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Suicide and Human Dignity: An African Perspective

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Abstract: This paper examines the moral status of physician assisted suicide by paying particular attention to autonomy in the context of death and dying and its implication for the idea of 'dying with dignity'. It argues that physician assisted suicide is sometimes morally justified given the basic philosophical issues of autonomy, self-determination and freedom. The paper underscores the fact that competent agents (patients) who are suffering due to pain and who have the apparent capacity to make free and informed choices should be able to choose when it is appropriate to end their lives drawing on the cultural construct of the Yoruba worldview that celebrates suicide in avoiding shame --*Iku ya j'esin* – a principle of dignity in dying. The paper concludes by emphasizing quality of life as a fundamental purpose of human existence without which life is meaningless, stressing the Yoruba conception of good health (*alaafia*).

Key words: Human Dignity · Yorubas · Physician assisted suicide · Quality of life · Autonomy

INTRODUCTION

In everyday language, suicide is the taking of one's life, for example by overdosing on barbiturates and attempted suicide is the failed attempt to take one's own life [1]. The issue of suicide is becoming more important as the possibilities of medical intervention increase and the economic strain of supporting life beyond the limits of what people define as life worth living grows, as the wave of fundamentalism sweeping the Islamic world makes battlefield martyrdom more likely, as the issue of assisted suicide is addressed more aggressively and as the AIDS pandemic continues to rage creating an almost ideal suicidogenic confluence of the quality of life issues debated against a backdrop of economic strain [1].

Physician-assisted suicide remains one of the controversial topics that has dominated medical literature over time. It calls for the need to ask fundamental questions about death and dying, raising questions about the extent to which we are and should be free to direct our lives and our deaths. These questions include: is suicide a right judgment on life and on those who live it? Could suicide be rational and rationally chosen?. Could it be the product of fully autonomous choice? What is a good life? What are the roles of medicine and technology in alleviating human suffering?. Does the requirement of the sanctity of life sometimes contradict that of the quality of life?.

Since suicide takes a different turn in the field of medicine, this work examines the morality of physician assisted suicide in this field. It questions the value of human life drawing from the Yoruba example of the quality of life. The work argues that given the notion of human freedom and autonomy in moral philosophy, a competent patient should be able to choose when to end his life from the point of view of human dignity. Also, in spite of various arguments against assisted suicide in the medical profession, suicide, in certain circumstances is morally justifiable.

The work concludes by emphasizing that based on the Yoruba concept of *Iku ya j'esin* (death is preferable to shame and disgrace), suicide is sometimes a means of avoiding shame and indignity. Here the quality of human life (*igbesi aye alaafia*) takes precedence over the sanctity of human life (*emi eniyan*) because physician assisted suicide should be seen as a dignified moral and godly choice for those suffering from terminal illnesses and those in severe pain.

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ON SUICIDE AND HUMAN DIGNITY

Currently in the western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution [2]. Shneidman [2] suggests that attempted suicide should be used only in cases where the person was clearly trying to die, for example by shooting himself or herself in the head, but lived anyway. Following Kreitman *et al.* [3], Shneidman suggests that the term parasuicide be used to describe all those seemingly suicidal instances in which the intention to die was not clear, often reflected in the non-lethal means selected. Finally, when people engage in self-destructive behaviour whose long range consequence may be death, the terms subintentional death or indirect suicide should be used [2]. For the purpose of this paper, the term physician assisted suicide will be employed.

Physician assisted suicide generally refers to a practice in which the physician provides the patient with a lethal dose of medication upon the patients requests, which the patient intends to use to end his/her own life. It refers to the physician providing the means for death, most often with a prescription from the patient. The patient, not the physician, will ultimately administer the lethal medication [4]. This is often contrasted with euthanasia in which the physician acts directly by giving a lethal injection to end the patient's life. It is often argued that physician assisted suicide may be a rational choice for a person who is choosing to escape unbearable suffering and that the physician's duty to alleviate suffering may sometimes justify the act of providing assistance with suicide. This argument relies a great deal on the notion of individual autonomy and dignity, recognizing the right of competent people to choose for themselves the course of their life including how it will end.

However, there are two senses in which dignity is typically attributed to human beings. First, usually through some actions, human beings can be said to express dignity. In this sense persons are said to speak 'with dignity' or carry themselves with dignity. Second, human beings can be said to have dignity, even though they are not in the first sense, always dignified in their behavior. Having dignity is not a way of presenting oneself to others but is rather an attribution of a characteristic value to human beings. It is the second sense of having dignity that is philosophically and ethically most fundamental for it refers to the minimum dignity which belongs to every human being qua human. It does not admit of any degree. It is equal for all humans [5].

The most influential proponent of the view that human beings have dignity is Immanuel Kant (1724-1804). Kant's influential account stems from his suggestion in the Groundwork of the Metaphysic of Morals [6] that all things have either a price or a dignity. In short, Kant claims that when things have a price, this entails there is something for which it would be morally acceptable to trade them. By contrast, a human being has dignity and there is nothing else -- neither power nor pleasure, nor good consequences for all of society – for which it is morally acceptable to exchange any human being. Kant [7] puts his ideas as follows:

Every human being has a legitimate claim to respect from his fellow human beings and is in turn bound to respect every other. Humanity itself is a dignity; for a human being cannot be used merely as a means by any human being but must always be used at the same time as an end. It is just in this that his dignity (personality) consists, by which he raises himself above all other beings in the world that are not human beings and yet can be used and so over all things. But just as he cannot give himself away for any price (this would conflict with the duty of self-esteem), so neither can he act contrary to the equally necessary self-esteem of others, as human beings, that is, he is under obligation to acknowledge, in a practical way, the dignity of humanity in every other human being. Hence there rests on him a duty regarding the respect that must be shown to every other human being [7].

Although Kant commonly speaks of the dignity of the moral law or the 'categorical imperative', it is ultimately the dignity of the source of that law which Kant identifies as autonomy or the human capacity for *practical reason* that is the focus of his account of human dignity. In Kant's view, the human capacity for moral action – the ability to have one's will directed by reason and not by the inclination of the moment – clearly distinguishes the moral worth of humans from the value of other sentient creatures. And since Kant insists it is not rationally conceivable that anything other than the

capacity for practical reason is of comparable value, the categorical imperative requires that human dignity should never be violated by treating human beings as if they are solely means to the ends of others. Thus, insofar as persons have dignity, they have an incalculable value that prohibits justifying one violation of human dignity by the thought that it would prevent two or more similar violations [8]. When dignity is treated as a substantive value, this means placing a high priority (above price) on the preservation, development, exercise and honoring of our rational capacities [9].

Bedau [10] identifies the key strands in Kant's thinking about human dignity as: a person's dignity refers to a person's worth, dignity is a value that all humans have equally and essentially, human dignity is intimately related to human autonomy, human dignity is inseparably connected to self-conscious rationality and human dignity provides the basis for equal human rights. Thus, the Kantian idea of human dignity involves and consists of a certain cluster of interrelated attributes which together confer on persons a certain status. This status is constituted by equal worth and capacity for autonomy and rationality of all persons, a status not shared with other things or even other creatures; it is reflected above all in the equal human rights that all persons enjoy' [10].

However, more traditional readings treat dignity as a status of inviolability not a value that can be quantified and weighed but a worth to be respected, esteemed and honored in all our actions [9]. In contemporary discussions, the idea of human dignity is often associated with human rights or some other conceptions of basic rights. Beyleveld and Brownsword [11] describe human dignity as the foundation on which human rights are constructed. The idea is that each and every human being has inherent dignity; that it is this inherent dignity that grounds or accounts for the possession of human rights (it is from such inherent dignity that such rights are derived); that these are inalienable rights; and that, because all humans have dignity, they hold these rights equally [11]. In medical ethics, the idea of dignity is often employed in an attempt to discredit paternalistic (hence autonomy-denying) treatment of terminally ill patient. Any discussion of the morality of physician assisted suicide will have to address questions about the rights we have over our own lives, about ways in which these rights are to be balanced against both the responsibilities we have to particular others and the responsibilities that we have for the effects that our actions have on others in general. It will have to take account of the importance for human beings of autonomy and self-determination.

THE IDEA OF AUTONOMY AND COMPETENCE

Autonomy in the context of this paper will be employed as it relates to individual decision making in health care especially consent and refusal. According to Beauchamp and Childress [12], the term autonomy when applied to individuals implies self-governance, liberty rights, privacy, individual choice, freedom of the will, causing one's own behavior and being one's own person. The autonomous individual acts freely in accordance with a self-chosen plan while a person of diminished autonomy is controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans [12].

Almost all theories of autonomy agree that liberty and agency are essential for autonomy. In these two senses, the traits of the autonomous person which include capacities of self-governance, such as understanding, reasoning, deliberating and independent choosing are taken into account. Autonomous actions are analyzed in terms of normal choosers who act intentionally, with understanding and without controlling influence that determine their action. To respect an autonomous agent therefore is to acknowledge that person's right to hold views, to make choices and to take actions based on personal values and beliefs [12]. Respect, on this account, involves acknowledging decision-making rights and enabling persons to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult or demean others rights of autonomy.

In contemporary ethics, Immanuel Kant [13] and John Stuart Mill's [14] interpretation of respect for autonomy have contributed a great deal to the subject of autonomy. For Kant [13], respect for autonomy flows from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own moral destiny. To violate a person's autonomy is to treat that person merely as a means, that is, in accordance with others' goals without regard to

that person's own goals. Mill's [14] concern is with the individuality of autonomous agents. According to him, sociology should permit individuals to develop in relation to their convictions as long as they do not interfere with a like expression of freedom by others; but he also insists that we sometimes are obligated to seek to persuade others when they hold false or ill-conceived views [14]. These two conceptions are in support of respect for autonomy: Mill emphasizes not interfering with and actively strengthening autonomous expression while Kant stresses a moral imperative of respectful treatment of persons as ends in themselves.

Respect for autonomy in health care obligates professionals in health care to disclose information, go probe for and ensure understanding and to foster adequate decision-making. Discharging this obligation requires equipping them to overcome their sense of dependence and achieve as much control as possible and as they desire. It follows therefore that respect for autonomy goes beyond respecting a person's choice it extends to respecting the life choices that a person makes which includes respecting a person's choice in favor of death over life. This according to Beyleveld and Brownsword [11] is what makes the person that particular person. According to John Harris.

The point of autonomy, the point of choosing and having the freedom to choose between competing conceptions of how and indeed why, to live, is simply that it is only thus that our lives become in any real sense our own. The value of our lives is the value we give to our lives. And we do this, so far as this is possible at all, by shaping our lives for ourselves. Our own choices, decisions and preferences help to make us what we are, for each helps us to confirm and modify our own character and enable us to develop and to understand ourselves. So autonomy, as the ability and the freedom to make the choices that shape our lives, is quite crucial in giving to each life its own special and peculiar value [15].

The implication of the above is that competent agents have the apparent capacity to make free and informed choices about whether to live or end their lives. In fact, competent patients generally have the right to make their own health-care decisions, even decisions that others believe are contrary to the patient's interest [16].

Competence has been defined as the ability to perform a task [17]. It depends not only on a person's abilities but also on how that person's abilities match the particular decision-making task he or she confronts. Patients are competent if they are able to understand the available information about their conditions, to consider with medical advise the risks, benefits and burdens of different treatments or courses of action and thus to make informed decisions [18]. They are incompetent if they are unable, whether permanently or temporarily, to make decisions about their medical care. From these two senses of competence and incompetence, one can infer that physician assisted suicide describes a situation where a competent patient has formed a desire to end his/her life but requires help to perform the act, perhaps because of physical disability [18].

However, in clinical practice, it has been observed that competence vary over time. Therefore the competence to decide is relative to the particular decision to be made hence a person should not be judged incompetent with respect to everyday life. However much it varies, standards of competence are often set for its determination. This standard specifies the conditions a competent judgment must satisfy. Standards of competence feature mental skills or capacities closely connected to the attributes of autonomous persons such as cognitive skills and independence of judgment. Micheal Tooley [19] identifies standards of competence. They include consciousness, having preferences and conscious desires, feelings, being able to experience pleasure and pain, having thoughts, being self-conscious and capable of rational thought, having a sense of time, being able to remember ones past actions and mental states, the ability to envisage a future for oneself, having non-momentary interests, involving a unification of desires over time, being capable of rational deliberation, the ability to take moral considerations into account in choosing between possible actions, having traits of character that undergo change in a reasonably non-chaotic fashion and the ability to interact and communicate with others.

The above cognitive features suggest a link between competence in decision-making and autonomy. Patients are competent to make a decision if they have the capacity to understand the material information, to make a judgment about the information in light of their values, to intend a certain outcome and to communicate freely their wishes to care givers. In Law, medicine and philosophy, there is a sense in which the characteristics of the competent person are also the properties possessed by the autonomous person. Although autonomy and competence are different in meaning

(autonomy being self-governance and competence being the ability to perform a task), the criteria of the autonomous person and the competent person are similar. This is because an autonomous person is often necessarily seen as a competent person for making decisions and that judgment about whether a person is competent to authorize or refuse an intervention should be based on whether that person can choose autonomously in particular circumstances.

However, the idea that human beings have a basic right to 'die with dignity' has been a centerpiece of contemporary debates about the morality and legality of assisted suicide. What arguments are there in favor of and against physician-assisted suicide?. Is physician-assisted suicide always morally wrong? Or is it sometimes or always morally justified?.

AN EVALUATION OF THE MORAL STATUS OF PHYSICIAN ASSISSTED SUICIDE

Physician assisted suicide has been condemned on so many grounds. The most prominent argument often employed is the argument from the intrinsic wrongness of killing. This argument has it that the taking of a human life is simply wrong and since physician assisted suicide involves taking a human life, this act can be described as killing hence it is wrong. Killing is understood as morally wrong in virtually all cultures and religious systems. Judaism, Christianity, Islam, Hinduism, Buddhism, Confucianism and many other religious traditions prohibit killing; so do the moral and legal codes of virtually all social systems. Although most religious and ethical systems recognize some forms of killing as justified - killing in war, killing in self-defense, killing in capital punishment and so on -- in these cases, the person killed is guilty; in assisted suicide, the person killed is innocent [20].

Another argument against physician assisted suicide which issues from the integrity of the profession states that doctors should not kill; this is prohibited by the Hippocratic Oath. The physician is bound to save life, not to take it. To permit physicians to kill patients would undermine the patient's trust in the physician. Closely related to this argument is the slippery slope argument which centers on the likely problems that may arise from abuse. According to this argument, legal and societal recognition of physician assisted suicide will lead by gradual degrees to outright abuse: from a few sympathetic cases of suffering we will move to the coercion of dying patients by malevolent family members who harbor long resentments or fragile ones who cannot bear the stress, to the callousness of cost-cutting insurers and health-maintenance organizations and the greed, arrogance or impatience of physicians who for a variety of reasons do not take adequate care of their dying patients. Finally, we will reach the point where patients with disabilities or chronic illnesses or other conditions requiring extraordinary care are forced into 'choosing' physician assisted suicide when that would otherwise not have been their choice [20]. In spite of these arguments against physician assisted suicide, one can say, based on some arguments that physician-assisted suicide is sometimes morally justifiable.

The arguments in favor of physician assisted suicide appeal to the conjunction of two fundamental moral principles: self-determination and mercy. These moral principles are acknowledged as basic by physicians, patients and observers. Ethical and moral arguments include the principle of self-determination to control the time, place and nature of one's death, placing quality at the end of life above the sanctity of life. Other factors include the desire to preserve dignity and personhood in the dying process and opposition to prolonging life by using sophisticated medical technology when it is recognized that care is futile.

Closely connected to self-determination is the principle of autonomy. This principle states that persons should have the right to make their own decisions about the course of their own lives whenever they can. Making a case for this principle, Margaret Battin [20] explains that just as a person has the right to determine as much as possible the course of his or her own life, a person also has the right to determine as much as possible the course of his or her own dying. If a terminally ill person seeks assistance in suicide from a physician freely and rationally, the physician ought to be permitted to provide it. This argument appeals to the central values of autonomy, involving both freedom from restriction (liberty), the capacity to act intentionally (agency) and the social principle of respect for person's autonomous choice which they entail. According to this argument, even when choices are socially shaped, they should be respected as autonomous as long as there is appropriate evaluation of decision-making capacity.

In the context of end-of-life medical care, respecting autonomy for the dying patient not only means honoring as far as possible that person's choices concerning therapeutic and palliative care, including life-prolonging care if it is desired, but could also mean refraining from intervening to prevent that person's informed, voluntary, self-willed choice of suicide in preference to a slow, painful death, or even providing assistance in realizing that choice. No person should have to endure terminal suffering that is unremitting, unbearable or prolonged when the burdens of life outweigh the benefits in terms of uncontrollable pain, severe psychological suffering and loss of dignity or of the quality of life as judged by the patient [20]. When the circumstances are not remedied, the dying patient should be able to ask for and receive help in assisted suicide.

Another argument in favor of physician assisted suicide appeals to mercy. According to this argument, if the physician is unable to relieve the patient's suffering in other ways acceptable to the patient and the way to avoid such suffering is by death, then as a matter of mercy, death may be brought about. Not all techniques of pain management developed by Hospice and others can treat all pains and relieve all suffering. The principle of mercy plays a role in what the patient conceives of as an easy death, taking into consideration both his or her own comfort and the comfort of family members or others who will be observers of the death or directly affected by it.

Legal arguments state that it would be in the best interest of dying patients to be able to regulate practices that are currently being used covertly for assisted suicide. Such regulations would also provide safeguards for practitioners who are currently complying illegally with patient requests out of compassion (www.ape.com).

Medical arguments contend that competent terminally ill patients wishing to choose physician assisted suicide may feel abandoned by physicians who refuse to assist. The criticism that medical doctors agreeing to assist in suicide would be violating the Hippocratic Oath has been refuted on many grounds. First, the original oath prohibiting killing also prohibited abortions, surgery and charging teaching fees, all of which have been modified to meet contemporary realities. Second, physician assisted suicide unlike euthanasia, does not involve the ending of life by the physician as it is the dying person himself or herself who makes the requests. Third, the oath requires physicians to take all measures necessary to relieve suffering and some interpret this to include assisted suicide when that is the only way suffering can be relieved (www.ape.com).

In most societies, suicide in whatever form it takes, is morally unacceptable because life is good and depriving a person of a good life is generally thought to harm him. However, suicide could be good for an individual and a caring thing to do. Consider the case of a person who has enjoyed a full and vigorous life but for whom as a result of an incurable and painful terminal illness, his life has become an intolerable burden. Such a person might decide however much he loves life, enough is enough. In such circumstances, suicide might be a blessing; suicide might be both desirable for him and an act of kindness on the part of someone who cares for him. In fact, if the capacity to control one's actions by reference to the choices one has made is the distinctive source of human dignity, then to deny such a person the opportunity to choose and control his life is to offend his or her dignity. The value of exercising self-determination presupposes some minimum of decision-making capacities. Hence self-determination as it bears on physician assisted suicide involves people's interest in making important decisions about their lives for themselves according to their own values or conceptions of a good life and in being left free to act on those decisions [21].

Individual self determination has special importance in choices about the time and manner of one's death, including assisted suicide. Most people are very concerned about the nature of the last stage of their death. This reflects not just a fear of experiencing substantial pain or suffering or of being abandoned by loved ones when dying, but also a desire to retain dignity and control to the extent possible during this last period of life. Death is today increasingly preceded by a long period of significant physical and mental decline, due in part to the technological interventions of modern medicine designed to stave off death [21]. Many people adjust to their disability and dependence and find meaning and value in new activities and ways. Others find the impairment and burdens in the last stage of their lives at some point sufficiently great to make life no longer worth living. For some patients near death, maintaining the quality of one's life, avoiding great pain and suffering, maintaining one's dignity and ensuring that others remember them as they wish them to become of paramount importance and outweigh merely extending one's life. But there is no single, objectively correct answer for everyone

regarding when, if at all, one's life when critically or terminally ill becomes, all things considered, a burden and unwanted. If self-determination is a fundamental value, then the great variability among people on this question makes it especially important that individuals control to the extent possible the manner, circumstances and timing of their dying and death.

However, the right to assistance in suicide is plausibly construed as the dying patients right to help from his or her own physician, at least where there is a personal physician who knows the patient well, who has been directly, extensively and intimately connected with and responsible for that person's care, who may know the family and who understands, better than any other physician or other party able to provide assistance in suicide, that person's hopes, fears and wishes about how to die [20].

The moral right of self-determination is the right to live one's life as one sees fit, subject only to the constraint that this not involve harm to others. Because living one's life as one chooses must also include living the very end of one's life as one chooses, the matter of how to die is as fully protected by the principle of self-determination as any other part of one's life. Choosing how to die is part of choosing how to live. Also, the principle of mercy or avoidance of suffering underwrites the right of a dying person to an easy death, to whatever extent possible and clearly supports physician assisted suicide in many cases.

Suicide assisted by a humane physician spares the patient the pain and suffering that may be part of the dying process and grants the patient a 'merciful' easy death. The principle of mercy is relevant in two different senses. In the first sense, the dying patient is currently enduring pain or other intolerable physical symptoms (such as continuous breathlessness, nausea, vomiting) or is suffering from emotional and psychological anguish. In the second case, the patient with a terminal illness anticipates and seeks to avoid pain and suffering, knowing that they are highly likely to occur in the future course of the disease. Narrow constructions of the principle of mercy are typically interpreted to support just the patient's right to avoid current pain and suffering while broad constructions support preemptive strategies intended to avoid anticipated pain and suffering before they begin [20]. In these two senses, the right to control one's own dying as far as possible in order to avoid suffering or pain is viewed as the right to seek an easy death. It is not merely the 'right to die'; it is the right to try to die without suffering and with what is often called *dignity* that underscores the importance of the very end of life.

Again, life itself is commonly understood to be a central good for persons, often valued for its own sake, as well as necessary for the pursuit of all other goods within a life. But when a competent patient decides to request for physician assisted suicide, continued life is no longer seen by the patient as a benefit but now a burden. Consider the case of a terminally ill patient with amytrophic lateral sclerosis disease (ALS, or Lou Gehrig's disease). She is in pain and completely respirator dependent with no hope of ever being weaned from the respirator. She is unquestionably competent but finds her condition intolerable and persistently requests for physician assisted suicide [21]. Is the physician morally obligated to help?. The physician may elect to help but is not obligated to do so. This question also raises the question of whether the dying patient has rights to assistance in suicide. These rights would at a minimum include the 'negative' right not to be interfered with or prevented from committing suicide if the means are available from a willing physician and they might also include the 'positive' right to require a physician to provide such help if requested [20]. If there are such rights, do they impose obligations upon physicians, even when as physicians they do not want to participate and even when the law provides opt-out clauses protecting them from any legal obligation to do so?. These and other related questions and answers often provided account for reasons why many believe not only that physician assisted suicide is morally justifiable or even morally required in some circumstances but also that at least some suicides are rational hence physicians should where necessary, give a helping hand.

Howard Brody [22] provides reasons why physician assisted suicide should be an acceptable practice for physicians. According to him, physicians have a moral obligation to use medical means to relieve their patients suffering. In most cases, excellent palliative care will relieve suffering without hastening death. But in few cases, prolonged life will be incompatible with relief of suffering; and in those few cases physicians might have to use the medical means at their disposal to shorten life directly. Also, physicians have a moral obligation to respect the autonomous choices of their patients. Some few

patients, even when provided with excellent palliative care will autonomously select physician assisted suicide as their preferred option. Physicians should honor these requests in those cases. Since some few patients will experience unbearable suffering and will autonomously request physician assisted suicide, refusal to even consider the physician assisted option amounts to a form of patient abandonment. Again, while abuses of physician assisted suicide can readily be envisioned and indeed would be likely to occur in at least a few cases if physician assisted suicide is legalized, appropriate safeguards can provide adequate protection against abuse for the vast majority of cases [23]. Physicians are often best placed to apply and implement those safeguards.

Finally, medical technology usually keeps patients alive through the early stages of serious disease, precisely when many patients in earlier times died relatively quickly. Medicine thus allows patients today to enter the chronic and terminal phases of illnesses, during which suffering and loss of useful function may be extensively protracted well before death occurs. Medicine is thus indirectly responsible for the predicament of many suffering, terminally or chronically ill patients; it cannot turn its back upon them when they request relief of their suffering even at the price of shortening life [24].

Sadly, pain cannot always be relieved, nor is it always possible to control the many distressing symptoms that may be associated with the dying process. In such circumstances, some patients will ask for assisted suicide. Many doctors would like to assist their patients in such circumstances because they believe that physician assisted suicide is not only compatible with good medical practice, but actually required by it. Both the patient and the doctor may regard it as a moral act and view the law that prevents them from carrying out this act as unjust and immoral. For these people, physician assisted suicide is a more humane death than a more prolonged one in which the patient may be robbed off his or her dignity. Many people are afraid of the symptoms that threaten personhood, not so much the pain or even physical suffering, but the loss of dignity and selfhood. The classic example here is a patient with acquired immunodeficiency syndrome (AIDS) anticipating AIDS dementia, having seen friends who have gone through this losing their very sense of self and dignity, a descent into a kind of absurdity or degradation, not being able to say goodbye on ones own terms but totally dependent on others, without awareness or control [25].

Contrastively, people who suffer a sudden and unexpected death by dying quickly or in their sleep from a heart attack or stroke are often considered lucky to have died in this way rather than by a more drawn-out-process. We care about how we die in part because we care about how others remember us and we hope they will remember us as we were in 'good times' with them and not as we might be when disease has robbed us of our dignity as human beings. A dignified death is the kind of death a person wants to die, a death that respects the patients value and beliefs, his or her own evaluation of bearable or unbearable suffering and which fulfills, rather than contradicts that person's life history [25].

However, physician assisted suicide is usually viewed as a solution to a life that a person wants to avoid. Yorubas believe that at least some suicides – those that are designed to end a life that has been lived to the fullest before it declines to a level that the suicide considers would be a life not worth living – are a celebration of life.

SUICIDE AND HUMAN DIGNITY: A YORUBA PERSPECTIVE

Yoruba, the third largest ethnic group in Nigeria, are a group of people who inhabit south-western Nigeria predominantly Lagos, Oyo, Ogun, Ondo and Kwara states of Nigeria and the eastern parts of the Benin Republic (formerly Dahomey). Yoruba communities extend as far west as Togo. More than seventeen Million Yoruba live in these areas [26]. They speak a language called Yoruba which belongs to the Niger-Congo family of African languages. Many Yoruba make their living mainly by farming. A large number of them live in cities and work on family-owned farms in surrounding areas. Still, other Yoruba work in technical jobs, in business, or in such professions as law and medicine.

In order to have an adequate understanding of the whole idea of suicide among the Yorubas, it is imperative to briefly discuss their cosmology and beliefs about death. Yorubas conceive the cosmos as consisting of two distinct but yet inseparable realms – *aye* (the visible world of the living) and *orun* the spiritual and invisible domain of the ancestors, gods and spirits. The two realms are closely connected in the sense that the inhabitants of *orun* regularly involve themselves in

human affairs. Thus a typical Yoruba community is not just perceived as a geographical entity with clearly defined boundaries and with a web of horizontal networks of kinship familial relationships. Instead it is also seen as a transcendental continuum, which stretches back into the past to include the dead represented by the ancestors and at the same time anticipating the future world of the yet unborn. These three elements: the dead, the living and the unborn always feature prominently in Yoruba traditional discourses on life [27].

The Yoruba concept of death is the material existence of phases or steps in which we need to work hard to receive the perfect maximum of our goals on earth. According to the Yorubas:

Awaye iku kosi, orun nikan laremabo (nobody has ever come to the world without returning to heaven (a way of describing death). We will all die one day but whoever goes to heaven will not return hence the need to ensure that one works hard on earth to achieve ones set goals in life).

The Yoruba concept of death (*iku*) can be traced to the history of creation. This is because the foundation of most African value systems, thought patterns and general attitudes to events and phenomena such as life, disease and death is the belief in the unity of creation [28]. When *Olorun* (God) tried to find suitable matter to create man, all the *Ebora* (spirits) left to look for it. They brought different things but none was meant for the required aim. Then death (*iku*) appeared with its hands full of dirt and in its misery of weeping. It said to *Olodumare* (another aspect of God) that in the beginning I gave it to *Orisanla* and *Olugama* (deities in Yorubaland) and later to yourself *Olodumare*. You breathed the life breath into them. *Olofi* (a third aspect of God) determined that since *Iku* was the one who chose the suitable material, it would have the privilege of reclaiming it to its origin at any time [29]. This is why at the end of our earthly existence, Iku takes us to the return to dirt.

Suicide has always been reflected in Yoruba social thought as *Iku ya j'esin* (death is preferable to shame, dishonor and indignity). Considerations of dignity play a significant role in the choice of suicide by the individual concerned. That an individual chooses death (*iku*) means he considered it to be a better option than shame (*esin*). The desire to preserve personal dignity in the face of impending shame is a major factor that moves some patients to ask for physician assisted suicide. The agency of these individuals in choosing death (*iku*) over pain (*inira*) is here acknowledged. 'Indirect' pressures for death could be presented by harrowing circumstances of life where the individual concerned did not wish to compromise his honor or where he felt he was approaching a situation of public ridicule. Terminally and chronically ill patients sometimes take advantage of this disadvantageous condition and turn such around to earn for themselves respect (*iyi*) and esteem (another aspect of respect (*iyi)*) in death instead of the original ridicule that would have been their lot. Physician assisted suicide thus serves a dignifying purpose for them. What then does it mean to have dignity in death?. What circumstances are considered medically shameful at different stages of a person's illness?.

Just as futile treatment (*aisan ti ko gbo oogun*: a treatment that defies medical solution) is disgraceful so also is prolong illness (*aisan ti ko lojo*). According to Ali Mazrui [30], 'suicide becomes respectable when the life which it ends had at once aspired to great hights and is now descended to such depths'. In essence such life is perceived by the individual as lacking quality and value, devoid of the features of a good life and hence not worth living. Talking about a life worth living, John Broome [31] explains that when we say a life is worth living, we are referring to the life's personal value and not its general value. The Yorubas describe such a life as *aye alaafia, irorun ati idera (*a healthy life devoid of pain and suffering*)*. A life worth living is worth living to the person whose life it is. That is to say this person is better off living it than not. If we conclude that a particular life is generally better not lived than lived, perhaps because it is the life of a terminally and chronically ill person, then we should express our conclusion by saying the life is not worth living (*aye inira, irora ati aini alaafia)*.

The Yorubas emphasize the value of good health from which conclusions about a life worth living is often drawn. For them, nothing is as valuable as good health (*kosi olun ti oto alaafia*). This is well captured in the saying that:

Alaafia ni oogun oro (health is wealth) without a good health many set goals in life cannot be achieved. Similarly, Piri lolongo o ji akii bokunrun eye lori ite (a person's health state determines how agile such a person is).

Good health cannot be compromised. The World Health Organization [32] defines health as not merely the absence of disease but complete physical, psychological and social well-being. The implication of this is that a healthy individual will live a life worth living. A life is worth living if it is better that one lives it than not living it hence a person's personal betterness relation applies only between histories in which the person lives. A person's existence is no doubt bad if his/her life goes badly and perhaps her existence is good if her life goes very well, but at intermediate levels of wellbeing – neither bad nor very good – existence is neutral [31]. Sometimes, the dignity of a person may be more important than the need to preserve life especially when all other measures to prevent suffering have failed hence each competent person has a right to decide for himself/herself, that his life should be ended, if certain irremediable medical conditions ensue [33]. For the Yorubas, competence is determined by the ability to independently make decisions.This is expressed as:

Bose wuni lase imole eni (One determines ones faith the way one deems fit). This metaphorical claim seeks to explain the notions of autonomy and competence in decision making.

However, *Iku ya j'sin*, a Yoruba adage preferring death to shame also has its equivalent in other African cultures. John Illife [34] writes about the Falasha or Beta Israel group in fifteenth and sixteenth century Ethiopia who in their fight for independence sometimes killed themselves or one another to escape capture while declaring that it is more meritorious to die honorably than to live in shame. Similarly, the Igbos of the Eastern part of Nigeria describe death with dignity as:

Onwu ka ihere nma (death is better than shame). Similarly, it can de described in relation to a life which has lost its value and quality due to illness, disease, pain and suffering and hence not worth living as:

Odi ndu onwu ka nma (one is better dead than alive) The Igbos believe in the principal force, God (*Chineke)* who is seen as the supreme creator, the provider of all good including life (*Chibundu*) and the cause of death (*onwu*). God as the head of the universe also has assistants –plenipotentiaries, or nature deities such as the sun god (*Anyanwu*) and the earth goddess (*Ala*). The assistance gods are the dispensers, the 'controllers' of God's beneficence among human society. Among the members of the spirit plane are the ancestors, saints and patriarchs in the Christian-judeo context, who are seen by the Africans as man's lobbyists and intermediaries in the spirit world. Consequently, the members of the spirit plane are feared and respected for it is believed that any dislocation of the relationships between them and man leads to the impairment of the divine roles [28]. Disturbance in the relationships results in the loss of supernatural favors and protection and ultimately to the prevalence of malevolent forces such as evil spirit divine tools for retribution and punitive visitation which sometimes resulting to death (*onwu*).

In both instances cited above and also the Yoruba conception of death as a means of avoiding shame, the issue of the sanctity of life creates a big problem. For the Yorubas, the need to preserve life is of utmost importance. For them, life has no duplicate (*emi o l'aaro*) and there is value in long life. In fact they believe there is positive gain in a preserved life only if such life is a healthy one. This longevity of life is often reflected in the saying:

Ire aiku bale oro (the beauty in longevity of life is the procurement of wealth). The issue here is longevity of life with good health hence the quality of life takes precedence over the sanctity of life. The presence or absence of diseases and illnesses are important in determining quality of life. A quality of life instead of a length-of-life criterion should determine what is normal and what is not. An operational definition of normalcy is the usual state of how one feels and acts physically, psychologically, socially, spiritually and economically when one is not ill [35].

The assessment of quality of life derives from western concepts of illness and of men's fate. In the west, illness is almost an external intervention, adversely affecting an otherwise self-determined life course. Calman [36] sees a gap between the patients' expectations and achievements in his definition of quality of life. For him, the smaller the gap, the higher the quality of life. Conversely, the less the patient is able to realize his expectations, the poorer his quality of life. In his analysis, Calman [36] shows that the gap between expectations and achievement may vary over time as the patient's health improves or regresses in relation to the effectiveness of treatment or progress of disease.

Quality of life can be given a number of more or less broad interpretations depending on the scope of the evaluative factors concerning a person's life that it is taken to include. Dan Brock [37] takes the concept of 'a good life' to refer to the quality of life of persons in its broadest interpretation. One condition that may plausibly contribute to a person's

quality of life or good life is his/her physical mobility hence aspects of a person's quality of life may play a role in judgments about his quality of life or about how good a life he has.

It is noteworthy to point out that quality of life (*igbesi aye alaafia*) must be viewed on a number of levels. The overall assessment of well-being is the top level and may be described as an individual's overall satisfaction with life and one's general sense of personal well-being. Bert Spilker [38] identifies five major domains of quality of life. They include: physical status and functional abilities, psychological status and well-being, social interactions, economic and or vocational status and factors and religious and or spiritual status. Similarly, Haavi Morreim [39], makes a distinction between subjective and objective quality of life. Subjective quality of life judgments appeal to material facts about a person and his or her condition (though they may also include facts about the person's private psychological states), together with that persons value judgments about how those facts affect his/her quality of life. Objective quality of life on the other hand are made on the basis of intersubjectively observable, material facts about a person (facts concerning his/her body, mind, functional capabilities and environment), together with a socially shared evaluation of those facts, specifically of how those facts determine the person's quality of life.

The essential issue that determines whether a quality of life judgment is objective or subjective is whether the evaluative judgments concerning a particular individual's quality of life are and must be shared by some wider group or are instead, only the individuals own. Most patients decisions against life-sustaining treatment is based on their judgment of the benefits and burdens of such treatment and in some instances patients may give significant weight to other factors such as religious obligations, the emotional burdens and financial costs for their families and so on. Except for patients who hold a form of vitalism according to which human life should or must be sustained at all costs and whatever its quality, the request for physician assisted suicide by competent patients inevitably involves an assessment of their quality of life.

Thus far, this review has examined the moral status of physician assisted suicide. It emphasizes the whole idea of dying with dignity taking into account the philosophical discourse of autonomy and competence. The work also drew on the Yoruba conception of dying with dignity (iku ya j'esin) in other to further justify allowing a competent patient to decide the course of his/her life including his death. The work concluded by stressing that health is wealth (*alafia loogun oro*) hence a competent patient whose health is in a bad state with the attendant consequence of a low quality of life should be allowed to determine the appropriate time to end his life.

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