



Physicians Disposition to Active/Passive Euthanasia in Nigeria: A Survey of Doctors in Enugu, Nigeria

Nwankwo TO^{1*}, Obioha KCE¹, Aniebue UU¹, Obioha JO², Onyeka T³ and Okereke-Davids C¹

¹Department of Obstetrics and Gynecology, University of Nigerian Teaching Hospital, Ituku-Ozalla, Enugu State, Nigeria

²Enugu Study Centre, National Open University of Nigeria, Nigeria

³Department of Anaesthesia, University of Nigerian Teaching Hospital, Ituku-Ozalla, Enugu State, Nigeria

Abstract

Background: Physician assisted death (Euthanasia) has gained a wide range of debate, dating from the medieval to contemporary times. Conflicting interests existed amongst different religious bodies, health care system, and the legal system, in providing assistance to hasten the death of patients who wish to die.

Objectives: This study assessed the Physicians disposition to active/passive euthanasia in Nigeria where there is no enabling law.

Materials and Methods: A Cross-sectional survey of doctors practicing in Enugu state Nigeria was done using a pretested self-administered structured questionnaire with sections on socio-demographic characteristics, clinical experience and attitudes towards euthanasia. The Chi square test was used to assess the factors influencing the attitudes toward euthanasia.

Results: The mean age of the respondents was 33.6 ± 7 years. Majority (53%) of the respondents were Roman Catholics. One hundred and ninety three respondents (72.6%) rejected euthanasia in all circumstances. Forty one respondents (15.4%) declared that the conduct of euthanasia may be acceptable depending on the condition, while 32 (12%) declared euthanasia to be completely acceptable.

Conclusion: There was poor attitude to and acceptance of euthanasia by Physicians in Enugu, Nigeria. These poor attitude and acceptance to passive or active euthanasia in Nigeria was found to be significantly influenced by moral and religious beliefs, which are deep-rooted in our environment. Legislatures should make enabling laws to permit either passive/active euthanasia in very carefully selected cases in Nigerian to stifle litigation and possible culpability against physician positively disposed to euthanasia in appropriate circumstances.

Keywords: Euthanasia; Doctors; Attitude; Nigeria

Introduction

Physician assisted death (Euthanasia) has gained a wide range of debate in the ancient, medieval, and contemporary times. Conflicting interests have existed amongst different religious bodies, health care system, and the legal system, in providing assistance to hasten the death of patients who wish to die. In these debates, some see euthanasia as an act of compassion and sympathy to a patient who needs it, others see it as a form of murder or violation of God's commandment, while some health care professionals see it as violation of the Hippocratic Oath [1,2].

Studies have been widely published in the professional literatures that examined the attitudes about the right-to-die issues of physicians and their patients [1,2], World Health Organization (WHO) is not clearly in support or against the question "should euthanasia or Physician assisted suicide be legal?" It is pertinent to note that active euthanasia is illegal in almost all jurisdictions and assisted suicide is surrounded by moral ethical and philosophical controversy. However, Legislations in Netherlands and few states in the United States of America (USA) such as state of Oregon, have begun to favor voluntary euthanasia and/or physician-assisted suicide under specific conditions [3-6].

The termination of life on request and assisted Suicide Acts of 2002 of Netherlands states that

OPEN ACCESS

*Correspondence:

Theophilus Ogochukwu Nwankwo,
Department of Obstetrics and
Gynecology University of Nigeria,
Nsukka, Nigeria, Tel: 234-0803-751-
1519;
E-mail: theophilus.nwankwo@unn.edu.
ng

Received Date: 30 Mar 2017

Accepted Date: 06 Jul 2017

Published Date: 13 Jul 2017

Citation:

Nwankwo TO, Obioha KCE, Aniebue
UU, Obioha JO, Onyeka T, Okereke-
Davids C. Physicians Disposition to
Active/Passive Euthanasia in Nigeria: A
Survey of Doctors in Enugu, Nigeria. J
Clin Obstet Gynecol Infertil. 2017; 1(2):
1010.

Copyright © 2017 Nwankwo TO. This
is an open access article distributed
under the Creative Commons Attribution
License, which permits unrestricted
use, distribution, and reproduction in
any medium, provided the original work
is properly cited.

Table 1: Socio-demographic characteristics of respondents.

Characteristics	Frequency n=266	Percent
Sex		
Male	193	72.6
Female	73	27.4
Age (years		
≤ 29	80	30.1
30-39	131	49.2
> 40	55	20.7
Religion		
Roman Catholic	141	53
Protestants	119	44.7
Others	6	2.3
No of years post-graduation		
<5	127	47.8
5-9	57	21.4
10-14	37	13.9
>15	45	16.9
Rank of Doctor		
Consultants	37	13.9
Senior Registrars/Principal Medical Officers	62	23.3
Registrars/Medical Officers	80	30.1
House Officers	87	32.7

euthanasia and Physicians assisted suicide is not punishable if the attending Physician acts in accordance with criteria of due care. These criteria concern the patient's request, the patient's suffering (unbearable and hopeless), the information provided patient the absence of reasonable alternative, consultation of another Physician and applied method of ending life [7]. The Northern Territory of Australia legalized voluntary euthanasia and assisted suicide in 1996 but the federal government overrode the legislation in 1997 [3-6]. There are different ways of bringing on the death of someone who is terminally ill. The Oregon is one of the few states in USA where terminally ill patients may legally end their lives if they choose. Here the Oregon Death with dignity Acts allows terminally ill patients to receive a prescription for lethal medication which they administer themselves after completing the consent process. To be eligible, patients must be given six months or less to live, be at least 18 years old and submit three separate doctors request. There are different ways of bringing on the death of someone who is terminally ill [8].

The first is suicide, which is usually defined as self-killing. People kill themselves for a variety of reasons, and in many cases are for emotional and mental health problems, which are often tragic. Many people do not know how to successfully carry out suicide or access the right drugs to do so. There is also the issue of the need for courage to override one's survival instinct, making suicide one of the most difficult tasks a person can perform. A number of people who have attempted end-of-life suicide failed; in the aftermath they report that, while they wished they would have succeeded, they doubt whether they could regain the courage to try again [3,5,6].

Euthanasia is a deliberate intervention undertaken by a doctor with the express intention of ending a life, and to relieve intractable suffering of a patient [9], or the termination of life by a doctor at the

Table 2: Doctors experience with care of terminally ill patients.

Experience	Frequency	Percent
Care for terminally ill friends and close relations		
Parents	47	17.7
Grandparents	16	6
Uncle/Aunt	19	7.1
Cousins/In-laws	15	5.6
Close friends	15	5.6
None	154	57.9
Number of terminally ill Patients attended to in past year		
0-4/year	80	30.1
5-10/year	54	20.3
5-10/month	22	8.3
5 or more/week	23	8.6
Not sure	87	32.7

Table 3: The attitude to euthanasia among doctors.

Attitude	Frequency
Response to the conduct of euthanasia	
Not Acceptable	193
Acceptable in some conditions	41
Acceptable	32
Request for termination of life	
Active Euthanasia	31
Passive Euthanasia	47
Physician Assisted Suicide	4
No Request	249

request of a patient [10]. There are different types of situations in which euthanasia might be carried out, and this leads to additional distinctions. First, there is the distinction between active and passive euthanasia. Active euthanasia means causing the death of a person through a direct action in response to a request from that person. In a clinical setting, a doctor might actively perform euthanasia by administering a lethal dose of drugs to the patient who wishes to die, through pills or an injection. In contrast, passive euthanasia means hastening the death of a person by altering some form of support and letting nature takes its course. This is done by taking a patient off life support, or deciding not to put the patient on life support *ab initio*. In some other situations physicians may allow patients to die by avoiding futile care or medical futility, which implies clinical actions serving no useful purpose in attaining a specific goal for a given patient [1].

The term euthanasia is classified into voluntary, involuntary, and non-voluntary euthanasia, based on whether informed consent is given by the patient or not [11,12]. Euthanasia conducted with the consent of the patient is referred to as voluntary euthanasia. When it is conducted against the consent of the patient, it is referred to as involuntary euthanasia. Nevertheless, if conducted where the consent of the patient is unavailable as in child euthanasia, it is termed non-voluntary euthanasia [11,12].

Assisted suicide is used when the patient brings about his or her own death with the assistance of a physician or another person who serves as a third party [13]. Here, a third party provides the person

who wishes to die with the resources to carry out his or her suicide. What is critical with assisted death is that the third party only provides the death causing agent, and the person seeking death actually carries out the death-causing act. Spouses and family members, though, are not necessarily the best third-parties to assist in death but may sometimes receive the request to do so. Sometimes there may be conflicts of interest, for example if a wife or husband of the person who wishes to die was weary of giving care and wanted the situation resolved quickly. The ideal assisted death would be one that was done under the supervision of a physician, who would be impartial and was aware of the details of the patient's prognosis [6,9,13].

Non-voluntary euthanasia is illegal worldwide. Active voluntary euthanasia is legal in Belgium, Netherlands, and Luxembourg. Passive voluntary euthanasia is legal throughout the United States. Assisted suicide is legal in Switzerland and the US states of Oregon, Washington and Montana [11-13].

This study aims at determining the disposition of physicians, practicing in Enugu state South East of Nigeria, to active and passive euthanasia.

Materials and Methods

This cross-sectional survey was conducted between February and June 2015, on medical doctors that are members of Nigerian Medical Association practicing in Enugu State.

Data collection was with the use of a pretested self-administered structured questionnaire reflecting age, gender, religion, duration of practice, specialty, designation, and attitudes toward euthanasia; whether 'pro' or 'anti' euthanasia and the reasons 'for' or 'against' euthanasia. These questionnaires were administered to consecutive consenting members of Nigerian Medical Association, Enugu state chapter, in the Ordinary General Meeting (OGM) of the Nigerian Medical Association, Enugu State, and also during Weekly Clinical Meetings in the three tertiary Hospitals in the state; University of Nigeria Teaching Hospital (UNTH) Enugu, National Orthopedic Hospital (NOH) Enugu, and Enugu State University Teaching Hospital. Only doctors absent in the OGM were surveyed during the departmental conferences or clinical meetings. Verbal consent was obtained from participants. Ethical clearance was obtained from the University of Nigeria Teaching Hospital ethical committee.

To minimize poor response by the participants or loss to follow up, the participants were encouraged to fill and submit the completely filled questionnaires immediately. Participants who were unable to completely fill their questionnaires immediately gave their contact addresses and phone numbers which were used to follow them up through phone calls, and physical contacts. Afterwards, all data were entered into an electronic database using SPSS version 17.0 for Windows. Statistical analysis was both descriptive and inferential at 95% confidence level. Continuous variables were analyzed using the mean, standard deviation. Discrete variables were analyzed using proportions. Pearson's Chi-square test was used to assess for factors influencing attitude towards euthanasia; P-value less than 0.05 was considered statistically significant.

Results

A total of 300 doctors were surveyed, and of which 266 questionnaires were completely and properly filled and returned, giving a response rate of 88.7%.

Respondent's characteristics

The mean age of the respondents was 33.6 ± 7 years, with age range of 22-68 years. Most (49.2%) were within the age range of 30-39 years. Ninety nine percent of respondents were Christians with 53% and 44.7% being of catholic and protestant denominations respectively. Only 2 (0.75%) were Muslims. Most respondents (72.6%) were males.

Only 42.1% of the respondents have ever cared for terminally ill friends or close relatives. Of these, care of parents was 17.7%, grandparents (6%), uncle/aunt (7.1%), cousins/in-laws (5.6%), and close friends (5.6%). Majority (57.9%) has never cared for any terminally ill relative (Table 1).

In the past 1 year, 30.1% of the respondents attended to less than five terminally ill patients. Fifty eight others (20.3%) attended to 5-10 terminally ill patients in the previous year (Table 2).

In the last one month, 8.3% of the respondents attended to at least 5-10 terminally ill patients. While in the last one week, 8.6% of the respondents attended to five or more terminally ill patients.

One hundred and ninety three respondents (72.6%) declared that the conduct of euthanasia was not acceptable under any circumstance. Forty one respondents (15.4%) declared that the conduct of euthanasia may be acceptable depending on the condition, while 32 (12%) declared that euthanasia is acceptable. Thirty one (11.7%) had received requests to offer active euthanasia, and 17.7% (47/266) received requests to offer passive euthanasia and 3.4% (9/266) had practiced passive euthanasia despite absence of enabling law. Only 1.5% received request to offer physician assisted suicide, while a majority (69.2%) of the respondents had never received any requests for any form of euthanasia (Table 3).

The religious practices of the respondents are shown in Table 4. Religious practice was found to significantly influence the attitude of doctors to the practice of euthanasia ($p=0.001$).

The respondents who had practiced euthanasia in one way or the other mainly belong to the group with flexible religious practice who occasionally attend religious worships while vast majority of the respondents who rejected the practice of euthanasia mainly belong to the group with very rigid religious practice/belief who frequently attend religious worships.

However, age, sex, type of religion, and number of terminally ill patient cared for per year had no statistical significant association with respondents' attitude to the practice of euthanasia.

There was no statistical significant association between doctor's time of graduation, type of hospital, rank, or medical experience and the practice of euthanasia.

Discussion

This study has shown that majority of the doctors in the study area had negative attitude towards euthanasia. The findings in this study suggest that though 30.8% of respondents received request for euthanasia (11.7% for active, 17.3% for passive and 1.5% for Physicians assisted suicide) from patients and relatives, few were favorably disposed towards the practice of both active and passive euthanasia in our studied Physicians in Nigeria. This negative disposition towards euthanasia may be because doctors in Nigeria are highly religious and may strongly believe in divine healing. Majority of doctors in this environment see euthanasia as a form of murder or going contrarily

Table 4: The influence of sociodemographic factors on the attitude towards euthanasia among doctors.

Characteristics	No to Euthanasia	Yes/may agree to Euthanasia	x ²	p-value
Age				
<29 (n=80)	68 (85%)	12 (15%)	0.857	0.652
30-39 (n=131)	117 (89.3%)	14 (10.7%)		
>40 (n=55)	48 (87.3%)	7 (12.7%)		
Sex				
Male (n=193)	165 (85.5%)	28(14.5%)	2.859	0.091
Female (n=73)	68 (93.2%)	5 (6.8%)		
Religion Roman				
Catholics (n=141)	113 (80.2%)	28 (19.2%)		
Protestants (n=119)	101 (84.9%)	18(15.1%)	4.545	0.101
Others (n=6)	4 (66.7%)	2 (33.3%)		
Religious practice/ Believe (Attendance of worship)				
Frequently (weekly) (n=125)	112 (89.6%)	13 (10.4%)		
Often (Monthly) (n=114)	104 (83.9%)	10 (16.1%)	16.92	0.001
Occasionally (> Monthly) (n=27)	17 (63%)	10 (37%)		
No. of terminally ill cared for/year				
0-4/year (n=80)	74 (92.5%)	6 (7.5%)	5.88	0.208
5-10/year (n=54)	49 (90.7%)	5 (9.3%)		
5-10/month (n=22)	20 (90.9%)	2 (9.1%)		
5/week (n=23)	19 (82.6%)	4 (17.4%)		
Not sure (n=87)	71 (81.6%)	16 (18.4%)		

to God's commandment, as well as violation of the Hippocratic Oath [1,2]. The Nigerian law is silent on the terminology "euthanasia", thus, any such case is treated as murder as stated in the Nigerian's criminal code, penal code, and constitution of the federal republic of Nigeria [14-17]. However, this non-legalization of euthanasia in our country may be a co-factor leading to the negative attitude.

More so, our people may have developed very negative attitude towards euthanasia probably due to the following arguments against the practice of euthanasia:

1. The wrongness of intentional killing; which propagates that Euthanasia is wrong because it is deliberate killing, and societies throughout history have condemned intentional killing of other people no matter what the situation or intent might be [18,19].

2. Slippery slope; which propagates that euthanasia will lead to abuses, and ultimately result in actively euthanizing people against their wills. While in some situations it may be tempting to put someone out of his or her misery through active euthanasia, society will get accustomed to the idea of killing people to solve problems. Eventually euthanasia will be permitted in non-end-of-life situations [18,19].

3. Possible recovery; which propagates that euthanasia is wrong because we cannot tell for certain if a person's condition is really hopeless or not. There is usually the possibility of some recovery, such as through a spontaneous remission, or a new discovery of cure, or even a mistaken diagnosis. Though this might be infrequent, but it's not worth risking the lives of those who might be lucky enough to recover [18,19].

4. There is no assurance of voluntariness; this explains that

even if patients appear to give consent for, or authorize euthanasia, we can't be sure that their consent is truly voluntary. They might not be in the proper state of mind to fully understand the options. Worse yet, they might be influenced by the preferences of family members who may want to be free from the expense and burden of continued treatment, thus, wishing to end the life of the critically ill [18,19].

Nevertheless, the acceptance of euthanasia by the respondents in this survey was found to be as low as 12%. The low acceptability of euthanasia found in this study corroborated the findings by Stronegger et al. [20] in their study of euthanasia movement in the United States of America, but quite in contrast to the report from previous studies that at least 6 in every 10 Americans in the United States support euthanasia [21,22].

This low acceptability may also be attributed to religiosity and non-legalization of the act. Though 15.4% of the respondents in this survey indicated that euthanasia was acceptable in some conditions, the majority of respondents (72.6%) categorically stated that it was not acceptable under any condition.

In this survey, it was found that majority of doctors who were negatively disposed to euthanasia were among the highly religious groups (those that attend religious worships weekly and monthly) & older people while the few that accepted the practice were more of the younger and non-religious groups, doctors who had attended to terminally ill relatives and or close friends, and doctors who were general practitioners. This report corroborated the report by Ward and Tate [23] in Japan.

The finding that 30.8% of respondents in this study had received requests for varying types of euthanasia was comparably lower than 41% found by researchers in Australia [24], and quite lower than

75% and 60.4% reported by Dutch family doctors [25] and Ward and Tate [23] in Japan respectively. This lower rate of request in our environment could be possibly due to the low level of education in this part of the world and the strong believe that pain and suffering are part of life, and divine healing could suddenly come from God, and requesting to be killed may bring a negative life-after-death in form of "hell fire". More so, patients in this part of the world may be unaware of the prognosis of their illness, due probably to poor disclosure from care givers.

The factors affecting the attitude (acceptability or rejection) of doctors to euthanasia in this study are multifactorial, ranging from religious, moral, and legal medical factors. Moreover, this socio-cultural, religious and legal factors influencing the acceptance or rejection of euthanasia in this study is similar to the reports of other studies in both developed and developing countries [20,22,26]. Regression analyses by Stronegger et al. [20] showed that rejection of active voluntary euthanasia was positively correlated with experience with care of seriously ill persons, a conservative worldview, and level of education. High family income was associated with lower levels of rejection. More so, the survey done in America in 2003 shows that the senior citizens who frequently attend religious services, those with lower levels of education, blacks, conservatives, and Republicans were most likely to object to euthanasia and doctor-assisted suicide [22,26].

Despite all these factors, different countries have peculiar ways of dealing with issue concerning the practice of euthanasia. Previously reported levels of practice of euthanasia in other studies also vary widely depending on religious and socio-cultural factors, whether the practice is legalized or not in the particular population studied, the contents of the questionnaire and the operational definitions.

In this survey, variables like age, sex, experience with care of terminally ill, time of graduation, area of practice, years of experience as a doctor, rank and type of hospital were not found to be associated influence on the practice of euthanasia. This is similar to the reports in the United States of America [20]. However, religious practice was significantly associated influence with the rejection of euthanasia. The reason could be due to the believe that the practice of euthanasia contradicted the moral standard of Christianity as was earlier quoted by Saint Thomas Aquinas [25,26]. In similar studies from Malaysia and Pakistan, the attitude to the practice of euthanasia were influenced by the beliefs of the respondents [27,28].

Conclusion

The attitude of doctors towards the practice of Physicians assisted death (euthanasia) in Enugu, Nigeria is very poor. The acceptance of euthanasia amongst the doctors in Enugu, Nigeria is also very poor. These poor attitude and acceptance of Physicians assisted death (euthanasia) in Nigeria were found to be significantly influenced by religious beliefs and practices and moral factors which were deep-rooted in our environment. The Nigerian law is silent on the term euthanasia proper legislation is advocated on this to provide enabling environment for possible practice of euthanasia for the carefully chosen few that may benefit from this.

References

1. Emanuel EJ, Fairclough DL, Daniels ER, Clarridge BR. Euthanasia and physician assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public. *Lancet*. 1996;347:1805-10.
2. Bachman JG, Alser KH, Doukas DJ, Lichtenstein RL, Corning AD, Brody

H. Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. *N Engl J Med*. 1996;334:303-9.

3. Kuhse H, Singer P, Baume P, Clark M, Richard M. End-of-life decisions in Australian medical practice. *Med J Aust*. 1997;166:191-6.
4. Euthanasia home page, WHO Biography. ProCon.org/view.source.php?sourceID=00087.
5. Ganzini LG, Nelson HD, Schmitt TA, Kraemer DF, Delorit MA, Lee MA. Physicians' experiences with the Oregon death with Dignity Act. *N Eng J Med*. 2000;342:557-63.
6. Kissane DW, Street A, Nitschke P. Seven deaths in Darwin: Case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *Lancet*. 1998;352:1097-102.
7. <https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request>.
8. Norman-ready S. Suicide, death, right to die, eviction, physicians. Oregon Assisted Suicide law. OLR Report. 2002.
9. Harris NM. The euthanasia debate. *J R Army Med Corps*. 2001;147:367-70.
10. <http://www.bbc.co.uk/ethics/euthanasia/>.
11. Perrett RW. Buddhism, euthanasia and the sanctity of life. *J Med Ethics*. 1996;22:309-13.
12. LaFollette H. Ethics in practice: an anthology. Oxford: Wiley-Blackwell, USA; 2002. pp. 25-6.
13. Rachels J. Active and passive euthanasia. *N Engl J Med*. 1975;292:78-80.
14. Nwafor AO. Comparative perspectives on euthanasia in Nigeria and Ethiopia. *Afr J Intern Comp Law*. 2013;18(2):170-91.
15. Nigeria: Criminal Code Act [Nigeria], Cap C38 LFN 2004, 1 June 1916, available at: <http://www.refworld.org/docid/49997ade1a.html> [accessed 7 July 2017].
16. The Nigerian Penal code Cap 89. Section 225, Offence related to the cause of death.
17. <http://www.wipo.int/edocs/lexdocs/laws/en/ng/ng014en.pdf>.
18. <http://www.bbc.co.uk/ethics/euthanasia/overview/introduction.shtml>.
19. B.B.C News, Mon 16/10/95, 2.43pm Nigerian time (13 43G.M.T) under this law, the first case ever of legal voluntary euthanasia occurred in North Australia, CF BBC News 16/9/96 6hrs G.M.T.
20. Stronnegger WJ, Burkett NT, Grossschadl F, Freidi W. Factors associated with rejection of active euthanasia a survey among the general public in Australia. *BBC Medical Ethics* 2013;14:26.
21. Appel JM. Duty to kill? A duty to die? Rethinking the euthanasia controversy of 1906. *Bull Hist Med*. 2004;78(3):610-34.
22. Gurney EJ. Is there a right to die? A study of the law of euthanasia. *Cumberland-Samford Law Rev*. 1972;3(3):235-61.
23. Ward BJ, Tate PA. Attitudes among NHS doctors to request for euthanasia. *BMJ*. 1994;308(6940):1332-4.
24. <http://euthanasia.procon.org/view.timeline.php?timelineID=000022>.
25. Van DerWal G, Van Eijk JT, Leenen HJ, Spreeuwenberg C. Euthanasia and assisted suicide. How often is it practiced by family doctors in the Netherlands? *Fam Pract*. 1992;9:130-4.
26. Garcio-Romero H, González-González A, Galicia J. Acceptance or rejection of euthanasia. Survey of 3021 Federal Government employees. *Gal Med Mex*. 1998;134:629-36.
27. Dash SK. Medical ethics, duties and medical negligence awareness among the practitioners in a teaching medical college, hospital-A Survey. *J Indian Acad Forensic Med*. 2010;32(2):153-6.

28. Rathor MY, Rani MF, Akter SF, Azarisman SM. Religion and spirituality in specific clinical situations in medical practice; a cross-sectional comparative study between patients and doctors in a tertiary care hospital in Malaysia. *Med J Islam World Acad Sci.* 2009;17:103-10.