside the ICU) will benefit most from treatment in the ICU. The 89-year old patient is removed from ICU and dies a few days later, whilst the 16-year old boy survives.

Case 3: A baby is born with extreme deformities of anencephaly. The baby needs help in breathing, feeding and general nursing, without which the baby would die in a few days time. Babies born with anencephaly cases normally do not survive for

[22] This could explain why withdrawing and withholding treatments are generally not taken as forms of euthanasia.
[23] There are only three intensive care units at the University Teaching Hospital in Lusaka, the general ICU, the neonatal ICU and the pediatrics ICU (Dr. S. Macha, Personal Communication, 30 June 2009).

long. In the Zambian medical setup, such babies are often aborted before birth following the Termination of Pregnancy Act of the Laws of Zambia (Dr. S. Macha, Personal Communication, 30 June 2009). But, because the mother did not attend the antenatal clinic, the deformities were not detected. The physician is in a dilemma because he knows that the equipment needed to aid the anencephaly baby could easily help many other babies that surely need such equipment. Moreover, the physician feels that futile treatments, treatments that do not considerably help the patient with desired outcomes, are not worth applying especially when many other patients with better prospects of survival could benefit from such treatments. Even though it is not mandatory that such futile treatments be given, the physician continues to provide treatments even though a few months later the baby dies.

Case 4: Mr. G is in the cancer hospital suffering from lung cancer that has spread to most parts of the body making chemotherapy, a standard treatment of cancer available at the hospital, futile. Mr. G is in extreme pain and has been told that, at most, he has 2 months before he dies but that the pain will continue because he is not responding to standard painkillers. The attending physician, Dr. Y is approached by Mr. G to actively end Mr. G's life or to give him a large dosage of a pain killer which is known to hasten death. Dr. Y uses existing guidelines such as the Hippocratic Oath to look up to and refuses to do as Mr. G requests for the Doctors primary role is to save and preserve lives.

These are some of the cases that could arise in Zambia involving ethical decisions that relate to euthanasia. Cases relating to babies born with extreme deformities, and cases where immediate rapid assessments have to be done with regard to who benefits the most from a scarce medication, are very common in health institutions in Zambia (Dr. S. Macha, Personal Communication, 30 June 2009). In his research on Euthanasia in Zambia, Landilani Banda (2004) asserts that lack of life-sustaining equipment in hospitals makes physicians decide who benefits from such treatment and who does not. But by so doing, some form of involuntary euthanasia is performed. He also asserts that some forms of passive euthanasia do occur although these are done silently and no physician talks about such cases (Banda, 2004: 41-47). Despite some medical professionals denying that euthanasia is an issue in Zambia

but is rather a Western concept,[24] living in a global world, such an issue cannot be left without discussion. With the increase of terminal illnesses such as AIDS and some forms of cancer, end-of-life issues need to be more openly discussed. Lack of life-saving medical resources also means that some form of involuntary euthanasia is being practiced especially when decisions are made to withhold or withdraw life-saving treatments and procedures.

2.2 Organised Debates, Discussions, or Literature on Euthanasia in Zambia

Euthanasia in Zambia is still a very new concept and, as such, it has not been widely discussed. So far, only one debate stands out that was organised by the Zambia Medical Association where key experts and doctors debated on arguments for and against euthanasia and its applicability in the Zambian context. This took place at Ridgeway campus, School of Medicine of the University of Zambia in 2006. However, there was no agreement arising from the debate on whether some forms of euthanasia could be acceptable in the Zambian situation. It would appear that some discussants just took euthanasia to mean active euthanasia without ever considering passive euthanasia or even looking at cases where patients are allowed to die due to scarce medical resources, as relating to euthanasia.

There seems to be very little, if any, literature on euthanasia in Zambia. The Medical Council of Zambia guidelines can be seen as the most specific guidelines on death and dying issues. These are outlined in a book edited by Dr. Sekelani Banda (1997: 128) entitled, *A Handbook of Medical Ethics for Medical Students and Health Professions,* where the following are mentioned that could be used as guidelines in cases that relate to euthanasia:

> 18. Allow death to occur with dignity and comfort when death of the body appears to be inevitable;
> 19. Support the body when clinical death of the brain has occurred, but need not prolong life by unusual or heroic means;
> 20. May, when death of the brain has occurred, support cellular life in the body when some parts of the body might be used to prolong the life or improve the health of others.

[24] Landilani Banda quotes Dr. Kukuchabe of the University Teaching Hospital (UTH) as having this belief.

However, in general, there is a significant lack of literature dealing with euthanasia in Zambia and this is coupled with a serious lack of knowledge on the issue. It would appear that many lawyers, parliamentarians, and even medical practitioners do not fully understand what euthanasia is and the ethical issues surrounding it. Many would tend to consider euthanasia as murder and therefore shun any discussion on it. No case has been heard in the Zambian courts relating to euthanasia and the issue has not been discussed in parliament. There has also been little media coverage of any euthanasia case in Zambia compared to other countries like the USA, the Netherlands and Italy where there is media coverage on the issue (Banda, 2004). Amongst medical practitioners in Zambia, according to Dr. S. Macha (Personal Communication, 30 June 2009), euthanasia is not a very popular topic for discussion and few are interested in formally discussing it or even considering that some forms of euthanasia could be morally acceptable or even legalised. It should be noted, however, that although international documents such as the Declaration of Geneva, Declaration of Helsinki, and some guidelines of the World Medical Association (WMA) do offer guidelines which are applicable to doctors in the medical profession worldwide, they do not specifically make reference to euthanasia as discussed in this dissertation. Although the Declaration of Geneva only talks about maintaining the utmost respect for human life, the World Medical Association resolution on euthanasia is very clear. The Association states that "Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."[25] The WMA went further to clearly state their belief that euthanasia is in conflict with basic ethical principles of medical practice and encouraged all National Medical Associations and physicians not to practice euthanasia. These international guidelines are quite clear on euthanasia but most national medical associations have their own guidelines on the practice that differ from that of the WMA. For example, the Netherlands would allow certain forms of euthanasia that are forbidden by the WMA. It is not clear the extent to which Zambia abides by the directives of the WMA.

[25] Available at: http://www.wma.net/e/policy/e13b.htm [accessed on 2 July 2009].

2.3 The Influence of Religion

Religion in Zambia tends to play an important role in the moral standards of people in the country and this has a significant effect on the attitudes people take towards issues relating to life and death. What religion and religious leaders say on an issue has enormous influence on what persons do personally and professionally. An example of this is the issue of abortion.[26] Though some forms of abortion are legalised and acceptable in Zambia through the *Termination of Pregnancy Act* of the Laws of Zambia, many physicians refuse to terminate pregnancies citing religious reasons (Dr. S. Macha, Personal Communication, 30 June 2009). Most religious views, especially Christian views as has been discussed in Section 1.4, would not support euthanasia of any kind. Catholics are most prominent with this view that no form of euthanasia could be morally acceptable considering the sanctity and value of human life and that only God can give or take away life. Such religious beliefs have a great influence on discussions on euthanasia in Zambia. Most physicians who are Christians would find it very difficult to consider ending or helping to end the life of a patient. The lack of discussion on the issue by physicians could also be attributed to religious views that forbid ending of life for whatever reason. It should be noted, however, that medication that would be given with the intention of controlling pain would not be considered as a form of euthanasia although it would have the effect of hastening death.

2.4 Conceptions of Death by Some Zambians in the Discussions on Euthanasia

In most Zambian cultural systems and beliefs, the way a person dies has a very symbolic meaning and death can be said to be a family or communal affair. Family members often have a large say with regard to a person's death. They decide whether such a death is caused by other human beings (through witchcraft, or dubious means) or by natural causes. Normally, after a person dies, there is a quick inquiry into what could have caused such a death, and this is decided by the family of the deceased. In most near-death situations, family members, especially those close to the patient,

[26] Although it can be argued that some forms of abortion could qualify as cases of euthanasia, I have left out such discussions on abortion mainly because abortion is a separate moral issue demanding different kinds of arguments for or against it. Moreover, there is no consensus that the foetus should be considered as a human being or not. It is worth mentioning that on Abortion, Zambia has very explicit guidelines and laws on it especially the Termination of Pregnancy Act, Chapter 304 of the Laws of Zambia.

would gather around the death bed to support their loved ones. This makes it difficult for physicians to exercise some paternalism over the patient to decide what is good for them when family members see it as their responsibility to decide the way forward for such patients (Dr. S. Macha, Personal Communication, 30 June 2009). Death is often feared and regarded as sacred in the spiritual sense because it is a way through which we meet with ancestors. Death is usually not discussed at all. Some Zambians especially those in rural areas often regard death as having a cause and often the cause is harm by another human being.

With such conceptions and regard for death, hastening death through active means or withdrawing and withholding treatments becomes very difficult. In cultures where death is seen as a result of some harm by another human being (as in Tumbuka and Bemba cultures), to facilitate the death of a patient would not help at all in finding who is responsible for such a death (whether it be the witch who has bewitched the patient or the physician who has hastened the death of the patient). Consequently, the circumstances surrounding death can be a cause of great fear with the result that discussions about death tend to be avoided.

2.5 Systematic Teaching of Medical Ethics in Medical Training

In the Zambian medical training with reference to physicians, nurses, pharmacists, physiotherapist and other health care providers, medical ethics as a formal and examinable systematic course (that also looks at the use of ethical theories on current practice) is not provided in the curriculum, according to Professor J. Karashani (Personal Communication, 29 June 2009). This is unfortunate because in the daily work of health care providers, many ethical issues occur. The lack of a systematic medical ethics course in health care training could possibly contribute to the lack of interest in ethical issues that arise from practice in delivering health care services. This became clear from the lack of interest shown by some of those interviewed on the subject of euthanasia or common ethical issues in the provision of health care. Ethics, and more specifically euthanasia, according to Dr. S. Nzala (Personal Communication, 29 June 2009), is only discussed or pushed by a few medical practitioners that are interested in the issue. However, despite the lack of a formal course on medical ethics that covers euthanasia being given in the School of Medicine, some physicians have began pushing for such an organised course to be

developed and incorporated in the training of health care providers (Dr. S. Macha, Personal Communication, 30 June 2009).

2.6. Laws or Guidelines on Euthanasia in Zambia

At present the only guidelines that physicians can refer to that touch on cases of euthanasia are the general Laws of Zambia, the various codes of ethics (e.g., the Hippocratic Oath), and the general guidelines of specific hospitals on doctor-patient relationship (Naomi Longwani Banda, Personal Communication, 25 February 2009). These stress the physician's role in saving the lives of patients and caring for the patients. In the Zambian Constitution, in its Bill of Rights (Part III of the Constitution – Fundamental Rights and Freedoms of the Individual), it is clear that the right to life ought to be protected. "A person shall not be deprived of his life intentionally except in execution of the sentence of a court in respect of a criminal offence under the law in force in Zambia of which he has been convicted" (Article 12.1). Among the exceptions referred to, there is none that allows euthanasia to be performed (Article 12.2). In all the Laws of Zambia, euthanasia is not explicitly dealt with and the word "euthanasia" does not even appear.

The Zambia Medical Association (ZMA) and the Zambia Nurses' Association (ZNA) through the Medical and Allied Professions Act (Chapter 297 of the Laws of Zambia) and the Nurses and Midwives Act (Chapter 300 of the Laws of Zambia) concentrate on the behavioural practices and malpractices of doctors and nurses. The two Acts deal with requirements for training of medical professionals, registration to practice in Zambia, and the type of consequences that follow from malpractices and not following the given guidelines. Questions of euthanasia have not been seriously considered in the Acts and again, in both Acts, the word "euthanasia" does not even appear.

In the medical ethics guidelines for Zambian healthcare providers by the Medical Council of Zambia, euthanasia is touched on from references to the responsibilities of the healthcare provider. These responsibilities are: "allow[ing] death to occur with dignity and comfort when death of the body appears to be inevitable; [and] support[ing] the body when clinical death of the brain has occurred, but need not prolong life by unusual or heroic means" (Medical Council of Zambia, 1997: 128). Despite a hidden reference to euthanasia, these guidelines are by far inadequate to

deal with cases of euthanasia where one not only allows death when it is inevitable but intends to allow death for the good of the patient. The Ministry of Health has no policies or guidelines that deal with issues relating to euthanasia (Naomi Longwani Banda, Personal Communication, 29 December 2008). At the University Teaching Hospital (UTH) and in other Zambian health institutions, there are no clear hospital policies or guidelines dealing specifically with euthanasia (Banda, 2004: 45).

Due to the lack of guidelines and extensive discussion on euthanasia, withdrawing and withholding treatment becomes a difficult decision for the healthcare provider because his or her sole mandate is saving lives, not ending them. Contemplating active euthanasia is difficult for most Zambians given current guidelines and the *Laws of Zambia* (Naomi Longwani Banda, Personal Communication, 29 December 2008) that forbid suicide and murder that are often associated with active euthanasia.

When it is clear that euthanasia is a moral issue, having no guidelines or simply leaving all decision-making powers to physicians is not an ethical way of proceeding especially when the rights of patients are involved. Current general guidelines on medical practice do not deal adequately with cases of euthanasia. In these decisions, what is forgotten is that how a person dies is very important to the person and family. The whole question of how a person spends his or her last minutes or days before death is not considered fully. Human autonomy and self-determination in terms of wishes of patients, rights of patients and their surrogates are not seriously taken into consideration.

The lack of written and widely discussed regulations and even laws on euthanasia can lead to indecision on the part of Zambian healthcare professionals on what would be the right course of action. Withdrawing treatments and withholding treatments, as well as directly causing a patient's death, are seen as going against the physician's sole mandate to save lives (Dr. K. Bowa, Personal Communication, 29 June 2009).

Despite the fact that there are some documents in Zambia that can be referred to in cases of euthanasia (e.g., Medical Council of Zambia guidelines, 1997 or the Laws of Zambia), having no explicit guidelines means that medical decisions that are made in health care facilities are left mainly to the judgement of physicians. The existing documents include the oath that physicians swear when beginning their medical career, the Zambian Constitution, Medical and Allied Professions Act (Chapter 297

of the Laws of Zambia), and the Nurses and Midwives Act (Chapter 300 of the Laws of Zambia). These guidelines are insufficient for they do not provide a clear definition of euthanasia nor guidelines on what can be done or cannot be done given different scenarios that relate to the different types of euthanasia.

Most Zambians and healthcare professionals refer to euthanasia as only active euthanasia and this has led to reluctance in openly discussing the issue and pushing for some guidelines on the topic. This has also led to the denial that any euthanasia is ever practiced in Zambia (Dr. S. Macha, Personal Communication, 30 June 2009). Passive euthanasia is generally not seen as euthanasia. Murder in Zambia is morally and legally wrong and so is being an accomplice to murder. There is general reluctance by students of medicine in Zambia to discuss the ethical framework in medical issues which include issues on euthanasia (Vincent Mulenga, Personal Communication, 16 August 2008).

Despite recognising the rights of patients in Zambia, that include the right to refuse treatments, it is generally the physician who chooses what is in the best interest of the patient even when such treatments or their withdrawal would lead to death. In most of these situations, patients or their guardians are not consulted enough (Naomi Longwani Banda, Personal Communication, 29 December 2008).

The denial that euthanasia happens in Zambian health care facilities by some and denial that euthanasia is really an issue worth consideration blinds us from looking at the broader picture to find an ethical way of proceeding. The fact that euthanasia is being discussed in many countries (e.g., in Australia, the United States of America, the United Kingdom, the Netherlands) shows that it will soon be an area of discussion in Zambia also. Some medical professionals in Zambia assert that there ought to be some guidelines and even laws on euthanasia (see Banda, 2004: 44-45).

2.7 Emerging Concerns on Euthanasia in Zambia

Some officials at the Ministry of Health and at the University Teaching Hospital confirmed that euthanasia is slowly becoming an area of concern where clear policy measures will soon be needed (Naomi Longwani Banda, Personal Communication, 29 December 2008; Dr. S. Macha, Personal Communication, 30 June 2009). Since we are living in a global world where some Zambians find themselves in countries where euthanasia is practiced or discussed, it seems just the right thing to start

discussing it here in Zambia with the view of establishing clear guidelines or even laws on euthanasia.

Given the many development challenges that the Zambian health care facilities face, it is imperative that such guidelines be developed. These challenges include lack of adequate medical resources, inadequate access to scarce medical resources, and unfair distribution of medical resources especially between urban and rural communities. Other concerns are high poverty levels (64% in 2006), high maternal mortality rates (449 per 1000,000 live births), high infant mortality rates (119 per 1,000 live births),[27] general challenges in the medical sector (malaria, HIV and AIDS, cancers), and lack of blood for patients needing blood transfusion. These situations can lead to questions of whether it is morally acceptable to use so many resources on people with terminal illnesses when these resources could easily benefit many non-terminal patients. These concerns mean that some patients, when in excruciating pain, or suffering terminal illnesses, will not be adequately helped due to lack of advanced medical resources. It is difficult to adequately address the needs of such patients without clear guidelines and respect of their self-determination.

As can be seen above, despite the pertinent questions that arise from euthanasia discussions and problems in the health care facilities, some regulations, written or oral seem the ideal way of proceeding. In Zambia where clear guidelines on euthanasia do not exist, it is difficult for physicians to make decisions that relate to euthanasia. Consequently, an important focus of this dissertation is to reflect ethically on the permissibility of impermissibility of certain kinds of euthanasia. This will be done in what follows through availing of the approach to morality as proposed by Alan Donagan.

[27] Figures cited from the Zambia Demographic Health Survey 2008, quoted from: http://ww.unief.org/infobycountry/zambia_44198.html [accessed on 14 October 2008].

PART II: ETHICAL ASSESSMENT OF EUTHANASIA

CHAPTER 3: ALAN DONAGAN'S THEORY OF MORALITY

In this chapter, I give an overview of Donagan's theory of morality. In his theory, he explains what he calls the fundamental principle of morality that states: "It is impermissible not to respect every human being, oneself or any other, as a rational creature."

3.1 General Overview of *The Theory of Morality*

In his book, *The Theory of Morality,* renowned philosopher Alan Donagan describes what would be an ideal theory of morality. He calls his theory "The" theory of morality and not "A" theory of morality not because he wants to prove that his is the only theory of morality but mainly because he wants to be precise on what he is talking about, i.e., describing morality that is inherent in, and that has been running in, western history. This is what he calls the Hebrew-Christian tradition. Despite that, his work is mainly a descriptive work. Donagan argues for his theory by contrasting it mainly to consequentialism[28] and showing that other theories would be inconsistent to an ideal theory of morality. Donagan calls what he describes, "the theory" because it gives a guide on how one ought to live a good life. Donagan uses one fundamental principle from which all other duties, which he calls precepts, can be deduced. These precepts are universal in nature given the rationality of human beings.

His methodology is unique in that instead of manufacturing a brand new theory of morality altogether, he goes back in history, considering both religious and philosophical traditions to find a consistent traditional morality and argues its applicability to present real life moral dilemmas. He is careful not to jump to moral

[28] Consequentialism refers to those moral theories which hold that the consequences of a particular action form the basis for any valid moral judgment about that action. Examples of consequentialist moral theories are utilitarianism and ethical egoism.

principles that depend on theistic beliefs as is the case in Christianity and Judaism. He admits that although different philosophers and the Hebrew-Christian tradition believed in different ways of explaining morality (e.g., some believing in consequentialism or deontology or virtue ethics), the underlying idea of these explanations is a common one and based on similar principles. Donagan chooses the second formulation of Immanuel Kant's Categorical Imperative[29] to refine his own theory because it is based on moral philosophy (rationality and impartiality) and not theism. Donagan regards Kant's Categorical Imperative[30] as the ideal portrayal of the common morality that is inherent in Western civilization.

His (Donagan's) book is divided into three main parts. Chapter 1 gives a general introduction that explains what an ideal theory of morality is and why he has chosen Kant's second formulation of the Categorical Imperative as representative of the Hebrew-Christian traditional morality. Chapters 2, 3, and 4 describe the theory Donagan believes is one that is inherent in Hebrew-Christian tradition. Finally, in Chapters 5 to 7, he defends the theory against major foreseeable arguments against it. He does this by first dealing with theories that could bring about inconsistencies to his theory (Chapter 5), then arguing against consequentialism in order to assert that deontological[31] theories are the best moral theories (Chapter 6), and ending with asserting that his theory of morality forms the foundation for common morality (Chapter 7).

3.2 An Ideal Theory of Morality

Taking a very historical and analytical approach to morality, Donagan, in his first chapter, assesses the different traditions to define what constitutes the ideal theory of morality. Donagan claims that starting with the Stoics, Jews, Christians, and other philosophers (e.g., Aristotle, Aquinas, Kant and Hegel), an ideal theory of morality is one that shows that morality is a system that is common to all (Donagan, 1977: 6). "A morality … is a set of precepts of conduct ascertainable by human reason and

[29] This formulation states that we 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.
[30] A categorical imperative unconditionally demands performance of an action for its own sake; it has the form "Do A." This has been contrasted to a hypothetical imperative that conditionally demands performance of an action for the sake of some other end or purpose; it has the form "Do A in order to achieve X."
[31] Deontological ethical theories say that the rightness or wrongness of an action does not solely depend on consequences of that action but on other things like duty or obligation and the nature of an act itself.

binding on any rational being by his being such" (Donagan, quoted from Wertheimer, 1983: 303). Donagan goes further to assert that a normal adult would have a system to guide his conduct even when he has never known of any morality. This conception that morality is common to all, as claimed by Donagan, should be binding to all human beings because of their common rationality. All rational creatures would come up with this morality, with certainty, using human reason. The different ways that morality has manifest itself in Stoicism, Judaism, Christianity does not defeat the fact that morality is common to all but just highlight the differences in using precepts that are derived from the common morality to address different moral dilemmas.

Immanuel Kant developed a comprehensive moral theory that does not depend on Christian belief. Earlier philosophers like Aquinas treated morality theologically. Kant developed the theory as common and grounded in autonomous reason. Kant further explained that his theory only reaffirmed the traditional philosophical conception that morality was purely rational (Donagan, 1977: 8-9). Donagan accepts the idea of an ethical community in which morality is lived as dispositions of affection and conduct. When morality is taken on its own without the community, it can easily be empty and only applicable in a vacuum.

Therefore, it can be said that according to Donagan, an ideal theory of morality is one that is (i) rational, (ii) common to all across traditions, and (iii) applicable in an ethical community. These conditions for an ideal theory of morality have also been endorsed by moral philosophy. When one looks at an ethical way of proceeding, rationality is important. In addition, the underlying principles of such a way of proceeding ought to be common to all even across all traditions. When a theory becomes irrelevant because it is not common to all traditions, then such a theory immediately stops being an ideal one. Furthermore, ethical theories should be applicable in an ethical community that is constituted of human beings. Usually, the term ethical community is used rather than just rational beings because some human beings would have lost their rationality, e.g., those in comatose condition or the severely mentally retarded persons. Morality would even apply to these persons that have lost their rationality because they belong to the ethical community.

3.3 The Fundamental Principle

Donagan states that the fundamental principle of morality is, "It is impermissible not to respect every human being, oneself or any other, as a rational creature" (Donagan, 1977: 66). Donagan's fundamental principle is derived from Kant's second formulation of the Categorical Imperative that states that "Act that you use humanity, whether in your own person or in the person of any other, always as an end and never merely as a means" (quoted from Guyer, 2006: 70). Donagan persuasively argues that his fundamental principle is a clearer statement of the Kantian categorical imperative. The principle stresses that any ethical action is one that respects humans as rational creatures. From this one fundamental principle, specific moral precepts can be derived. The moral precepts should be mediated only by "specificatory premises."[32] Deriving precepts from one fundamental principle makes it possible to make this principle applicable to day-to-day situations.

Let us examine Donagan's principle more closely. Key to this principle are the words "impermissible", "respect" and "rational creature." The word "impermissible" as used by Donagan, means that it is absolutely morally unacceptable for an action to be done. "Respect" should be understood as a way someone treats another. The way of treating that person should only be as a rational creature. This type of respect is not the one you give due to admiration, educational achievements, wisdom, or respect of a child for a parent. It is respect shown because of the rationality of other human beings. Such treatment is not based on consequences of one's action, virtues or contracts. Because his theory does not depend on consequences, virtues or contracts, Donagan's theory is a deontological moral theory. Put in other words, it is a duty for person *A* to respect rational creature *C* simply because of *C*'s rationality. A rational creature simply refers to human beings. Stipulating human beings as rational creatures can be said to safeguard against persons that segregate others because of race, colour, tribe or perceptions of the term "human being." Rational creatures include all human beings even those that might not be logically rational, e.g., mentally retarded persons, those in coma, those in Persistent Vegetative State, those severely depressed, and even those that are just perceived as irrational. This inclusion in the rational community by Donagan is very important in the discussion on

[32] Specificatory premises are premises that identify "… a specific action as falling or not falling under the fundamental generic concept of action [in this case] in which every human being is respected as a rational creature" (Donagan, 1977: 68).

euthanasia because many of the difficult cases on euthanasia deal with persons who have stopped using their rational capabilities.

Donagan divides the fundamental principle of his theory into first- and second-order levels based on ideas from the Hebrew-Christian tradition. First-order principles are about the permissibility or impermissibility of action or intentions. These principles examine what kinds of actions are permissible in themselves. The second-order principles are about the culpability or in-culpability of agents in acting. They are about the conditions under which an agent can be blamed or not blamed for acting (Donagan, 1977: 145). Therefore first-order questions ask, "Is it (ethically) permissible or impermissible to do an action of this kind?" The second-order questions then ask, "Is the person who did this action worthy of praise or blame?"

3.4 Some Problems With Donagan's Fundamental Principle

Donagan's theory might be regarded as problematic because (i) it overlooks motives for acting morally, (ii) it denies the value of acting out of respect of rights of others, and (iii) his theory can be used to defend two sides of the same argument.

First, Donagan restricts the motive for acting morally to respect of rational creatures. But I think that motives of sympathy, one's own benefit, altruistic feelings, family ties, praise, etc., can make people act morally other than just out of respect for rational creatures. Also, presuming that there can only be one fundamental principle of morality might be problematic. Despite the credibility of the respect principle and its applicability, there can be other fundamental principles moving people to behave in a moral way. For example, faith in God and following requirements of such a faith can be a fundamental directive for behaving morally.

Second, Donagan does not deal with the possibility of a person acting morally merely out of respect of rights of oneself and others other than respect out of rationality. Nozick in his book, *Anarchy, State and Utopia* highlights a problem that needs some consideration. He states that respect for others is derived from the rights of persons and individual rights with the dignity that these rights entail (quoted from Wertheimer, 1983: 304). This analysis poses the problem of respect of rationality being the fundamental principle. "Rights" then would be conceived as the fundamental principle from which respect is derived. I think that although rights are important, the rights are respected because of human beings being rational.

Third, Donagan's principle seems to support opposing sides of an argument when difficult cases are considered. For example, suicide is such a distinct case that can show that this principle can support opposing sides of an argument. Using Donagan's principle, suicide would be morally permissible if a competent, rational person considered the respect due to oneself and others. Put differently, using the same Donagan's principle suicide would be morally impermissible if that person's decision to kill himself is misinterpreted as rational and out of self-respect when it is because of difficulties he is going through or certain deep beliefs.

This Chapter has given a summary of Donagan's fundamental principle that is described in his book, *The Theory of Morality.* The principle asserts that "It is impermissible not to respect every human being, oneself or any other, as a rational creature." Donagan claims that this is a clear formulation of Immanuel Kant's categorical imperative, "Act that you use humanity, whether in your own person or in the person of any other, always as an end and never merely as a means." Some problems were also highlighted with this fundamental principle that relate to motives of action, consideration of rights, and that the principle can be double edged in its application.

CHAPTER 4: ETHICAL ASSESSMENT OF EUTHANASIA

In this chapter, I apply Donagan's theory to the problem of euthanasia. The basic idea is that human beings have reason (rationality); human beings would reasonably wish for a good death; given their rationality and respect for themselves as rational creatures, euthanasia in certain cases should be morally acceptable. The chapter explains an argument that can be applied to the problem of euthanasia with the hope of determining what circumstances and types of euthanasia can be morally permissible and which ones are impermissible, using Donagan's fundamental principle of morality.

4.1 The Argument

From Donagan's fundamental principle of morality "It is impermissible not to respect every human being, oneself or any other, as a rational creature" (Donagan, 1997: 66) and the argument that he puts forward:

> The purely moral question, then, reduces to this: Are there any circumstances in which a human being would not fail to respect himself as a rational creature by killing himself? If there are, it will be permissible in those circumstances for him to kill himself, and for another to help him, although not to kill him against his will (Donagan, 1977: 77),

the following argument can be made:

(1) If there are circumstances in which a human being would not fail to respect himself as a rational creature by killing himself, then it is permissible that others help him to die – if this is not against his will;

(2) There are such circumstances in which a human being would not fail to respect himself as a rational creature by voluntarily killing himself;

(3) Therefore, in such circumstances (those in 2), it is permissible for others to help those who would kill themselves to die.

This argument has the form of a *modus ponens*, which is a valid form of reasoning.

The first premise has been derived from the fundamental principle of Donagan that "It is impermissible not to respect every human being, oneself or any other, as a

rational creature" (Donagan, 1997: 66). From this principle, if it can be ascertained that there are circumstances where killing oneself would not go against this fundamental principle, it would be permissible for others to help one to die or for one to help others to die. If I respect others as rational beings, I ought to do the same to myself for I am also a rational creature just as they are.

The crucial part in this argument is to show that there are circumstances in which a human being would not fail to respect himself as a rational creature by killing himself. Donagan's fundamental principle would forbid killing but not all forms of killing like some types of euthanasia. In certain circumstances, some forms of killing may be morally acceptable. To respect oneself as a rational creature refers to persons in full control of the decisions they make, having examined all considerations that affect oneself and others. There can be circumstances where it would be rationally acceptable for a person to willingly kill himself, e.g., when one's life is not worth living like where one is suffering extreme pain and is nearing death (painful terminal illness) or where simply life becomes burdensome to live.

Generally, human beings would want to avoid death and if death were to come, they would want it to be a peaceful and gentle one. Rational creatures have plans for their lives and the future. Normally when these plans, hopes and dreams come into fruition, we are glad that they did. Because of the experience of nearing death that sometimes comes in a very painful way or in circumstances where, though not terminal, life becomes almost worthless to live (like those in Persistent Vegetative Stage), a person ought to have a plan and control on how such experiences are lived and ended. This control in a person to plan and decide how their last days on earth are lived and how their deaths come about ought to be respected if we recognise all human beings as rational creatures. Denying them control of their future and plans of how they live their lives would be denying the respect due to a rational creature. Such a denial would be going against Donagan's fundamental principle of respect of rational creatures.

To sum up the second premise, there are circumstances in which a person killing himself is actually in accordance with the fundamental principle of a person respecting himself as a rational creature. These circumstances are when life becomes extremely burdensome because of illness or excruciating pain that cannot be controlled when one is near death. A person in such situations can competently and

rationally choose to end their own lives. To deny such a person who chooses to end their lives would be failing to respect them as rational creatures. Therefore it follows that it would be permissible in such circumstances for others to help such a person to end his life.

The last part of Donagan's assertion is very important, that this killing is not done against the will of the person killing himself or being helped to die. This means that there has to be an explicit will of a person to end his life. In other words, it should be the rational will of a person being killed that he wants to die.

Specifying circumstances where it is permissible for a person to kill herself or others to help him die are very important for the discussion of when it is permissible to perform euthanasia. Since Donagan clearly states that if it can be ascertained that there are circumstances when it is permissible for a person to kill herself, the following section outlines those circumstances.

4.2 When Euthanasia is Morally Permissible

From the discussion above, it can be concluded that all circumstances of euthanasia that fulfil the second premise as outlined in Section 4.1 above would be morally permissible. Let us now examine which kinds of euthanasia would be morally permissible using the argument given above. Since we stated that the patient who chooses competently to kill himself could be helped to die when there are sufficient reasons to choose death such as when he is terminally ill and in debilitating pain, **voluntary euthanasia** is morally permissible. It is voluntary in that a person competently decides the manner in which they want to die. In voluntary euthanasia, a patient should have full control on the method that will be used to help him die, be it active or passive. Passive euthanasia will be restricted to patients and those dependent on some treatment to continue living or those who need a certain treatment to continue living. A patient not on treatments that are necessary for their life or those who do not need certain treatments to continue living will have to be considered for active euthanasia and these patients would have to make decisions considering these facts. Active euthanasia can easily be applied to both groups, those on life support or needing it and those who are not on life support. But in cases where a patient is on life support the easiest way to help them is to withdraw treatment whilst for those not on life support, the easiest way of helping them to die

might be giving them a lethal injection that lets them die gently and painlessly (of course here we are not talking of minor pains caused by an injection needle). It is worth noting that even though this might seem straightforward, a patient may still choose certain ways of dying other than what would be easy to do. A patient on life support can still ask to be given a lethal drug to end their life. Similarly, a patient who is not on life support may choose that large doses of painkillers be given that will definitely hasten death. It can be said therefore that there is a certain degree of control on whether an active means is used or a passive means is used.

Caution has to be taken here that not all circumstances of apparently voluntary euthanasia are accepted as morally permissible. In cases where there is coercion, where one starts perceiving oneself as a burden to one's family and friends and where one feels that it is common practice, given such circumstances, it is not permissible that he must choose euthanasia. In these cases, the choice ceases to be the person's and it ceases to be autonomous and rational. Unfortunately, in countries where euthanasia is legally acceptable, it might be easier for a patient to choose euthanasia, not that they would have rationally chosen it but simply because it seems to be the normal thing to do. These difficulties are what makes clearly defining euthanasia important in ethical assessments of euthanasia.

As regards to **non-voluntary euthanasia**, only one circumstance can be said to be morally permissible; namely, when a person being helped to die would have earlier, when competent, signed a will (referred to as a "living will") that if they were found in such a situation as in the case of irreversible coma or other situations, they should be allowed to die or actively helped to die. This would still be within limits of permissible circumstances. The biggest problem of these circumstances of non-voluntary euthanasia are that preferences of human beings change, posing the difficulty of knowing with certainty that this is the rational will of the person being helped to die at that time. In one instance and circumstance, a person may choose to be helped to die but in other instances, they may decide to die naturally. This can be seen from suicide cases. Some persons who have attempted to commit suicide but failed or have been interrupted, have later on decided not to kill themselves but to live a full and happy life. I will still argue that given the circumstance and what would be the most rational thing to do, it would be permissible for a "living will" to be binding on a person's wish to be helped to die. This is because at that point when

a person is incompetent, they cannot rationally change their minds and choose a different way of dying. Their decision when they were competent still stands.

4.3 When Euthanasia is Morally Impermissible

The kinds of euthanasia that would not be considered morally permissible would be those that do not conform to the fundamental moral principle of respect and the argument given above. Given that there are six types of euthanasia that we have identified and have been working with in this dissertation, **involuntary euthanasia** stands out as one kind of euthanasia that would not be morally permissible. Involuntary euthanasia, as we defined it above, is when a person who is competent enough to choose is killed without his consultation or consent. In this case, a person who would have chosen not to die is killed. Although such cases of euthanasia have been condemned worldwide beginning (on a consistently planned level) with the Nazi Action T4 killings, it is highly debatable that in certain rare circumstances such cases do happen. It is difficult to imagine many cases of involuntary euthanasia where a physician decides to kill a competent person without consulting them even when it might be conceived to be for the good of that person. According to Donagan's principle, such a case of involuntary euthanasia would be impermissible given a human being's rationality. This is because we have not followed his will, which is not known since the patient has not been consulted.

What is debatable though is whether **non-voluntary euthanasia** would be morally permissible or impermissible? In these cases, the patient is incompetent and they cannot choose on their own what is morally good or bad. It is left really to their parents, spouse, guardian, attorney or physician to choose for them. Given that we cannot really know what another person would have chosen for themselves given the situation they find themselves in, without that person's direct competent will (as in a living will), it cannot be said here that it would be permissible for another human being to accurately choose for the incompetent person to be helped to die. This becomes worse, given the pressures of society in terms of costs, inheritance, burden of sickness, or simply living a place where euthanasia is an acceptable trend. It can be argued that in countries where euthanasia is legally acceptable, surrogates would easily choose that the person be allowed to die. Whilst in countries where euthanasia is legally forbidden, most surrogates would not even suggest that the person be

helped to die assuming that this would be what the incompetent person would have chosen. Also, when the person is considered a burden or when there are big gains from a patient's death, this can facilitate an irrational decision to let the person be helped to die.

Non-voluntary euthanasia where another person chooses on behalf of the incompetent person to end the incompetent's life, would be impermissible because, no other person can really know another's wish at the point of dying as explained above that it is difficult to make an accurate decision on what another person would have chosen.

In these cases, following Donagan's principle and his explanation as given above, the manner in which such a death is brought about does not matter, in terms of passive or active. What is important, coupling with my arguments is the decision of a person to die or not to die, a death that is painless and gentle. So, involuntary active and involuntary passive euthanasia would be morally impermissible. To sum up, non-voluntary euthanasia, cases where a patient being helped to die signed a living will, would be morally permissible but cases where a surrogate makes a decision on behalf of the incompetent patient being helped to die would be morally impermissible.

4.4 Discussion

From the assessment of ethical decisions in euthanasia, it is important to see how the argument formulated using Donagan's fundamental moral principle is crucial to arguing which circumstances and kinds of euthanasia can be morally permissible.

It has to be stressed that what is morally permissible is very different to what is legally permissible, although in some cases they might amount to the same conclusion. If in an imaginary world Z, active involuntary euthanasia is legally permissible, this does not automatically amount to saying that such euthanasia in world Z is morally permissible. In legalising euthanasia, moral considerations ought to be made but might not be necessarily the reason for legalising euthanasia. Saying that something is morally permissible is very different from saying it is legally permissible. An act can be legally permissible even when it is morally impermissible and vice-versa.

Donagan's fundamental principle of morality stressing rationality and freedom to choose one's end-of-life demands that some kinds of killing and ways of being helped to die be morally permissible in circumstances where the person decides to die or be helped to die.

Although decisions about death are difficult and often morally confusing, such decisions are unavoidable in some situations. The manner in which a person dies is very crucial to one's plan for the future and one's happiness. It makes rational sense that that person's rational wish, plan, and desire be granted. It would be disrespectful of one's rationality if such rational decisions are trivialised by religious moral dictums for easy decisions and answers or simply out of fear to labour hard for the best moral and logical arguments for the practice.

In this Chapter, an argument was formulated from Donagan's fundamental principle that "if there are circumstances where one would not fail to respect oneself by committing suicide, then it would be permissible for others to help him end his life." This argument was then used to argue that voluntary and non-voluntary (where there is a living will) euthanasia would be morally permissible. Involuntary euthanasia and non-voluntary (where another person chooses on one's behalf) would be morally impermissible.

CHAPTER 5: RECOMMENDATIONS AND CONCLUSION

5.1 Recommendations

Having given a clear definition of euthanasia, its history, the guidelines in the Zambian situation, an overview of some arguments for and against euthanasia, and having ethically assessed the different types of euthanasia, I recommend the following:

5.1.1 *That voluntary euthanasia and non-voluntary euthanasia where a living will is involved should be made legal in Zambia.* Care should be taken here that not all instances of voluntary euthanasia should be legal and that additional guidelines should be adopted like consultation with other physicians, and the circumstances in which a person is making a decision. These additional requirements would safeguard against the abuse of such legal requirements for euthanasia.

5.1.2 *That clear definitions of euthanasia are given in philosophical debates for they are key to determining what types of euthanasia are permissible or impermissible*. In some of the available literature on euthanasia, euthanasia is discussed as though all types of euthanasia were just one. Lack of clear definition of euthanasia has led to many types of killing being discussed as euthanasia. In some literature, the Catholic Church's acceptance of death that is brought about by withdrawing burdensome (extraordinary treatments) has been interpreted as Catholics supporting certain types of passive euthanasia. The killings of Jews by the Nazis between 1939 and 1945 is often cited as euthanasia in literature even when one aspect of these killing is missing to make them cases of euthanasia, namely that the act of killing is done for the benefit of the person killed. Cases of deaths that happen due to lack of modern scarce treatments or through mistakes made in the health facility can easily be cited as cases of euthanasia when no clear definition of euthanasia is given. Simply defining euthanasia as a "good death" or "mercy killing" is inadequate for reasonable application of ethical theories.

5.1.3 *That clear distinction of the types of euthanasia is necessary for a fuller discussion of euthanasia. In discussions on euthanasia, suicide and physician-assisted suicide should be discussed separately.* Lumping together euthanasia,

suicide and physician-assisted suicide makes discussions that are peculiar to euthanasia to be blurred. This is in part because people's perceptions towards suicide are that it is wrong and normally done because one is depressed or trying to escape responsibility of an undesirable action. The distinction between suicide, euthanasia and physician-assisted suicide should be clear enough to make sure that conclusions that are made on suicide are not the same made for euthanasia. In short, suicide is the ending of one's life; physician-assisted suicide is the ending of one's life with the help of a physician; and euthanasia is the intentional killing of a person or allowing them to die for it is believed that it is good for them. It would be difficult to have common conclusions on permissibility or impermissibility of all these as though they meant the same thing.

5.1.4 *That comprehensive written regulations be promoted in Zambia for they will inform on decisions on legalising certain types of euthanasia and forbidding others.* Since we have established that it is inevitable for euthanasia to happen in Zambia or at least that medical professionals, at one time or the other encounter situations where euthanasia is requested, guidelines on the practice are very important. The Ministry of Health being the custodian of coming up with laws on health-related issues should therefore take interest in discussions on euthanasia that would potentially lead to widely acceptable policies or laws. The University of Zambia (School of Medicine and the Department of Philosophy and Applied Ethics) could offer the expertise providing the moral and practical basis for such policies or laws. These regulations, policies or laws could in turn be incorporated in the codes of conduct of medical professionals (by the Zambia Medical Association or the Medical Council of Zambia) but also in the codes of conduct of health facilities. Without being prescriptive, such regulations ought to be clear enough of the position of Zambians on the issue of euthanasia. As we have seen in Chapter 4, certain types of euthanasia can be morally permissible. Also in other countries like the Netherlands and Belgium, certain types of euthanasia are decriminalised and/or legal. This shows that euthanasia is not always as forbidden and bad as it is usually seen. The non-discussion of end-of-life issues and euthanasia in particular, denies the basic respect and dignity that is due to a human being, given their rationality and autonomy. These regulations could even be in the form of oral guidelines that are known by medical professionals and the public.

Such laws should be objective enough to the perceptions of Zambians and should consider the ethical considerations of Zambians. Even when it is agreed that all types of euthanasia ought to be illegal, the need for regulations on such should be clearly spelt out. Leaving decisions regarding euthanasia to laws prohibiting murder or laws regarding abortion is not enough especially when end-of-life decisions are made almost on a daily basis by medical professions, patients, and surrogates.

For guidelines, policies or laws to be put in place in the Zambian setup, more discussion should be allowed and promoted on the issue of euthanasia in Zambia. For example, the Zambia Medical Association, Zambia Nurses Association and other medical professional associations should promote these discussions on euthanasia and the importance of end-of-life decisions. The training of medical professionals should incorporate in their curricula medical ethics that would include discussions on euthanasia and other end of life decisions. This kind of module on euthanasia should be as unbiased as possible, giving students room in the discussion.

These discussions could be the possible venue for coming up with a common view of euthanasia in Zambia. Through discussions and the professional discussions by medical professionals, policy makers and academicians, we would be able to find out what types of euthanasia would be first, morally permissible, and second, made into a policy or law. The respect due to human beings as rational creatures even those that might request euthanasia should be taken seriously in such discussions.

These discussions that have the potential of leading to clear guidelines on euthanasia would require training of medical professionals on application of ethical theories on euthanasia but also different ways of performing euthanasia. There is no sense in accepting legally or morally some forms of euthanasia when the procedures are not fully understood by those who perform them. As was indicated in Chapter 2, as medical training in Zambia does not concentrate on the philosophical approach to issues in medical ethics, incorporating philosophical medical ethics into the medical curriculum could be one way of moving forward.

5.2 Conclusion

This dissertation has considered euthanasia from a moral point of view using Alan Donagan's fundamental principle of morality that states that "It is impermissible not to respect every human being, oneself or any other, as a rational creature" (Donagan,

1977: 66). From this, an argument was formulated that was used to assess which types of euthanasia are morally permissible and which are not. The basic argument is:

(1) If there are circumstances in which a human being would not fail to respect himself as a rational creature by killing himself, then it is permissible that others help him to die – if this is not against his will;

(2) There are such circumstances in which a human being would not fail to respect himself as a rational creature by killing himself;

(3) Therefore, in such circumstances (those in 2), it is permissible for others to help those who would have killed themselves to die.

This argument led to the conclusion that voluntary euthanasia and non-voluntary euthanasia which is done following the directives of the living will are morally permissible. Involuntary euthanasia and non-voluntary euthanasia which is done at the request of a surrogate, are morally impermissible.

Such moral considerations as the ones made in this dissertation ought to be taken seriously when policies, guidelines and laws are made. Finding the moral basis for such regulations is very important. Despite the fact that learning from other countries can be important in the debate on euthanasia, there is no reason to accept or reject something simply because other countries are accepting or rejecting it. Accepting certain types of euthanasia should be based on moral foundations that can be established as has been done in this dissertation. When a moral basis for an action is found, following such regulations becomes very important as not only a legal obligation but also a moral obligation. Respect for human beings as rational creatures, to borrow Alan Donagan's phrase, and respect of all human rights, to borrow the language of the United Nations, demands that informed decisions of human beings be taken very seriously.

In Zambia where such guidelines are lacking, it is imperative that guidelines be established if the rationality of human beings is to be taken seriously and respected.

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APPENDIX:
INFORMAL INTERVIEW GUIDE

[One aim of this research is to find out whether there are any guidelines regarding euthanasia in Zambia. I also want to find out what guidelines medical personnel use when they encounter certain life and death situations. The research does not aim at finding whether health professionals practice euthanasia nor is it to find out perceptions or attitudes of health professionals on the euthanasia.]

QUESTION: Given the cases below, are there any guidelines that guide the practice of euthanasia in your health care institution?

Case 1: Voluntary Active Euthanasia

Jecks is dying from a progressively debilitating disease, she has reached a stage where she is almost totally paralyzed and periodically she needs a respirator to keep her alive. She is suffering considerable distress. Knowing that there is no hope and that things would get worse and still being competent, Jecks wants to die. She asks her doctor to give her a lethal injection to end her life.

Case 2: Voluntary Passive Euthanasia

Following an accident in which Den, a member of a fire rescue squad, was trying to rescue potential victims in a burning building, Den suffered severe burns and head injury after the building collapsed on him. He is now unable to breathe or eat unaided. The attending physician after brain tests confirm that he is still competent because none of the vital parts of the brain were destroyed. After being on the ventilator for more than three years with no significant improvement and seeing that his health is deteriorating quickly with the prognosis that he could die in less than six months, he asks the physician to discontinue the ventilator and the artificial nutrients.

Case 3: Non-voluntary Active Euthanasia

A six-month old baby is suffering severe anencephaly. The physician's assessment is that the baby could live like that for another 6 to 7 months but would certainly die because babies born with anencephaly normally do not grow up to adulthood. Seeing the suffering of the baby and after consulting with the parents of the child, you feel that you ought to do something because the baby seems to be in exceptional pain and distress.

Case 4: Non-voluntary Passive Euthanasia

Mr. A was riding his bike home from a friend's house when a truck hit him. Taken immediately to a hospital emergency room, he was put on life-support and treated aggressively for a severe head trauma. The neurologist called in to assist said that he would have been killed instantly except for the helmet he was wearing. Now three months later, Mr. A is in a deep coma, with minimal response to sharp and intense pain. There are no prospects of recovery and he is on a ventilator and is receiving artificial nutrition and hydration plus doses of antibiotics. He could go on living for years on the life support without waking up from the coma. You are the attending physician and you think that he is better off dead. Having failed to identify Mr. A or any of his relatives, you the attending physician has to decide.

Case 5: Involuntary Active Euthanasia

Trevor is HIV positive. He has been living with HIV for about 20 years. In the past two years, his HIV condition progressed to full-blown AIDS disease. Despite the efforts at giving him antiretroviral treatments, he is not responding to the drugs anymore. His body is emaciated, he cannot move or feed himself but he is still very sharp and competent. He is brave enough and plans to fight the disease to its bitter end. He knows he is going to die soon but he has not communicated anything to his attending physician, Dr. B or his wife on whether he wishes to continue living or end his life. Dr. B considering Trevor's life as not having any quality since Trevor is in extreme pain and is going to die soon, feels a moral obligation to decide on behalf of Trevor, after all, it is the physician's duty to decide what is best for the patient according to the Hippocratic Oath.

Case 6: Involuntary Passive Euthanasia

Chucks is on life support needing artificial feeding and breathing devices to aid in feeding and breathing because he cannot eat or breathe by himself. 7 years earlier Chucks was involved in a motor vehicle accident that damaged most of his body, leading to amputation and several chest operations. His brain was untouched so he could still talk, think and process what was said to him. In short, he is still competent. But Chucks T. is in intolerable pain but has indicated nothing to his physician on his preference on having life-support terminated. The physician thinks that it would be best for Chucks to die. What can be done in the current scenario?

Do you have anything else to say as regards euthanasia in Zambia which you think is important?

THANK YOU VERY MUCH FOR TAKING TIME TO ANSWER THESE QUESTIONS!

[The information you give will only help the researcher to ascertain whether there are adequate regulations, laws or policies regarding euthanasia in Zambia and as such, this information is not sensitive to be kept confidential. This part of research only deals with what are the guidelines on euthanasia in Zambia.]