THE ETHICAL AND LEGAL IMPLICATIONS BEHIND THE LEGALISATION OF EUTHANSIA IN UGANDA.

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DECLARATION

I Ndimwibo Alan do hereby declare that this research is my original work, save for the references to various online and printed texts for which due acknowledgement has been given and further that this study has not been submitted in similar form and content for the purpose of the conferment of any degree or otherwise to any individual, university, website or institution.

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DATE: 27/06/2019

This dissertation has been submitted for examination with my approval as the university supervisor.

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Dr chima.

SUPERVISOR

DATE: 27-5-2019

DEDICATION.

To my parents, brothers, and sisters.

Your unwavering support, encouragement and positive criticism has been a pivotal contribution to the fulfillment of this journey and a source of reflection, and hearty laughs for our family.

This study couldn't be compiled without you. Your inspiration and benevolence has been immeasurable.

ACKNOWLEDGEMENT.

It would be in vain to state that this study resulted from the sole effort of the author. It has taken the selflessness input of a lot of people to finally finish the study, piece by piece, brick by brick.

I thank the Almighty God for his steadfast love and uncountable blessings. My sincere gratitude goes to my supervisor Mr. KAHAMA for his guidance time and dedication to my study.

I am greatly indebted to all the medical practioners who took the time from their busy schedules to fill out my Questionnaires and particularly Dr. Henry Nuwamanya of international hospital Kampala for going out of his way to assist me in getting respondents for my Questionnaires.

Finally, I could not conclude without recognizing all the terminally ill people of the world.

You filled me with great empathy and were an immense source of motivation throughout my study, it is because of you that I chose and undertook this particular topic for study.

May God fill you with peace and may you never lose hope.

ABSTRACT.

The suggestion that euthanasia should be authorised by law, to a considerable extent raises some plausible moral, ethical, philosophical, and religious issues as well as legal and constitutional questions.

In addition, the euthanasia debate has been fueled by a number of social and legal developments. These include the advent of modern medical technology and the availability and use of artificial measure to prolong life.

Therefore, this study will examine and analyze all the factors to provide a deeper and more uniform insight into mercy killing, in conjunction with the Ugandan legal system and constitutional dispensation.

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TABLE OF STATUTES

Statutes

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CHAPTER 1

TITLE

THE ETHICAL AND LEGAL IMPLICATIONS BEHIND THE LEGALISATION OF EUTHANSIA IN UGANDA.

1.0 INTRODUCTION.

Questions regarding death and dying have recently become popular topics for discussion by lawyers, physicians, theologians, philosophers, and the public. Is euthanasia murder? Should steps be taken towards legalization? Is private regulation an effective method for control? These questions are numerous and others are being asked with increasing frequency. These are urgent questions that require careful and thorough analysis and comprehensive answers. This study will describe euthanasia as a concept and practice. It will discuss and propose whether euthanasia should or should not be legalisedS in Uganda.

This study is for examining euthanasia as a concept, the manner and form in which it is practiced in different legal systems that have legalised the same, its role and purpose in today's society.

1.1.0 BACKGROUND TO THE STUDY.

Research into the topic outlined above was necessitated by the need to preserve the human dignity of the terminally ill in Uganda, in the spirit of the constitution of Uganda.

People ailing from serious illness that have stripped them off their health, livelihood, peace of mind and dignity have been consigned the footnotes of Uganda's social-economic advancement and constitutional change. The constitution is silent on the rights and needs of these people.

While advancement in medical research and treatment has offered hope to countless people grappling with complicated illnesses throughout the world, a great number still continue to endure a demeaning, undignified and intolerable life as a result of their illness.

A constitution is the source, the jurisprudential fountain head from which other laws must flow, succinctly and harmoniously[1]

A constitution is a living document; it goes beyond addressing the needs of the living, but the posterity as well[2]

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[1]S.N mwangi a history of constitutional making in Kenya 2012 page 1

[2]S.N mwangi a history of constitutional making in Kenya 2012 page 70

In order for the people of Uganda to recognize, respect, and appreciate the constitution, we must enjoy and feel protected by this supreme law[3] we must see its effects in our day to day life.

The constitution of Uganda 1995 thrust a robust and progressive bill of rights into the Ugandan system that provides for among other things the right to life and human dignity[4]. As a consequence and within the letter and spirit of those provisions, it will be examined if legalizing euthanasia would offer relief to persons enduring endless and incurable suffering, as a result of illness for them to end their life voluntarily subject to the approval of qualified medical practioners and within the strict and explicit provisions of the law.

Our attitudes towards death have in recent years. In the past death was simply something that happened to us and had to be accepted. However with technology developments, it has become impossible to exercise greater control over our dying. Albeit the extent to which people should have control of their or another's death is highly controversial[5] .

Therefore owing to the controversial and maligned nature of the topic of euthanasia, and taking into account the pluralistic nature of the society we live in, I shall also look into and compare the implementation of the practice of euthanasia in countries that have legalised the same, and the lacunas that are likely to pop up if euthanasia is allowed in Uganda, and lastly the chances of success of such a practice within our borders.

[3]Article 2(2) Ugandan constitution 1995.
[4]Chapter 4 article 22 and 24 respectively of the 1995 constitution of Uganda
[5]J herring, medical law and ethics 4th edition page 473

1.2.0 STATEMENT OF THE PROBLEM

Euthanasia and related issues has caused a great debate across the globe. Courts and legal scholars have faced a considerable challenge of determining whether euthanasia can truly fall within the scope of the fundamental human rights as recognized by a raft of international conventions, treaties and constitutions across the world.

Euthanasia and related issues are topics that courts have struggled to deal with. In Britain, the House of Lords called upon parliament to legislate on the area. Politicians, lawyers and judges have exhibited hands off approach[6], for many opponents of euthanasia.

At the heart of the issues surrounding euthanasia is the principle of sanctity of life,[7] they argue that the right to life is inviolable. For example, the House of Lords select committee on medical ethics concluded that the prohibition on intentional killing was "the cornerstone of law and of social relationships[8]

From a religious perspective, this vies is also largely upheld and respected. Pope john Paul II said in one of his speeches that[9] "euthanasia is a grave violation of the law of God. 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 hold of this life. Man cannot do with it as he wills.

More still God has given to human kind the gift of life. As such, it is to be revered and cherished. Those who become vulnerable through illness or disability deserve special care and protection. We do not accept that the right to personal autonomy requires any change in the law in order to allow euthanasia.[10]

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[6]Page 473 ibid.

[7]Holy bible genesis 1:26, 1 Corinthians 2:16, Job 1:21, John 10:10, Matthew 22:39, psalms 139:13-16, john 13:34

[8]Page 517 ibid.

[9]Vitae gospel or life Paul john pope II 1995.

[10]Church of England 1999

1.3.0 OBJECTIVES.

1.4.0 GENERAL OBJECTIVE

To describe euthanasia as a concept and practice and to discuss and propose whether euthanasia should or should not be legalised in Uganda.

1.5.0 SPECIFIC OBJECTIVES.

a) To examine euthanasia in detail, trace its historical background and explore and interrogate the legal definition of death.
b) To analyze the legal concept of euthanasia and examine the emerging jurisprudence on euthanasia and how it is practiced in different legal systems.
c) To make a thorough analysis of the questionnaire used to come up with my findings about the topic.
d) To make a summary of the research topic and make recommendations on whether euthanasia should be adopted in Uganda.

1.6.0 RESEARCH QUESTIONS.

1. Does euthanasia contradict the right to life?

2. Is there legal and ethical justification in legalizing euthanasia?

3. Should euthanasia be legalised in Uganda?

1.7.0 SCOPE OF THE STUDY

The main focus of this study was the concept of euthanasia, its practice in the world today and in the past. This study does not include all countries where the practice is done but few countries that have been used as a case study, the study goes on to trace the history of euthanasia as a concept and covers the question on whether it can be legalised in Uganda. I employed the qualitative approach to conduct my research and used the cognitive theory to help uncover the true emotional drivers behind a person's support for euthanasia or dislike of the practice. It should be noted that the general public did not participate in the survey due to time and pecuniary limitations, getting respondents to participate in the study was an uphill task since most hospitals had a rigid and complex procedure for soliciting respondents from their staff by researchers.

1.8.0 SIGNIFICANCE OF THE STUDY

To describe euthanasia as a concept and practice, it will discuss and propose whether euthanasia should or should not be legalised in Uganda based on the manner and form in which it is practiced in different legal systems that legalised it.

1.9.0 LITERATURE REVIEW

2.0 A HISTORICAL OVERVIEW OF EUTHANASIA

Euthanasia is a term derived from a Greek word meaning happy or fortunate in death. It is commonly used now to denote the merciful infliction of death to avoid torment in fatal and incurable diseases, usually by the consent of the patient or family.

Accounts exist of tribes, ancient and modern who abandoned their aged and infirm, choked, starved or even stomped or clubbed them to death[11]

In some Eskimo cultures an old or sick Eskimo tells his family that he is ready to die and the family if it is a good one they will immediately comply by abandoning the aged person to the ravages of nature by killing him[12]

Roman historian Plutarch, in his historical accounts of the city state of Sparta in Greece stated;

"The father had no authority to rear his child, when born but brought it to a place called the "lesche". Here the elders of the tribe sat and examined the infant but if it were feeble and ill shaped, they sent it to the so called place of casting out a chasm near Mt. taygetos considering that for a child ill- suited from birth for health and vigor to live was disadvantageous for itself and for the state."

This was albeit a more brutal and inhumane form of Euthanasia, an antithesis of the euthanasia allowed today by law.

From a philosophical perspective, both Plato and Aristotle were in favour of some sort of infanticide, similar to the practice in Sparta.

Plato in the republic wrote[13]

"The children of inferior parents, and any deformed offspring's of others, they (guardians) will secretly put out of the way as is fitting."

The city state of Athens also seemed to have a form of state assisted suicide. The roman writer libanius reports:

"Whoever no longer wished to live shall state his reasons to the senate and after having received permission, shall abandon life. If your existence is hateful to you, die. If you are

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[11]History of euthanasia <http:www.christian life resources.com/article/historical look at euthanasia 280 > (30th June 2015)

[12]D Humphrey and A wictett, the right to die 1985 (DH)

[13] (380 BC).

overwhelmed by fate, drink the hemlock, if you are bowed with grief, abandon life, let the magistrate apply him with the remedy, and his wretchedness will come to an end."

The conclusion that can be drawn from these accounts is that among wise men of Greece ending one's life for reasons of pain, illness was considered rational though this was not unanimously upheld.

In Judaism and Christian Rome, the taking of life except when done by civil authorities in the interest of justice was never condoned. The suicide of the king Saul in the bible[14]

The Talmund[15] forbids suicide and does not even discuss mercy killing. It is written in the Talmund, "..... And let not thy (evil) inclination assure thee that the grave is a place of refuge for thee."

Islam has held largely the same view. Several ayat[16] in the Koran talk about death. The Koran states that it is God who gives life and he is the one who takes it away. The Koran[17] confirms that it is Allah only who gives life and takes it away. It reads "we have decreed death among you."

Allah also says in[18] "he it is who gives life and causes death. And when he decides upon a thing he only says to it: be! And it is". "Verily we give life and cause death; and to us is the final return."

Later, renaissance Europe adopted a more relaxed approach to euthanasia, and was even amenable to the idea of voluntary euthanasia.

Sir thorn more, in his utopia in 1516 stated "if besides being incurable the disease also causes constant excruciating pain some priests and government officials visit the person concerned and say..... since your life is a misery to you, why hesitate to die you are imprisoned in a torture chamber, why don't you break out and escape to a better world, well arrange for your release ..... If the patient finds these arguments convincing, he either starves himself to death or is given a soporific and put painlessly out of his misery, but is strictly voluntary.

In the 18th century, this approach continued. French laws against suicide becoming more lenient with physicians such as parady's recommended an easy death for incurable and suffering patients.

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[14] 1st Samuel chapter 31 verse 4 is viewed in the context of his final alienation from the lord.
[15] (Means instruction, learning, a central text of rabbinic Judaism).
[16] "Ayat or ayah" in Arabic means a verse in the Koran.
[17] Surat al-waqiah
[18] Surat ghafir

German philosopher Arthur schonenphauer[19] emphasized individualism and human autonomy by stating that a man has "unassailable title to his own life and person.....It will be generally found as soon as the terrors of life reach the point at which they outweigh the terrors of death, a man will put an end to his life."

Nazi Germany[20] euthanasia was implicit and became a public issue in Germany after WW1, with the publication of the tract by Karl binding a lawyer, and Alfred Hoche psychiatrist[21] the book talks about the perversion of euthanasia to justify the extermination of the countless mentally and physically sick adults and children.

The actions of easy death have been applied for hopeless patients who are suffering extreme pain since ancient ages. These actions are forbidden from time to time. In Mesopotamia, Assyrian physicians forbade euthanasia. Again in the old times incurable patients were drowned in the river Ganges in India. In ancient Israel, some books wrote that frankincense was given to kill incurable patients.

Jewish society, following the teaching of the bible and sixth commandment "thou shall not kill", had rejected centuries ago every theory shortening the life of handicapped or disadvantaged people. Judaism considered life to be sacred and equated suicide and euthanasia with murder. Dr Immanuel jakobovitis, former chief rabbi of England explained, "cripples and idiots, however incapacitated, enjoy the same human rights (though not necessarily legal competence) as normal persons.....One human life is as precious as a million lives, for each is infinite in value...."

In Sparta, it was the common practice for each newborn male child to be examined for signs of disability or sickness which if found, led to his death. This practice was regarded as a way to save the person from the burden of existence.

In ancient Greece, suicide of the patient who was suffering extreme pain and had an incurable terminal illness was made easy and for this reason the physician gave medicine (a poisoned drink) to him. Plato wrote "mentally and physically ill persons should be left to death; they do not have the right to live.

The first objection to euthanasia came from the Hippocratic oath which says " I will not administer any poison to anyone when asked to do so, nor suggest such a course."

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[19] 1788-1860

[20] 1939-1945

[21] Entitled permission for the destruction of life unworthy of life in 1920.

In ancient Rome, euthanasia was a crime and this action was regarded as murder. However history notes that sickly newborn babies were left outside overnight, exposed to the elements.

In middle ages in Europe, Christian teaching opposed euthanasia for the same reason as Judaism. Christianity brought more respect to human beings. Accordingly, every individual has the right to live since God creates human beings and they belong to him and not to themselves. Death is for God to decree not man.

In the 15th-17th centuries sir Thomas more[22] is often quoted as being the first prominent Christian to recommend euthanasia in his book[23] where the utopian priests encouraged euthanasia when a patient was terminally ill and suffering pain(but this could only be done when the patient consented.

The English philosopher, Francis bacon[24] was the first to discuss prolongation of life as a new medical task, the third of three offices preservation of health, cure of the disease, and prolongation of life. Bacon also asserted that "they ought to acquire the skill and bestow the attention whereby the dying may pass more easily and quietly out of life.

In the 18th century, Prussia on 1st June 1974 passed a law that reduced the punishment of a person who killed the patient with an incurable disease.

Until the 19th century, euthanasia was regarded as a peaceful death, and the art of its accomplishment. An often quoted nineteenth century document is[25] the inaugural professional lecture of Carl F.H.marx, medical graduate of Jena. "Its man's lot to die" states Marx. He argued that death either occurs as a sudden accident or in stages, with mental incapacity preceding the physical. Philosophy and religion may offer information and comfort, but the physician is the best judge of the patient's ailment, and administers alleviation of pain where cure is impossible.

In the 20th century the efforts of legalization of euthanasia began in the United States in the first years of the 20th century. The newyork state medical association recommended gentle and easy death. Even more active euthanasia proposals came to Ohio and Iowa state legislatures in 1906 and 1907 but these proposals were rejected.

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[22] 1478-1535

[23] Utopia.

[24] 1561-1621

[25] "de euthanasia medica prolusion"

In 1920 two German professors published a small book with the title[26] which recommended the killing of people whose lives were "devoid of value.''. This book was the base of involuntary euthanasia in the third Reich.

The reduction in punishment for mercy killing was accepted in criminal law in Russia but this law was abolished after a short while.

A French physician called Dr.E. Forgue published an article named[27] in la revue de Paris, in 1925, and pointed out that killing an incurable patient was not a legal condition.

The laws that accept euthanasia as a legal condition are present in two countries of South America. According to the Uruguay penal code, a judge must not punish a person for mercy killing. A person must also be forgiven for this type of killing in Columbia.

Adolf Hitler admired Hoches writing and popularized and propagandized the idea. In 1935, the German Nazi party accepted euthanasia for crippled children and "useless and unrehabilitive" patients.

Before 1933 every German doctor took the Hippocratic Oath, with its famous "do no harm" clause. The oath required that the doctor's first duty is to his patient. The Nazis replaced the Hippocratic Oath with the "gesundheit", an oath to the health of the Nazi state.

Anyone in the state institution would be sent to the gas chambers if it was considered that he could not be rehabilitated for useful work. The mentally retarded, psychotics, epileptics, old people with chronic brain syndromes, people with Parkinson's disease, infantile paralysis, multiple sclerosis, brain tumors among others were those killed. The consent of the patient was absent in this type of euthanasia. This kind was applied by order.

Many people don't realize that prior to the extermination of the Jews by Nazi German, in the so called "final solution" as many as 350,000 Germans were sterilized because their gene pool was deemed to be unsuitable to the Aryan race, many because of mental disability, mental deficiency or homosexuality.

In 1936 the voluntary euthanasia association society was founded in England. The next year the English parliament (House of Lords) rejected a proposal to legalise euthanasia. In opinion polls of those years, euthanasia supporters had around 60% of their votes.

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[26] " releasing the destruction of worthless animals"

[27] "easy death for incurable patients"

According to Amos Dakota[28] , 53% of American physicians defended euthanasia. Approximately 2000 physicians and more than 50 religious ministers were among the members of American euthanasia society. At that time a majority of physicians in some American cities defended the subject.

In 1938, the euthanasia society of America was established in New York.

In October of 1939, amid the turmoil of outbreak of war, Hitler ordered widespread mercy killing of the sick and disabled.[29] Code named "Aktion T4" Nazi euthanasia program to eliminate "life unworthy of life" at first focused on newborns and very young children. Midwives and doctors were required to register children up to age three who showed symptoms of mental retardation, physical deformity, or other symptoms included in a questionnaire from the Reich health ministry.

The Nazi euthanasia program quickly expanded to include older disabled children and adults. Hitler's decree of October 1939 typed on his personal stationery and back dated to September 1, enlarged the authority of certain physicians to be designated by name in such manner to persons who, according to judgment, are incurable, can upon a most careful diagnosis of their condition of sickness, be afforded a mercy death.

On August 3, 1941, the catholic bishop Clemens August of Galen openly condemned the Nazi euthanasia programme in a sermon and this brought a temporary end to the programme.

A law proposal that accepted euthanasia was offered to the government in Great Britain in 1939. According to the proposal, a patient had to write his consent as a living will which must be witnessed by two persons. The will of the patient had to be accepted in the reports of two physicians. One of these was the attending physician; the other was the physician of the ministry of health. The will of the patient had to be applied after 7 days and most of the relatives of the patient had to speak with him 3 days before the killing action. But this proposal wasn't accepted.

In 1973 Dr. Gertuida postma, who gave her dying mother a lethal injection, received a light sentence in the Netherlands. The case and its resulting controversy launched the euthanasia movement in that country.

The Dutch voluntary euthanasia society launched its member's aid service in 1975, to give advice to the dying. It received twenty five requests for aid in the first year.

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[28] Medical research student Birmingham university questionnaire 1937

[29] "History place" website.

In 1976 Dr tenrei ota, upon formation of the Japan euthanasia society (now Japan society for dying with dignity), called for an international meeting of existing national right to die societies. Japan, Australia, the Netherlands, the united states were all represented. This first meeting enabled those in attendance to learn from the experience of each other and obtain a more international perspective on right to die issues.

In 1978, jeans way was published in England by Derek Humphrey, describing how he helped his terminally ill wife to die. The hemlock society was founded in 1980 in Santa Monica, California, by Derek Humphrey. It advocated legal change and distributed how to die information. This launched the campaign for assisted dying in America. Hemlocks national membership grew to 50,000 within a decade. Right to die also formed the same year in Germany and Canada.

The society of euthanasia assembled in oxford in the last months of 1980, hosted by the exit, the society for the right to die with dignity. It consisted of 200 members represented by 18 countries. Since its founding, the world federation has come to include 38 right to die organisations, from around the world and has held fifteen additional international conferences, each hosted by one of the member organisations.

On 5th may 1980, the Catholic Church issued a declaration on euthanasia.

In 1984, the Netherlands Supreme Court approved voluntary euthanasia under certain conditions.

In 1994, Oregon voter approved measure 16, a death with dignity act ballot initiative that would permit the terminally ill patients, under proper safeguards, to obtain a physicians prescription to end human life in a humane and dignified manner. The vote was 51-49 percent.[30]

In 1995, Australia's northern territory approved an euthanasia bill. It went into effect in 1996 and was overturned by the Australian parliament in 1997. Only four deaths took place under this law, all performed by doctor nitschke.

On 13 may, 1997 the Oregon house of r3epresentatives voted 32 -26 to return measure 16 to the voters in November for repeal (H.B 2954). On 10 June the senate votes 20-10 to pass H.B 2954 and return measure 16 to the voters for repeal. On November 4 1997 the people of Oregon voted by a margin of 60-40 percent against measure 51, which would have repealed the Oregon death with dignity act 1994. The law officially took effect (ORS 127.800-897) on 27 October 1997.

[30] www.life.org.nz/euthanasia.

In 1998, the Oregon health services commission decided that payment for physician assisted suicide could come from state funds under the Oregon health plan so that the poor would not be discriminated against.

In 1999, in the United States, Dr. jack Kevorkian was sentenced to 10-25 years imprisonment for the 2nd degree murder of Thomas youk after showing a video of his death, by lethal injection, on national television. Kevorkian's first appeal was rejected in 2001. Kevorkian helped a number of people to die and even though he had been previously prosecuted, he remained free from criminal charges until 1999.

In 2000, the Netherlands approved voluntary euthanasia. The Dutch law allowing voluntary euthanasia and physician assisted suicide took effect on the 1st of February, 2002 for 20 years previously; it had been permitted under guidelines.

Into the third millennium. In 2002 Belgium passed a similar law to the Dutch, allowing both voluntary euthanasia and physician assisted suicide.

In 2004 Lesley martin was convicted of attempted murder of her terminally ill mother. he served seven months of a fifteen month prison sentence, before being released on a good behavior bond, and subsequently failed, in two attempts to appeal against the conviction.

Switzerland, once known in the tourism business for its spectacular alpine landscape, the watches and chocolate has a new claim to fame as the world's death Mecca. Physically and mentally vulnerable patients have been lining up for a one way trip to Zurich.

In 2000 three foreigners committed suicide in Zurich. In 2001, the number of death of tourists increased to thirty eight, plus 20 more in Bern. Most of the death occurred in an apartment rented by dignitas, one of the four groups that have taken advantage of Switzerland's 1942 law on euthanasia to help the terminally ill die.

Dignitas has assisted the suicides of 164 people over the last four years. The Swiss parliament has been alarmed and there is a move to ban the 'suicide tourism' and to place tougher bans on assisted suicide.

When it was established in 1942, the Swiss euthanasia law was meant mainly to offer the opportunity for a dignified death for those with just two or 3 weeks to live.

Medical professionals had a pivotal role in this. In the trial of Adolf Eichmann[31] a heated exchange ensued between the judge and Eichmann's Defense counsel when the judge

[31]A German Nazi s.s lieutenant colonel and one of the major organisers of the holocaust

dismissed the argument that killing by gas was a medical matter. To which the Defense counsel replied;

"It was prepared by physicians a matter of killing and killing too is a medical matter"[32]

Over the years, the concept of euthanasia continued to gain worldwide attention. In 1980, the world federation of right to die societies was formed, with 27 groups from 18 countries.

Currently the federation consists of 45 right to die organisations from 25 countries. The federation provides an international link for organisations working to secure or protect the rights of individuals to self-determination at the end of their lives.[33]

World right to die day is celebrated November 2 in countries such as France, Italy, Mexico, New Zealand, and Venezuela.[34]

In 2011 the Dutch parliament debated whether a written request of euthanasia before the onset of dementia could still be used as grounds for termination later in the patient's life[35] they posed two requirements for the request of euthanasia. One, to establish hopeless and unbearable suffering and two ensure the patients consent is given freely and expressly.

J. Keown[36] in his book defines euthanasia as the intentional killing of a patient, by act or omission, as part of his medical care. But omission of treatment of a patient cannot be regarded as medical care. My understanding of medical care is the provision by a physician of services related to maintenance of health, prevention of illness, and treatment of illness or injury. This means that the medical practioner has to do everything within their means to save a life that is about to be lost, give palliative care to the sick which involves stopping pain that is severe rather than capitalizing on pain to end a patient's life. This undermines our trust in the medical profession. When we sanction euthanasia, the frail, elderly and the sick cannot be confident that the doctors will treat them rather than terminate them. Suffering and sick people need comfort and assurance not anxiety and fear as to what their doctors might do to them.

Michael Davies[37] in his book discusses the case of r v malcherk and steel[38] where the defendants were charged with murder for assaulting victims who were admitted and

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[32]<http:// journals.cambridge.org/download>(30 June 2015)
[33]http:// www.world.ne/about.us> (30 June 2015)
[34]https://en.m Wikipedia.org/wiki/world.
[35] Herring j protecting vulnerable adults oxford legal studies research paper no 10 2010.
[36]Euthanasia examined Cambridge university press 1995.
[37] Medical law 2nd edition oxford university press.

supported by a ventilator. Lord lane stated "where the medical practitioner, using generally accepted methods, came to the conclusion that the patient for all practical purposes was dead and that such vital functions as remained were maintained solely by mechanical means and accordingly discontinue treatment that did not break the chain of causation between initial injury and death.

The book does not cite the generally accepted methods that medical practitioners should use to end a person's life. Besides that doctors take the Hippocratic Oath to do everything within their means to save the life of a patients at all costs. This book does not address anything in relation to this oath as to how it would be contrary to allowing doctors or other medical practitioners perform euthanasia. It is thus my view that the doctor who withholds or withdraws treatment of a terminally ill patient is refusing to prolong the life of his patient at any cost and is only using active measures to bring human life to a premature end.

Secondly based on the fact that different doctors have different expertise what may appear as an end to life of a patient may not be the same to another medical doctor or physician. To him there could be a way out for the patient. So termination of life of a patient based on the judgment of one doctor as was stated by justice lane and supported by the author of the text would not be satisfactory enough to bring precious human life to an end.

L. Luke in his book[39] defines medical ethics to connote the rules of etiquette adopted by the medical profession to regulate professional conduct with each other. But also towards their individual patients and towards the society. And includes considerations of the motives behind that conduct.

He lists some basic principles of medical ethics which include,

- Autonomy that is people have a right to control what happens to their bodies.
- Beneficence: all healthcare provides must strive to improve their patients' health.
- Nonmaleficence: do no harm to the patients is the bedrock of medical ethics.
- Justice. This principle demands that the medical practitioner should be as fair as possible.

In his anti-euthanasia campaign he argues that doctors and other medical personnel should adhere to their professional standards in the practice of medicine and should not

[38] (1981) 2 ALLER 422.
[39]Medical ethics 1957.

kill a patient regardless of the pain he is undergoing or even at the patient's request. He proposes that a patient should die a natural death.

I support his argument because viewing questions about death from the standpoint of medical ethics would therefore exclude legal, theological, and other implications which are indispensable to a comprehensive treatment of them. From this point of view euthanasia is murder within contemporary criminal law in Uganda because it includes the elements constituting the offence regardless what it may be called.

The Uganda penal code[40]provides as follows "any person who of malice aforethought causes the death of another person by an unlawful act or omission commits murder."

It is my view that the doctor or medical practitioner in this case forms the intention to kill when he believes that the person is suffering which he attributes to the fact that he cannot survive. It becomes unlawful in the sense that it is against the provision of the 1995 constitution of Uganda[41] which provides "no person shall be deprived of life intentionally except in the execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellant court.

The practice is also against medical ethics to end the life of another person. The Hippocratic Oath covers several important ethical issues between doctors and patients.

The oath first establishes that the practioner of medicine gives deference to the creators, teachers, and learners of medicine. The oath also serves as a contract for doctors to work towards the benefit of the health of the public.

Other important tenants include maintaining the integrity of the doctor, ensuring the consent of the patients, preventing the exploitation of the patient, maintaining privacy and discretion, and forbidding deadly drugs and abortion.

One of the most important ideas codified in the Hippocratic oath is that the physician is accountable for his actions should problems arise.

After examining the above oath no provision for euthanasia is included, why then should the doctors go ahead and take the life of another under the belief that they are helping them to die peacefully and with dignity. Thus they should adhere to the medical standards or else the medical profession would turn out to be a threat for the terminally ill.

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[40]Section 188
[41]Article 22

Alfred Hocke professor of psychiatry at university of Freiburg and Karl binding, a professor of law at university of Leipzig in their book[42]

Argued that patients who ask for death should under very carefully controlled conditions be able to obtain it from a physician. The book does not labor to explain the very carefully controlled conditions that a physician can use to peacefully terminate the life of the patient and does not address what would follow if the patient did not provide consent however the doctor or physician so it relevant to terminate the life and he eventually terminates the life of the patient. So this still puts forward a question on whether this should be regarded as murder or not. Because the proponents of euthanasia say it is aimed at ending the suffering of the terminally ill patient and others say the doctor is the judge in this matter in this case in determining whether a patient is alive or dead my view is if it is left without any control it may be misused in that the doctors may look at the aspect of taking a person's life as normal and would even propose it where it is not necessary for example a person undergoing severe pain after losing a hand in a terrible accident and bleeding seriously, they could be a possibility that some malicious doctors mind will be corrupted into believing that they is nothing they could do to help out and hence would recommend that the patient be killed but peacefully this would eventually instigate fear into the public and would look at the medical profession as one that should not be fit for saving human life but rather one that takes human life.

Luis kutner[43], an attorney who practiced law in Chicago, Illinois, is credited with proposing that living will documents be used as a means of allowing people to express their wishes regarding end-of-life care. He published "Due Process of Euthanasia: The Living Will, a Proposal" in the *Indiana Law Review* in 1969. The paper was widely considered to be a milestone regarding the legal side of issues related to euthanasia and other matters dealing with the end of life. Kutner was motivated by his belief that people who wished to have assistance in committing suicide were denied legal rights and protections necessary to safeguard their wish to die. Those who agreed to assist them, he believed, should also be protected.

He posited that his proposed living will document would enable adults who were mentally competent and healthy to put their wishes in writing so that there would be no question about what kind of care the person wanted at the end of life. Living wills are Now common.

[42] "releasing the destruction of worthless animals"

[43] Due process of euthanasia

I agree with kutner view because he goes ahead to show how exactly the will should be drafted, to whom it should be addressed and even shows that the will is the clear intention of the party seeking death which cannot even be subject to legal measures in case his life is terminated with his or her consent based on the fact that they are suffering extreme pain and cannot even get better. So for example if a cancer patient states it out in their living will that once I start suffering unbearable pain please terminate my life then why not? This is far much better than living it to the doctors and physicians to decide over a person's life or death even without their consent by assuming that it is what is best for them.

Rita marker[44]A practicing attorney, Rita Marker has served as director of the International Task Force on Euthanasia and Assisted Suicide since the organization was founded in 1987. Marker previously served as an adjunct professor of Political Science and Ethics at the University of Steubenville, Ohio. She has written numerous Articles and spoken on issues related to bioethics and human rights throughout the world. Marker's other advocacy efforts include offering testimony to the Subcommittee on the Constitution, Civil Rights, and Property Rights of the U.S. Senate Judiciary Committee. Marker wrote *Deadly Compassion.* In this book, she examined the topic of euthanasia in terms of the suicide of Ann Humphry and argued against the legalization of euthanasia.

The author was against euthanasia but simply looking at one scenario which involved the way Ann Humphry was assisted to die against her will by her husband which she looks at as being improper but does not talk about what should happen in the event that consent is obtained from the terminally ill.

She suggests that it is actually more suffering to the person when their life is terminated but does not show how it amounts to more suffering. Because ordinarily a dead person would not feel the pain she is talking about. This leaves the readers to decide or predict or imagine the suffering that comes so the book still leaves many questions unanswered in regard to euthanasia. And as such would say it improperly addresses the issue of euthanasia by not handling some crucial elements.

Dr quill[45]Dr. Quill the physician referenced in quill v vacco[46] co-edited a book with Margaret Pabst Battin, Ph.D. In the introduction to this book, Drs. Quill and Battin write that the central question in this issue is not whether people would prefer "access to palliative care and hospice or access to physician assisted death" (2004, 1). They pose

[44] Deadly compassion
[45] Physician assisted dying the case for palliative care and patient choice.
[46] ibid

the central question as "What would you prefer, access to excellent palliative care and hospice by themselves or access to excellent hospice and palliative care plus legal access to a physician-assisted death as a last resort if your suffering becomes intolerable and you wish an earlier, easier death?" (Quill and Battin 2004, 1).

In this book they exhaust almost all the options available to a terminally ill patient before taking a final decision including the right to rescind in case they change their mind which I think is very fair to the patient because most times the state of mind in such severe pain makes them feel like they do not deserve to live however such pain may be short lived in the long run which I agree with.

Dr Edmund Pellegrino in his book[47] strongly advocates for the end of euthanasia. He argues that as a result of advancement in science and technology a disease that may appear incurable today may be curable the next day and so rushing into euthanasia may not be the best option for the terminally ill patient. He stresses that they should instead subject the patients to palliative care and try to relieve pain until a solution is found or else they live the patients to die a natural death amidst medication than help terminate their lives.

I agree with his argument Mercy killing is morally incorrect and should be forbidden by Law. It is a homicide and murdering another human cannot be rationalized under any circumstances. Human life deserves exceptional security and protection. Advanced medical technology has made it possible to enhance human life span and quality of life. Palliative care and rehabilitation centers are better alternatives to help disabled or patients approaching death live a pain-free and better life. Family members influencing the patient's decision into euthanasia for personal gains like wealth inheritance is another issue.

There is no way you can be really sure if the decision towards assisted suicide is voluntary or forced by others. Even doctors cannot predict firmly about period of death and whether there is a possibility of remission or recovery with other advanced treatments.
So, implementing euthanasia would mean many unlawful deaths that could have well survived later. Legalizing euthanasia would be like empowering law abusers and increasing distrust of patients towards doctors. Mercy killing would cause decline in medical care and cause victimization of the most vulnerable society. Would mercy Killing transform itself from the "right to die" to "right to kill"? Apart from the above reasons, there are some aspects where there is a greater possibility of euthanasia being mishandled.

[47] Transcultural dimensions in medical ethics.

How would one assess whether a disorder of mental nature qualifies mercy killing? What if the pain threshold is below optimum and the patient perceives the circumstances to be not worthy of living? How would one know whether the wish to die is the result of unbalanced thought process or a logical decision in mentally ill patients? What if the individual chooses assisted suicide as an option and the family wouldn't agree?

Wesley j smith in his book[48] in the introduction to the book argues that patients only choose the option of death because of the pain and depression. And if the pain can be dealt with then no one would request for euthanasia as this would rekindle their hopes of survival and free their minds from thinking about death.

He further argues that it is not a sane mind that makes people ask for euthanasia but the pain and agony they face from their terminal illness.

I vehemently agree with him on this position because,

1. Many pain killing drugs can now help a patient die with dignity.
2. A dying patient may not be able to make a rational decision.
3. A patient may have said they want euthanasia when they were nowhere near death; however, when faced with death they may change their mind but be incapable of telling anyone.
4. Many people recover after being "written off" by doctors.
5. Euthanasia makes life disposable – it could be the first step on a slippery slope.
6. Hippocratic Oath: doctors must try to preserve life. If euthanasia was legalised, the relationship of trust between doctors and patients can be destroyed.
7. If there were better facilities for caring for dying, there would be less need for euthanasia.
8. People might be pushed into saying they want euthanasia by relatives who do not want to look after them.

[48] Forced exit:euthanasia,assisted suicide, and the new duty to die

The Oregon Death with Dignity Act

The Oregon Death with Dignity Act (ODDA) is a citizens.' initiative that was first passed by the voters of Oregon in November 1994 by a margin of 51 percent in favor and 49 Percent opposed.20 The Act was delayed due to a legal injunction and multiple legal proceedings, including a petition that was denied by the United States Supreme Court. The Ninth Circuit Court of Appeals lifted the injunction in October 1997, and physician assisted Suicide (PAS) became a legal option for qualified terminally ill patients in Oregon.

In November 1997 the voters reaffirmed their support for the ODDA by Rejecting Measure 51, which asked them to repeal the Act on a general election ballot, by an increased margin of 60 percent in favor and 40 percent opposed. The Oregon Health Services (OHS) notes that the term *physician-assisted suicide* is used in the ODDA despite the fact that the Act explicitly states that ending one's life in accordance with the law does not legally constitute. "suicide."; rather, the term is used because it is so widely used by the public and scholars alike to describe the very act that the ODDA allows.

According to the Oregon Death with Dignity Act, an adult who is capable, who is a resident of Oregon, who has been determined by the attending physician and a consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die may make the informed decision to initiate a request for medication for the purpose of ending his or her life in a humane and dignified manner. On the Moral and Social Implications of Legalized Euthanasia This concise iteration of the ODDA requires some clarification in accordance with the specifications of the Act.

The term *adult* designates an individual who is 18 years or older and the term *resident of Oregon* applies (but is not limited) to individuals who have a driver's license, are registered to vote, own or lease property, or filed their most recent tax return in Oregon.

The term *terminal disease* designates an incurable and irreversible disease that has been medically confirmed by the attending and consulting physicians and is expected to, within reasonable medical judgment, produce death within six months. The term *capable* means that in the opinion of the court, attending physician, consulting physician, psychiatrist, or psychologist the patient has the ability to make and communicate informed health care decisions to health care providers (or can do so with the assistance of a person of their choosing).

The term *informed decision* is used to designate a decision made by a qualified patient based on an appreciation of the relevant facts and after being fully informed by the attending physician of the following:

- The medical diagnosis and prognosis;
- The potential risks and probable results of taking the prescription; and
- The feasible alternatives to using the prescription including (but not limited to) comfort care, hospice care, and aggressive pain control.

The term *attending physician* designates the physician who has primary responsibility for the care of the patient, while the term *consulting physician* designates a physician who is qualified by specialty or experience for consultation to confirm the diagnosis and prognosis regarding the illness of the patient.

The attending physician may sign the patient's death certificate, notwithstanding other legal restrictions. If either the attending or consulting physician suspects that the patient may be suffering from a psychiatric or psychological disorder or from depression that is causing impaired judgment, the patient must be referred for counseling. If the counselor determines that the patient is not suffering from impaired judgment, then (and only then) may the patient qualify for PAS. The Act specifies that the attending physician must:

- Make the initial determination of whether a patient has a terminal disease, is Capable, and has made the request voluntarily; On the Moral and Social Implications of Legalized Euthanasia

- Ensure that the patient is making an informed decision

- Refer the patient for counseling if appropriate

- Refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination as to whether or not the patient is capable of making an informed decision and is acting voluntarily;

- Recommend (but not require) that the patient notify next of kin;

- Counsel the patient about the importance of having another person present when taking the medication and of not taking the medication in a public place (the presence of physician at the time of ingestion is recommended, but not required);

• Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner;

• Verify immediately prior to writing the prescription that the patient is making an informed and voluntary decision;

• Fulfill the medical record documentation requirements of the Act;

• Ensure that all appropriate steps are carried out in accordance with the Act prior to writing the prescription; and

• Dispense the prescription directly, provided he or she is qualified to do so; or, with the patient's written consent, contact and inform a pharmacist of the nature of the prescription and then deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to the patient, the attending physician, or an expressly identified agent of the patient.

(The Act was modified from its original form in this regard, and now specifically allows pharmacists to refuse to participate in the ODDA who morally object to PAS). Once a qualified patient has made the first oral request to the attending physician, he or she must then make a written request followed by a second oral request in order to remain eligible to receive the prescription.

The second oral request must take place after the written request has been completed, and there is a mandatory 15 day waiting period between the two oral requests. The attending physician cannot write the prescription until 48 hours after the written request has been completed, and must remind patients of their right to rescind their request at any time upon receiving the second oral request.

The prescription generally consists of a lethal amount of barbiturates and other medications to help alleviate the nausea or vomiting that can sometimes occur when the barbiturates are ingested.

The primary medication used has changed from secobarbital to pentobarbital because the manufacturer of secobarbital (Eli Lilly) stopped producing the drug because of a lack of profitability and difficulty in producing the drug due to a shortage of supplies, not for ethical or publicity reasons.

On the Moral and Social Implications of Legalized Euthanasia the ODDA allows qualified individuals to obtain prescriptions for the purposes of ending their lives, but *specifically*

prohibits physicians from directly administering medication for the purposes of ending the life of the patient (active euthanasia). No professional organization or association, or health care provider, or physician may be punished *either* for participating *or* for refusing to participate in the ODDA.

Furthermore, participation in the ODDA does not have an effect upon a life insurance, health Insurance, accident insurance, annuity policy, will, contract, or statute.

The Annual Report
The Oregon Health Services (OHS) is required to annually review a sample of records maintained with regard to the ODDA and to ensure that all health care providers file a copy of the dispensing record with the OHS *upon writing a prescription* in accordance with the ODDA. Reporting is not required if a patient begins the process but never receives a prescription, and the number of individuals who begin the process but never receive the prescription is unknown.

However, one physician who has participated in the ODDA reported that she has begun and not finished the legislative process nearly twice as often as she provided prescriptions, suggesting the possibility that at least twice the number of patients who have participated in the ODDA make an initial inquiry or verbal request for medication which is left undocumented and unreported.

The OHS is authorized to make rules to facilitate the collection of information regarding the ODDA and (except as otherwise required by law) the information collected
Shall not be a public record and may not be made available for inspection by the public.
The OHS is then required to generate and make available to the public an annual Statistical report of information collected in a *neutral* manner in order that informed Ethical, legal, and medical decisions can be made based on interpretation of the data. *The Statistics* The Annual Reports provided by the OHS contain all of the statistical information regarding the ODDA that is made available to the public.

The Reports were obtained On the Moral and Social Implications of Legalized Euthanasia from physician and pharmacy reporting, physician interviews, and death certificates. The Fourth Annual Report was made available on February 6, 2002, and the other three Reports (plus a preliminary Report issued after the first 10 deaths under the ODDA were reported) can be found on the OHS website.30 According to the Reports, a total of 140 prescriptions have been written under the ODDA since physician-assisted suicide became legal in Oregon (24 in 1998, 33 in 1999, 39 in 2000, and 44 in 2001). Nineteen of the 33 patients who were prescribed medication under the Act in 2001 died after ingesting the medication; 14 died from their underlying disease; and 11 were alive as of

December 31, 2001. Two patients chose not to use prescriptions received in 2000 until 2001, bringing the total number of patients who died after ingesting the medication to 21 in 2001, 27 in 2000, and 27 in 1999, and 16 in 1998.

Thus, the total number of patients who have died after ingesting lethal medication prescribed in accordance with the ODDA regulations comes to 91 out of the 140 who have received a lethal prescription.

The 21 patients who died as a result of ingesting lethal medications in 2001 were comparable in many ways to the other 6,265 Oregon residents who died from similar diseases during the year, although they were slightly more likely to be women, to have graduated from college, and to have been divorced. Trends such as these do not seem to have a particular pattern, but have varied from year to year.

The most commonly mentioned end of life concerns were losing autonomy, decreasing ability to participate in activities that make life enjoyable, losing control of bodily functions, becoming a burden on family and friends, and suffering from inadequate pain control. Typically, the median age of participants is around 70, they are likely to have a high school diploma, and they tend to be white. One of the most important findings over the four year period is that *it has not been the case in any year that PAS was disproportionately chosen by terminally Ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking end of life care*.

The majority of patients who have chosen to participate in the ODDA suffer from some form of cancer (86 percent in 2001). It should be stressed that *most of the patients utilized hospice care at some point during their illness* (76 percent in 2001), while all of the patients who did not utilize hospice care were offered it and declined. Approximately half of the attending physicians were present at the time of ingestion, while other health On the Moral and Social Implications of Legalized Euthanasia.
Care providers were present in almost all of the remaining cases.

Approximately one-half of patients become unconscious within 3 minutes and die within 25 minutes, and complications are rare. A small number of patients have lived for longer than 24 hours after ingesting the medication and a small number have vomited shortly after ingestion.

Two physicians have been questioned in regard to submitting incomplete written consent forms, but formal charges have not been filed against them. Finally, Oregon physicians have consistently reported increased efforts to improve their knowledge of

the use of pain medications, to improve their ability to recognize psychiatric disorders (such as depression), and have been referring more patients to hospice care since the passage of the ODDA. Political Controversy In November 2001, U.S. Attorney General John Ashcroft issued a directive specifying a new interpretation of the Controlled Substances Act (CSA) that was specifically aimed at prohibiting physicians from prescribing medication for use in PAS on a federal level, but not intended to increase scrutiny on physicians who prescribe pain controlling medications.

According to Ashcroft's interpretation of the federal law, the dispensing of controlled substances to assist in suicide does not constitute a *legitimate medical purpose* and, therefore, the ODDA violates federal regulations. This reverses the policy of former U.S. Attorney General Janet Reno, who deferred to state law in the determination of what constitutes a legitimate medical practice. In response to these actions, Oregon Attorney General Hardy Myers filed a federal lawsuit claiming that the directive is inconsistent with the intended use of the CSA as created by Congress, and that it is unconstitutional on both Commerce Clause and Tenth Amendment grounds.

U.S. District Judge Robert Jones issued a temporary restraining order against Ashcroft's directive in response to the suit, thereby allowing physicians to continue participating in the ODDA pending legal proceedings which were to be held within the year.35 Timothy Quill, a leading advocate for the ODDA, charged Ashcroft with unjustly attempting to usurp the rights of the state of Oregon and its voters by attempting to circumvent the democratic process.36 He maintains that the ODDA has On the Moral and Social Implications of Legalized Euthanasia been a success, and that the continuation of the Act will provide important information that is vital in making the decision as to whether or not PAS can be regulated without undermining the quality of end of life care.

The legality surrounding the ability of states to govern their practice of medicine is somewhat unclear in this regard, but will likely be clarified to some extent as a result of these recent events. It has been suggested that the increase in support for the ODDA that occurred when the voters were (unsuccessfully) asked to repeal the Act in Measure 51 may have been due to the disapproval of voters who perceived Measure 51 as an attack on the democratic process.

It is not unlikely that a similar effect is occurring in Oregon now, caused by the feeling that Oregon's right to pass legislation regarding the practice of medicine within the state is being challenged. Some recent studies conducted by non advocacy organizations have demonstrated a strong support throughout the U.S. for legislation based on the ODDA to be passed in additional states (61 percent of those surveyed) and a public disapproval of Ashcroft's directive (58 percent).

In April 2002, U.S. District Judge Robert Jones ruled that Ashcroft lacks the authority to overturn the ODDA, noting that the legislation was passed after two votes in Its favor. According to the *Washington Post*, Jones. "Scolded." Ashcroft by saying that he was attempting to ."Stifle an ongoing, earnest, and profound debate in the various states concerning physician-assisted suicide." and concluded that the Controlled Substance Act did not support Ashcroft's directive.

In closing, Jones remarked that his. "Task is not to criticize those who oppose the concept of assisted suicide for any reason. Many of our citizens, including the highest respected leaders of this country, oppose assisted suicide. But the fact that opposition to assisted suicide may be fully justified, morally, ethically, religiously or otherwise, does not permit a federal statute to be manipulated from its true meaning to satisfy even a worthy goal."40 Despite this ruling, an appeal is expected to be filed and the end result of Ashcroft's directive is unlikely to be known for some time. As I mentioned above, the Annual Reports issued by the OHS have suggested that many requests for assistance in dying are motivated by one or more of a limited number of Concerns.

The identification of these concerns offers a rare and valuable insight into some
Of the more common hopes and fears expressed by persons engaged in the dying process.

On the Moral and Social Implications of Legalized Euthanasia 16 In the following section, I expand upon this issue and attempt to better explain the motivating factors which commonly prompt requests for assistance in dying.

The Leading Motivations for Requesting Physician-Assisted Suicide

The Fourth Annual Report on Oregon's Death with Dignity Act found that the most commonly mentioned end of life concerns for those who requested assistance in dying in accordance with the ODDA were: losing autonomy, decreasing ability to participate in activities that make life enjoyable, losing control of bodily functions, becoming a burden on family and friends, and suffering from inadequate pain control.41 Discussing the typical factors which have motivated such patients to request assistance in dying is one way in which we can better understand what the notion of a ."Death with dignity." Might really mean to an individual patient nearing the end of life.

2.1 RESEARCH METHODOLOGY

For this study, most of the information collected will stem from primary and secondary sources.

Primary sources shall include,

Statutes, constitutions, court decisions, cases, treaties and administrative regulations.

Secondary sources shall include,

Legal periodicals, articles, legal encyclopedias, law dictionaries, commentaries and online blogs.

The qualitative approach to collection of data will be employed. This will involve data collection from medical professionals with the aid of questionnaires.

2.2.0 CHAPTER BREAKDOWN

CHAPTER 1.

This chapter will contain the title, an introduction to the topic of euthanasia, background of the study, statement of the problem. It will also include the general and specific objectives of the research; it will contain research questions that helped me to conduct the research, scope of study along with the significance of the study. This chapter will also contain the literature review and the research methodology.

CHAPTER 2.

This chapter will discuss the legal definition of death, look at the medical technology and its potential to redefine the boundaries of life, and generally have a radical examination to consider what is meant by death.

CHAPTER 3.

This will look at the legal concept of euthanasia, explore the various types of euthanasia, and look at the position of the Ugandan constitution in line with the topic of study, discuss the emerging jurisprudence about euthanasia, examine euthanasia in the Netherlands, India, and in the United States.

CHAPTER 4.

This chapter will contain an analysis of the questionnaire which will include an introduction, the sampling process, data collection and findings, data presentation and discussion, strengths and limitations, acknowledgements and declaration of interests.

CHAPTER 5.

This will contain a summary about the topic; it will also contain recommendations, bibliography, and appendix 1 which will have a sample of the questionnaire used.

CHAPTER 2

2.4.0 THE LEGAL DEFINITION OF DEATH.

The legal definition of death has been the source of much academic commentary medical technology with its potential to refine the boundaries of life has forced radical reconsideration of what is meant by death.

Jean McHale and Marie fox in health care law text and material[49] establish that ascertaining the point at which death occurs may be of considerable practical and importance.

The assignment of the point of death is a crucial matter considering whether to withdraw life support i.e. passive euthanasia and determining criminal culpability of doctors while performing this procedure.

Michael Davies in the textbook on medical law[50] offers an insight into the idea of death from a purely medical perspective. He writes that "the idea of death combines the absence of cognition and respiration, combined with these two is the unifying matter of the brain stem". He describes how the system works in the following manner.

"The heart and lungs as a team supply oxygen to the brain, therefore the brain cannot function without the operation of the heart and lungs in turn, respiration itself is controlled by the brain stem, and it performs the 'vegetative' functions."

He goes further to state that according to current medical practices, the functions of the heart and lungs can be artificially maintained, but the not the functions of the brain stem. As far as technology stands at the moment, when the brain stem has irreversibly ceased to function, there can no longer be spontaneous heartbeat or respiration. This now leads to the popular conception that death has occurred.

Definition of death.

Broadly speaking, a number of options exist of what could amount to a definition in addition to the medical position such as human features of biological, religious or philosophical nature.

From a biological perspective, cessation of respiration and heart beat can amount to death. However there may be difficulty in maintaining that a person is dead if technology were available to produce mechanically the activities of the heart and lung.

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[49] 2nd edition Thomson sweet and Maxwell limited chapter 15 page 1089.

[50] See Michael Davies textbook on medical law 2nd edition oxford university press chapter 16 page 376-377

From a religious perspective it has been argued that human life begins when the soul enters the body, so it ends when the soul departs. This notion is however vague and prone to being construed differently among the existing strands of religious conviction.

From a philosophical perspective, the human body is the sum of its parts and loss of that capacity for bodily integration is tantamount to death.

Michael Davies, in relation to the philosopher's aspect of death writes,

"Humans are more than the flowing, of fluids. They are complex integrated organisms with capacities for internal regulation, with and only with these integrating mechanisms is homosapiens"[51]

Currently, the brain stem death is recognized, by the medical profession and by the courts, as the point of death.[52]

In 1968, the ad hoc committee of the Harvard medical school to examine the definition of brain stem death published its report and the brain death achieved worldwide recognition. The committee established the following fourfold criteria for brain death.

- Absence of cerebral responsiveness
- Absence of induced or spontaneous movement
- Absence of spontaneous respiration
- Absence of brain stem and deep tendon responses.

It is documented that no patient meeting the Harvard criteria has ever recovered despite the most heroic management. It is clear that the medical profession has reached a consensus as to the point of death.

Death at common law.
A locus classicus case on the judicial interpretation of brain stem death is the case of R v malcherk and steel[53]

The defendants were charged with murder the Defence claimed that the chain of causation was broken because after the assault, the victims had been supported on a ventilator and death occurred as a result of removal of the ventilator. Lord lane in his judgment stated,

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[51]M Davies textbook on medical law 2nd edition Oxford University press chapter 16 page 378.
[52]J MC hale and M fox health care law text and materials 2nd edition Thomson sweet and Maxwell limited chapter 15 page 1089.
[53](1981)2 ALLER 422

"Where the medical practioner, using generally acceptable methods, came to the conclusion that the patient was for all practical purposes dead , and that such vital functions as remained were being maintained solely by mechanical means and accordingly discontinued treatment, that did not break the chain of causation between the initial injury and death."

The case confirmed the judicial acceptance of recognition of brain stem death as death.[54]

The stance was also upheld in the case of RE A[55]

In this case a baby was taken to a hospital suffering from injuries apparently as a result of a fall at home. The child was found not to be having a heartbeat on arrival to the hospital. The child was transferred to another hospital where a number of attempts were made to resuscitate. The child was placed in a ventilator. Court considered whether the child had died thus could be removed from the ventilator. Johnson J in his judgment declared the child dead for legal and medical purposes and held that the doctor was not acting unlawfully because the child was already dead.

This case showed the need to seek judicial approval in withdrawing treatment and the ethical requirements of passive euthanasia.

On the other hand cases of patients in a persistent vegetative state,[56] who had no prospect of recovery, supported via artificial nutrition and hydration are a different matter, especially when it comes to withdrawal of treatment for such patients[57]

A PVS case was at the centre of the legal question regarding withdrawal of treatment. In the case of Aire dale NHS Trust v Bland[58]

Bland a football spectator was injured in a football ground in April 1989 at Hillsborough. He remained in this state and showed no signs of recovery. The hospital sought a declaration authorizing the discontinuation of all life sustaining treatment and medical support mechanisms.

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[54]Davies textbook on medical law 2nd edition Oxford University press chapter 16 page 382-83.
[55](1992) 3 Med L.R 303.
[56]PVS
[57]J MC Hale and Marie fox health care text materials 2nd edition Thomson sweet and Maxwell limited chapter 14 page 1021.
[58](1993) ALLER 521 (1993) A.C 879.

The court of appeal declared bland to be alive, though his condition may be described as a living death. The court stated that a doctor has a duty of care over his patient that includes acting in the patient's best interest and wishes.

The court thus held that the act of withdrawing treatment is no longer of criminal law if done in the patient's best interest.

2.5.0 THE LEGAL CONCEPT OF EUTHANASIA

Definition

John Keown defines euthanasia as the intentional killing of a patient, by act or omission, as part of his or her medical care.[59]

Black law dictionary defines euthanasia as the act or practice of causing or hastening the death of a person who suffers from an incurable disease or terminal disease or condition especially a painful one, for reasons of mercy.

There are in addition various classifications of euthanasia such as voluntary euthanasia, non-voluntary euthanasia, passive euthanasia and active euthanasia.

Black law dictionary defines all the classifications as follows.

a) Voluntary euthanasia is euthanasia performed with the terminally ill persons consent.
b) Non voluntary euthanasia is euthanasia of a competent, non-consenting person.
c) Passive euthanasia is the act of allowing a terminally ill person to die, by either withholding or withdrawing life sustaining support respirator or feeding tube.
d) Active euthanasia is euthanasia performed by a facilitator, such as a healthcare practitioner who not only provides the means of death, but also carries out the final death causing act.

The position of the Uganda constitution. The Ugandan constitution does not support or guarantee the right to euthanasia.[60] "no person shall be deprived of life intentionally except in the execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction and sentence have been confirmed by the highest appellant court".

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[59] J Keown, euthanasia examined Cambridge university press 1995.
[60] Article 22

This particular article however gives latitude to deprive life where a sentence has been passed by a competent court. Therefore there exist certain provisions under the constitution that could provide an argument for proponents of euthanasia.

The constitution further provides that "no person has the right to terminate the life of an unborn child except as may be authorised by law"[61] from this provision an argument may be put forth that it seems contradictory of the state to permit abortion under specific circumstances and refuse euthanasia. To this end one may ruminate on the following question;

If upon the opinion of a qualified medical professional, the condition of a terminally ill patient is deemed as so hopeless and death seems evident, why then should such a person not be allowed the freedom of choosing an earlier death to end his suffering?

In addition, the constitution provides that every person has a right to belong to, enjoy, practice, profess, maintain and promote any culture, cultural institution, language, tradition, creed or religion in community with others.

Thus, based on the understanding of this provision, those whose values and belief allow their conscience to support euthanasia should not be denied the right to undergo it, if they desire and freely consent. Equally those who do not support euthanasia should not be compelled to undergo the same.

The principle of double effect. Shawn D. pattisson writes in his book that the principle has its origin in the moral theology of t6he Roman Catholic Church. It holds that an act has two predicted consequences, one good and the other one bad, can morally be permissible where the intention is to achieve good, and the bad is unavoidable.[62]

Shawn affirms that it is permissible to produce a bad consequence only if,

- The act engaged in is not itself bad.
- The bad consequence is not a means to the good consequence.
- The bad consequence is foreseen but not intended.
- There is a sufficiently serious reason for allowing the bad consequence to occur.

The principle can apply to end of life decisions in two ways

1) Applied to patient reasons for refusing life sustaining treatment. Here the intentions of the patient are paramount. Refusing treatment with the primary intention of committing suicide violates the sanity of life. On the other hand,

[61]Article 22(2)
[62] SD pattisson medical law and ethics 4th edition sweet and Maxwell chapter 15-002 page 534.

refusing treatment with the primary the knowledge that death will result, but without the intention to die, does not violate the sanctity of life.[63]

2) Apply to doctor's reasons for administering life shortening treatment or otherwise accelerating the patient's death.

Administering life shortening treatment with intention of killing the patient is viewed as morally unacceptable. On the other hand, administering life shorteni9ng treatment with the intention of relieving the patients pain and distress is considered morally permissible, the case of air dale NHS trust v bland sufficiently predicates this statement, where it was held that a doctor has a duty to act in the best interest of the patient, a duty that may require the doctor to shorten the patient's life by withdrawing treatment to relieve the patients treatment to relieve the patients suffering.

The principle of double effect has been applied in determining a number of cases revolving around the circumstances mentioned above. Fo4r instance in the case of R v Adams[64]

Where it alleged that Dr Adams injected an incurably but terminally ill patient with increasing doses of opiates. In summing up to the jury, Delvin j brought up the principle of double effect.

Delvin j stated "..... If the first principle f medicine, the restoration of health, can no longer be achieved there is still much for a Doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measure he takes may incidentally shorten life."

Dr Adams was subsequently acquitted of murder on the grounds that ending of life was incidental to relieve pain.[65]

Michael Davies in his textbook on medical law states that according to the double effect principle, when doctors give pain relieving drugs in the knowledge that in addition to relieving pain, the same drugs will shorten life, then that is not seen as legal cause of death, since the "good effect" is desired while the "bad one" is not intended.[66]

The double effect principle lays a plausible legal and ethical justification for severely ill patients with no chance of recovery, to end their lives voluntarily. For such patients, the good intention is to alleviate their suffering at the hands of an incurable illness and the bad consequence, that is unavoidable, is inflicting death on themselves.

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[63] Ibid chapter 15-003 page 535.
[64] (1757) crim LR 365
[65] M Davies textbook on medical law 2nd edition Oxford University press chapter 15 page 346-47.
[66] ibid

This was the scenario in the case of R v COX[67]

Where Mrs. Boyes was suffering friom8 an incurable and increasing distressing form of arthritis, which made her hypersensitive to touch and this could not be eased by painkillers in its latter stages.

As the hypersensitivity to pain increased at the end of her life, Mrs. Boyes and her sons repeatedly requested that doctors in attendance end her life. Dr Cox administered a lethal dose of potassium chloride and Mrs. Boyes died. Ognall J stated, *"It was plainly Dr Cox's duty to do all that was medically possible to alleviate her pain and suffering, even if the course adopted carried with it an obvious risk that as a side-effect... of that her death would be rendered likely or even certain."* Here, the principle of double effect is manifested in the judgment set out. Death was an unavoidable and an unwanted consequence of the doctor carrying out his duty to alleviate his patient's pain and suffering. In addition, the court however held that *"...what can never be lawful is the use of drugs with the primary of hastening the moment of death."*[68]

2.6.0 EMERGING JURISPRUDENCE ON EUTHANASIA

Carter v Canada[69]

Facts: It was a crime in Canada to assist another person in ending their own life. The Canadian Criminal Code prohibited the provision of assistance in dying in Canada. The Canadian Criminal Code provided as follows, *"No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.*[70] The Code further provided, *"Everyone who counsels a person to commit suicide, or aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years*[71] After T was diagnosed with a fatal neurodegenerative disease in 2009, she challenged the constitutionality of the Criminal Code provisions prohibiting assistance in dying. She was joined in her claim by C and J, who had assisted C's mother in achieving her goal of dying with dignity by taking her to Switzerland to use the services of an assisted suicide clinic; a physician who would be willing to participate in physician-assisted dying if it were no longer prohibited; and the British Columbia Civil Liberties Association. The Attorney General of British Columbia participated in the constitutional litigation as of right.

Issue:

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[67] (1992) 12 BMLR

[68] M Davies textbook on medical law 2nd edition oxford university press chapter 15 page 346-347.

[69] (attorney general), 2015 SCC 5 supreme court of Canada

[70] Section 14

[71] Section 241 (a)(b)

Whether the criminal prohibition that gave a terminally ill person the choice of violently ending their life or suffering until they died violated their Charter rights to life, liberty and security of the person and to equal treatment by and under the law

Held: The Criminal Code unjustifiably infringed on the Charter and was of no force or effect to the extent that they prohibited physician-assisted death for a competent adult person who;
a. Clearly consented to the termination of life

b. Had a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that was intolerable to the individual in the circumstances of his or her condition. The prohibition on assisted suicide was, in general, a valid exercise of the federal criminal law power and it did not impair the protected core of the provincial jurisdiction over health. Health was an area of concurrent jurisdiction, which suggested that aspects of physician-assisted dying had to be the subject of valid legislation by both levels of government, depending on the circumstances and the focus of the legislation. Insofar as they prohibited physician-assisted dying for competent adults, who sought such assistance as a result of a grievous and irremediable medical condition that caused enduring and intolerable suffering, section 241 and 14 of the Criminal Code deprived these adults of their right to life, liberty and security of the person under section 7 of the Charter, that provided, "*Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*" Here, the prohibition deprived some individuals of life, as it had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. The rights to liberty and security of the person, which dealt with concerns about autonomy and quality of life, were also engaged. An individual's response to a grievous and irremediable medical condition was a matter critical to their dignity and autonomy.

The prohibition denied people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenched on their liberty. And by leaving them to endure intolerable suffering, it impinged on their security of the person. The prohibition on physician-assisted dying infringed the right to life, liberty and security of the person in a manner that was not in accordance with the principles of fundamental justice. The object of the prohibition was not, broadly, to preserve life whatever the circumstances, but more specifically to protect vulnerable persons from being induced to commit suicide at a time of weakness. Since a total ban on assisted suicide clearly helped achieve this object, individuals' rights were not deprived arbitrarily. However, the prohibition caught people outside the class of protected persons. It followed that

the limitation on their rights was in at least some cases not connected to the objective and that the prohibition was thus over-broad.

The case had to involve matters of public interest that were truly exceptional. It was not enough that the issues raised had not been previously resolved or that they transcend individual interests of the successful litigant; they also had to have a significant and widespread societal impact.

The appropriate remedy was not to grant a free-standing constitutional exemption, but rather to issue a declaration of invalidity and to suspend it for 12 months.

Nothing in this declaration would compel physicians to provide assistance in dying. The Charter rights of patients and physicians would need to be reconciled in any legislative and regulatory response to this judgment.

Tony Nicklinson v Ministry of justice[72]
Facts:
Mr. Nicklinson suffered a catastrophic stroke when he was aged 51. As a result, he was completely paralysed, save that he could move his head and his eyes.
He was able to communicate, but only laboriously, by blinking to spell out words, letter by letter, initially via a Perspex board, and subsequently via an eye blink computer.

Despite loving and devoted attention from his family, his evidence was that he had for the past seven years consistently regarded his life as "dull, miserable, demeaning, undignified and intolerable", and had wished to end it.

Because of his paralysed state, Mr. Nicklinson was unable to fulfill his wish of ending his life without assistance, other than by self-starvation. His preference was for someone to kill him.

Mr. Nicklinson applied to the High Court for:

(i) A declaration that it would be lawful for a doctor to kill him or to assist him in terminating his life, or, if that was refused
(ii) A declaration that the current state of the law in that connection was incompatible with his rights

[72] (2012) EWHC 2381

The High Court refused him both reliefs and he embarked on the very difficult and painful course of self-starvation, refusing all nutrition, fluids, and medical treatment, and he died of pneumonia.

Mr. Nicklinson's wife was then added, because she contended that she had a claim in her own right and substituted, in her capacity as administratrix of Mr. Nicklinson's estate, as a party to the proceedings, and pursued an appeal to the Court of Appeal.

The Court of Appeal gave Mrs. Nicklinson and another permission to appeal to the Supreme Court.

Held:
The Supreme court found that Mercy killing is a term which means killing another person for motives which appear, at least to the perpetrator, to be well-intentioned, namely for the benefit of that person, very often at that person's request.

Nonetheless, mercy killing involves the perpetrator intentionally killing another person, and therefore, even where that person wished to die, or the killing was purely out of compassion and love, the current state of the law is that the killing will amount to murder or manslaughter.

The Court concluded that only parliament had the power to change the law relating to murder, which would allow someone to assist another person to die.

The court stated, *"To do as Tony wants, the courts would be making a major change in the law... These are not things which the court should do It is not for the court to decide whether the law about assisted dying should be changed and, if so, what safeguards should be put in place."*[73]

Re Quinlan[74]
Facts:
In 1975, 21-year-old Karen Ann Quinlan suffered cardiopulmonary arrest after ingesting a combination of alcohol and drugs.

She subsequently went into a persistent vegetative state.56 Dr. Fred Plum, a neurologist, described her as no longer having any cognitive function but retaining the capacity to maintain the vegetative parts of neurological function.

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[73] http://www.judiciary.gov.uk/judgements/tony-nicklinson-judgement-16082012/(29 July 2015)
[74] Supreme court of new jersey 70 N.J 10, 355 A.2d 647,(1976)

She grimaced, made chewing movements, uttered sounds, and maintained a normal blood pressure, but was entirely unaware of anyone or anything.

The medical opinion was that Quinlan had some brain-stem function, but that in her case, it could not support breathing. She had been on a respirator since her admission to the hospital.

Quinlan's parents asked that her respirator be removed and that she be allowed to die. Quinlan's doctor refused, claiming that his patient did not meet the Harvard Criteria[75]for brain death.

Based on the existing medical standards and practices, a doctor could not terminate a patient's life support, if that patient did not meet the legal definitions for brain death.

Quinlan's father, Joseph Quinlan, went to court to seek appointment as his daughter's guardian, since she was of legal age, and to gain the power to authorize *"the discontinuance of all extraordinary procedures for sustaining Quinlan's vital processes."*

The court denied his petition to have Quinlan's respirator turned off and also refused to grant him guardianship over his daughter. Joseph Quinlan subsequently appealed to the Supreme Court of New Jersey.

He requested, as a parent, to have Quinlan's life support removed based on the U.S. Constitution's First Amendment.[76]

Held:

The New Jersey Supreme Court stated that an individual's right to privacy was most relevant to the case.

Although the U.S. Constitution does not expressly indicate a right to privacy, U.S. Supreme Court rulings in past cases had not only recognized this right but had also determined that some areas of the right to privacy are guaranteed by the Constitution.

The Court ruled that, *"Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present"*

It was further noted as follows:

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[75] Discussed earlier under the title the legal definition of death.

[76] The right to religious freedom.

"We have no doubt ... that if Karen were herself miraculously lucid for an interval and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death."

Balanced against Quinlan's constitutional right to privacy was the state's interest in preserving life. The court, in light of this stated,

"...we think that the State's interest ... weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State's interest."

The court also observed that life-prolonging advances had rendered the existing medical standards ambiguous, leaving doctors in a quandary. Moreover, modern devices used for prolonging life, such as respirators, had confused the issue of "ordinary" and "extraordinary" measures.

Therefore, the court suggested that respirators could be considered "ordinary" care for a curable patient, but "extraordinary" care for irreversibly unconscious patients.
The court suggested that hospitals form ethics committees to assist physicians with difficult cases like Quinlan's. The committees would not only diffuse professional responsibility, but also eliminate any possibly unscrupulous motives of physicians or families.

The New Jersey Supreme Court also ruled that, if the hospital ethics committee agreed that Quinlan would not recover from irreversible coma, her respirator could be removed.[77]

The above cases show that euthanasia has acquired a widespread recognition and approval. But whilst some countries such as England are reluctant to legalise euthanasia, their courts do envision the law making bodies of those countries soon putting in place a legal framework to allow seriously ill patients to end their life.

[77] http://www.libraryindex.com/pages/582/court-end-life-right-privacy-karen-ann-quinlan.html(29 July 2015)

CHAPTER 3

2.8.0 EUTHANASIA IN THE NETHERLANDS

Since 2002, the Netherlands has been one of the few countries where Euthanasia and physician-assisted suicide are under strict conditions regulated by law.

However, initially, the Dutch Penal code[78] made both Euthanasia and assisted suicide illegal.
The Dutch Penal code[79] provides as follows *whoever causes death by doing an act with the intention of causing death, or with the intention of causing bodily injury as is likely to cause death, commits an offence of culpable homicide.*

The code[80] further expounds on culpable homicide as murder when -
1. The act by which death is caused is done with the intention of causing death

2. If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused

3. If it is done with the intention of causing bodily injury to any person, and the bodily injury to any person, and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death; or

4. If the person committing the act knows it is so imminently dangerous that it must in all probability cause death, or such bodily injury is likely to cause death and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid.

Albeit, as a result of various court cases and legislation which will be discussed later, doctors who directly kill patients or help patients kill themselves would not be prosecuted as long as they follow certain guidelines.[81]

In the Netherlands, Euthanasia is an option for those patients who suffer unbearably and without any prospect of improvement, and who express the explicit wish to die by means of euthanasia.

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[78] Article 293 and article 294
[79] Article 293
[80] Article 294
[81] The royal Dutch medical association <http://knmg.artesennet.nl/dossier-9/dossier

The decriminalization of Euthanasia made the Netherlands the first country to formally sanction mercy killing.

The first glimpse of the Netherlands gradual acquiescence of euthanasia and PAS[82]began with the case of *Alkmaar*[83]

Where Article 293 and 294 of the Dutch penal code were interpreted by the Dutch Supreme Court as susceptible to the defence of *necessity* contained in the penal code[84]

The Penal Code provides, *any person who commits an offence under the compulsion of an irresistible force shall not be criminally liable.*

It was held that the defence of *necessity* would apply where the doctor acted according to 'reasonable' medical opinion.[85]

Legal framework & Practice

Euthanasia in the Netherlands is regulated by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act as from 2002. The Act[86] amended Article 293 of the Dutch Penal Code as follows –

offence of assisted suicide shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, and who informs the municipal autopsist of this in accordance with Article 7 second paragraph of the Burial and Cremation Act.

The Act provides that euthanasia and physician-assisted suicide are not punishable if the attending physician acts in accordance with criteria of due care.[87]

The Act elucidates due care will be established when the physician –

1. Holds the conviction that the request by the patient was voluntary and well-considered,

2. Holds the conviction that the patient's suffering was lasting and unbearable,

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[82] Physician assisted suicide
[83] Nederland jurisprudence 1985 No.106
[84] Article 40
[85] M Davies textbook on medical law chapter 15.3.2 page 353
[86] Article 20
[87] Article 2

3. Has informed the patient about the situation he was in and about his prospects, and the patient hold the conviction that there was no other reasonable solution for the situation he was in

4. The Act further provides, in relation to minors, that if the minor patient has attained an age between sixteen and eighteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request for termination of life or assisted suicide, after the parent or the parents exercising parental authority and/or his guardian have been involved in the decision process.

The physician and Patient do not arrive at the decision to terminate life on their own, A regional review committee[88] established under the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, reviews notifications made by physicians of cases of termination of life on request and assistance in a suicide, on whether a case of termination of life on request or assisted suicide complies with the due care criteria.

The committee is composed of an uneven number of members, including at any rate one legal specialist also chairman, one physician and one expert on ethical or philosophical issues. The committee also contains deputy members of each of the categories mentioned.[89]
The committee has the following powers –

I. Assess whether the physician who has terminated a life on request or assisted in a suicide has acted in accordance with the requirements of due care, referred to in of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[90]

II. The committee may request the physician to supplement his report in writing or verbally, where this is necessary for a proper assessment of the physician's actions.

III. The committee may make enquiries at the municipal autopsist, the consultant or the providers of care involved where this is necessary for a proper assessment of the physician's actions.[91]

The committee informs the physician within six weeks of the receipt of the report.

Further, The committee informs the Board of Procurators General and the regional health care inspector of its opinion if the committee is of the opinion that the physician

[88] Chapter III article 3
[89] ibid
[90] Article 2
[91] Article 8

has failed to act in accordance with the requirements of due care,[92] thus making the concerned physician Criminally liable.

The committee also informs the concerned physician of any provision of information to the public prosecutor.[93]

The committee also ensures the registration of the cases of termination of life or assisted suicide reported for assessment. Further rules on this may be laid down by a ministerial regulation.[94]

2.9.0 EUTHANASIA IN INDIA

In India, attempt to suicide is an offense punishable under the Indian Penal Code.
The Penal code provides under attempts to commit suicide *Whoever attempts to commit suicide and does any act towards the commission of such offense shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both*[95]

A Division Bench of the Supreme Court of India in *P. Rathinam v Union of India*[96]

Held: The right to live which Article 21 of the Constitution of India speaks of can be said to bring in its trail the right not to live a forced life, and therefore, section 309 violates Article 21.
This decision was, however, subsequently overruled by a Constitution Bench of the Supreme Court in – *Gian Kaurv State of Punjab*[97]

Held: Article 21 could not be construed to include within it the right to die'as a part of the fundamental right guaranteed therein; therefore, it was ruled that;

It could not be validly stated that section 309 is violative of Article 2.

In 2008 the Law Commission of India[98] submitted a review to the government to repeal section 309. The Law Commission said *"The Supreme Court in Gian Kaur focused on*

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[92] Article 9(2)
[93] Article 10
[94] Article 11
[95] section 309,indian penal code
[96] AIR 1994 SC 144
[97] AIR 1996 SC 946
[98] 210th report of the law commission of India-humanization and decriminalization of attempt to suicide

constitutionality of section 309. It did not go into the wisdom of retaining or continuing the same in the statute."

The Commission has resolved to recommend to the Government to initiate steps for repeal of the anachronistic law contained in section 309 of the IPC,[99] which would relieve the distressed of his suffering. The suicide rate in India is above the average world suicide rate.[100]

However, later in 2011, a landmark case delivered by the supreme court of India turned the tides and established a new status quo as far as euthanasia in India is concerned. In *Aruna Shanbaug v Union of India*[101]

Where Shanbaug, 60, a former nurse, was beaten and sexually assaulted in 1973 by a co-worker, a hospital janitor at Mumbai's King Edward Memorial Hospital. She suffered severe brain damage and paralysis after her attacker, Sohanlal Bhartha Valmiki, reportedly choked her with a chain. Valmiki was convicted of robbery and assault in 1974 and imprisoned for seven years.

After his release, he reportedly moved, changed his name and found another hospital job.

The petition asking that Shanbaug be allowed to die was brought by Pinki Virani, an author and right-to-die activist, after Shanbaug's family abandoned her. Virani argued that with the patient unable to see or speak properly, keeping her alive violated her basic dignity. Virani expressed regret that the court didn't put an end to Shanbaug's force-feeding. He stated, *"She still does not, after more than three and a half decades, receive justice, the bizarre postscript to Aruna's story is that those who claim to 'love' her and 'look after her' are the ones who want her not to rest in peace."*

Held: A two-judge bench of Supreme Court comprising of justices Markandey Katju and Gyan Sudha Mishra, in a landmark judgement on 7th March 2011, allowed passive euthanasia of withdrawing life support to patients in PVS but rejected outright active euthanasia of ending life through administration of lethal substances.

The apex court while framing the guidelines for passive euthanasia asserted that it would now become the law of the land until Parliament enacts a suitable legislation to deal with the issue.

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[99] Indian penal code

[100] A shaha legalizing euthanasia-issues and challenges(LLM thesis savitribai phule pune university 2014-2015

[101] (2011) 4 SCC 454

The bench also asked Parliament to delete Section 309 of the IPC as it had become *"anachronistic though it has become constitutionally valid."*

Katju J stated, *"A person attempts suicide in a depression, and hence he needs help, rather than punishment."*

The Apex Court further noted that though there is no statutory provision for withdrawing life support system from a person in PVS, it was of the view that passive euthanasia could be permissible in certain cases for which it laid down guidelines and cast the responsibility on high courts to take decisions on pleas for mercy killings. [102]

The Following guidelines were laid down:

a) A decision to discontinue life support has to be taken by the parents or spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient.
b) Even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires approval from the High Court concerned.
c) When such an application is filled the Chief Justice of the High Court should forthwith constitute a Bench of at least two Judges who should decide to grant approval or not. A committee of three reputed doctors to be nominated by the Bench, who will give report regarding the condition of the patient. Before giving the verdict a notice regarding the report should be given to the close relatives and the State. After hearing the parties, the High Court can give its verdict.

The matter of Euthanasia in India continues to be debated on from a jurisprudential perspective.

On 25 February 2014, a three judge bench of the Supreme court of India in *A Regd. Society v Union of India*[103] observed that the judgement in the *Aruna Shanbaug v Union of India* was inconsistent in itself, since the judgement claimed Euthanasia could only be allowed by legislation yet it went ahead to lay down guidelines on the same.

[102] shaha legalizing euthanasia-issues and challenges(LLM thesis savitribai phule pune university 2014-2015
[103] (2014) 5 SCC 338

The matter was referred to a five judge Constitutional bench that is yet to deliver its verdict on the issue.

3.0 EUTHANASIA IN THE USA

It is increasingly likely for Americans to die in institutions from chronic illnesses and public concern has become increasingly focused on how society can best protect the dignity and independence of individuals as they reach the end of life. There is a broad movement within the medical community to improve the quality of end of life care, and this trend is most aptly illustrated by the freedom granted to physicians in providing adequate pain control at the end of life; a goal which can be pursued even to the point of hastening death.

Yet the process of dying has been extended by the proliferation of medical technologies available to us and many of us will die while experiencing unnecessary pain. Furthermore, studies show that an overwhelming majority of Americans express a desire to die at home, and yet the vast majority of us will die in health care facilities.

The current trend in public debate favors the discussion of death and the current level of care provided at the end of life with an emphasis on honesty and openness and this increasing level of discussion is being matched with broad social movements to improve the care provided for the dying.

However, too many, dying. "well." involves having a certain amount of control over the place and manner of our deaths. Patients nearing the end of their lives often express concerns about receiving inadequate pain control, receiving too much care, or receiving too little care. To a large extent, these and similar issues can be adequately addressed within the current ethical and legal framework governing medical care.

Yet, there are many patients who express a desire to obtain assistance in dying at the place and time of their choosing. The recent passage of the Oregon Death with Dignity Act, which legalizes physician-assisted suicide and regulates the practice, has encouraged both public and Scholarly debate on the topic of legalized euthanasia.

It this concern, whether or not patients who request assistance in dying ought to be able to legally obtain euthanasia, which I will primarily address. I argue that individual acts of euthanasia can be morally justified and that euthanasia ought to be a legitimate medical option for those patients On the Moral and Social Implications of Legalized Euthanasia who request assistance in dying.

Individuals ought to be free to determine for themselves the manner in which they wish to die. A physician willing to provide euthanasia for a patient who competently makes a voluntary and informed request for assistance in dying ought to be legally permitted to provide the kind of care that the patient desires.

Furthermore, legalizing and regulating the practice of euthanasia will serve to increase the quality of care provided at the end of life. The leading objections against the moral permissibility of euthanasia fail to adequately demonstrate that individual acts of physician-assisted death cannot be morally justified and are incompatible with currently accepted medical practices. While some patients and physicians might understandably wish to avoid hastening death as much as possible, patients experiencing irremediable suffering can legitimately request euthanasia; this is a point on which even those staunchly opposed to legalized euthanasia agree.

However, some critics have argued that the potential abuses of poor or otherwise vulnerable patients would outweigh the benefits of legalizing and regulating the practice, regardless of whether or not individual cases of euthanasia can be morally justified.

Furthermore, some critics worry that pressing for the legalization of euthanasia will Ultimately result in decreasing the level of care provided at the end of life. I argue that an Honest and open-minded evaluation of the leading concerns regarding the moral and Social implications of legalized euthanasia reveal that these fears are largely unfounded Or misguided and do not adequately justify a blanket prohibition against euthanasia.
In Oregon, the legitimate medical option of physician-assisted suicide has not been disproportionately chosen by terminally ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking in end of life care.

Furthermore, Oregon physicians have consistently reported increased efforts to improve their knowledge of the use of pain medications to alleviate physical suffering, to improve their ability to recognize psychiatric disorders, and have been referring more patients to hospice care since the passage of the Act.

The results of this Death with Dignity initiative in Oregon have thus far demonstrated that the feared abuses are not occurring and that the goals of better health care and legalized euthanasia are not mutually exclusive; rather, they can be pursed in harmony.

I argue that Oregon should be allowed to proceed with its self-proclaimed bold experiment, and I support the continuation of Death with Dignity initiatives as a

legitimate movement likely to improve the quality of care provided to patients at the end of life.

Euthanasia is illegal in majority of the states in the USA. However, the States of Washington, Oregon and New Mexico have legalised Physician assisted dying.

For one to understand physician assisted dying in the U.S one must look in to the U.S legal system.

In the United States, the Constitution is the highest law of the land. Federal law enacted by the U.S congress follows next. The U.S Congress can adopt laws that control every state, however, this is subject to the circumstances of each state, the U.S Constitution and court decisions permit.

State legislation comes last. These are laws passed by a legislature of each state.[104]
In the state of Washington, Euthanasia is regulated by the Washington death with dignity Act.[105] It is a state legislation.

The Act[106] provides for who may make a request to end life.

It provides, *an adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her desire to die...*

Such an expression is made in writing requesting for medication that the patient may self-administer in accordance with the Act.[107] The Patient can rescind request at any time and in any manner without regard to his mental state.[108]

The Act[109] provides that the written request shall be in a prescribed form set out in the following manner –

[104] <HTTP:system.uslegal.com/> (18th august 2015)
[105] An act relating to death with dignity.
[106] Section 2(1)
[107] ibid
[108] Section 10
[109] Section 22

RERQUEST FOR MEDICATION TO END MY LIFE IN A HUMAN AND DIGNIFIED MANNER

I ..... am an adult of sound mind. I am suffering from ....., which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that I may self administer to end my life in a humane and dignified manner and to contact any pharmacist to fill the prescription.

INITIAL ONE:

..... I have informed my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full impact of this request and I expect to die when I take the medication to be prescribed. I further understand that although most death occurs within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed.....

Dated.....

DECLARATION OF WITNESSES

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request has done it voluntarily.

The Act also provides for safeguards to ensure credibility of the life ending process. The Act provides for the following responsibilities for the attending physician.[110] They include among others;

- Make an initial determination whether the patient has a terminal disease, is competent and has acted voluntarily
- To ensure the patient makes an informed decision by informing the patient

- His or her medical diagnosis
- His or her prognosis

- The risk of taking the life ending medication

- The feasible alternatives to ending life

- Ensure all appropriate steps as provided under the Act are followed before writing a prescription for medication to end life
- Deliver the prescription either personally or by mail to the pharmacist who in turn delivers it to the concerned patient

A consulting physician on the other hand examines the patient and his or her relevant medical records and confirms, in writing, that the attending physician's diagnosis that the patient is suffering from a terminal disease is correct, and verifies that the patient is capable, is acting voluntarily and has made an informed decision.[111]

The Act also provides for liabilities for malpractices. The Act provides that a person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing death is guilty of a Class A felony.[112]

Coercion or exerting undue influence on a patient s also prohibited and is also a Class A felony.[113]

In the state of Oregon, Euthanasia is regulated by The Oregon Death with Dignity Act. Just like in Washington, The Act allows physicians to prescribe patients lethal drugs in certain circumstances. The Act provides:

[110] Section 4
[111] Section 5
[112] Section 20(1)
[113] Section 20(2)

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner...[114]

The Act also provides for the prescribed form through which a patient makes a request to end his or her life, safeguards and liability for malpractices identical to the Washington death with dignity Act.[115]

The euthanasia debate in the United States began, in a sense, with the legal proceedings Surrounding the right to withhold or withdraw of life sustaining treatment.

The courts have consistently rejected a distinction between withholding and withdrawing life
Sustaining treatments, as well as a distinction between ordinary and extraordinary Treatment.[116]

Thus, artificial nutrition and hydration are considered to be medical treatment that competent patients or proxies may refuse, based on the constitutionally protected and deeply personal right of the individual to refuse to consent to invasive bodily intrusion or to refuse to continue life sustaining treatment. However, if there is a constitutionally protected right to assistance in active euthanasia or physician-assisted suicide, it has yet to be recognized and upheld in the United States legal system.
Karen Quinlan[117]

The first landmark case of this sort involved Karen Quinlan, a 21 year old woman who Suffered irreparable brain damage after she ceased breathing for unknown reasons during
A birthday party. Karen was treated aggressively, placed on a respirator, and given Artificial nutrition and hydration even though she was eventually diagnosed as being Permanently comatose.

The cost of maintaining Karen, which was nearly $450 per day, was being covered by the state.

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[114] Section 2
[115] Cambridge University press online books.
[116] Lawrence gostin deciding life and death in the court room: from quinlan to Cruzan, glucksberg and vacco. A brief history and analysis of constitutional protection of the right to die.
[117] Supreme court of new jersey 70 NJ 10,355 A.d 647,(1976)

As more and more possible causes of her coma were ruled out, it became clear to her adoptive parents and physicians alike that she was unlikely to recover. However, when her parents requested that the life sustaining treatment be stopped, they met with resistance and were forced to seek legal assistance to allow her to die.[118]

In 1976, the New Jersey Supreme Court ruled that Karen's right to privacy could be extended to her family, allowing them to make decisions regarding her medical care even if those decisions
Would result in her death.

After 10 years, the life sustaining treatments were ceased and Karen was allowed to die. The court found that the right to refuse treatment is based on the doctrine of informed consent and holds that physicians have a duty of care that requires disclosure of benefits, risks, and adverse effects of medical treatment. The court has also recognized a. "Liberty interest." of competent patients to refuse unwanted medical treatment that can be extended to the. "Dramatic consequences." of refusing life sustaining treatments.

Furthermore, a durable power of attorney allows a patient to designate an agent or proxy who may make health care decisions on his or her behalf.

Nancy Cruzan[119]

The second highly influential case involves a patient named Nancy Cruzan. When she Was 25, Nancy was involved in a serious automobile accident that left her in a persistent Vegetative state. The cost of providing care for Nancy was $130,000 per year, which (like
Karen Quinlan) was covered by the state.

Although her parents initially hoped that she would come out of her coma, after eight years of waiting they became convinced that she was unlikely to recover and made the decision to request that treatments keeping her alive be ceased. This decision was not supported by the hospital, and her parents were forced to go to court.

Many of her family and friends testified that Nancy would not want to be kept alive in such a condition, and in 1988 the local County Circuit Court ruled in favor of allowing the removal of life sustaining treatments.

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[118] Ronald munson,intervention and reflection : basic issues in medical ethics 6th edition
[119] 497 U.S 261 (1990)

However, the Missouri Supreme Court overruled this decision on an appeal, claiming that there was no. "Clear and convincing." evidence that Nancy would not have wanted to be maintained in a persistent vegetative state.

The case was then appealed to the United States Supreme Court, which ruled that the Missouri Supreme Court was right in requiring ."Clear and convincing." evidence for the decision to be made, but also found a constitutional. "Liberty interest." that grants proxies the power to make medical decisions on the behalf of others and that there is no rational basis for distinguishing between artificial nutrition and hydration and other forms of medical treatment.8 the case was
Then presented to the County Circuit Court, which ruled that the testimony provided by Nancy's family and friends did constitute. "Clear and convincing." evidence of her wishes, and she was allowed to die in December of 1990.

Vacco v. Quill[120]

In 1997, the United States Supreme Court ruled that New York's prohibition on assisting Suicide does not violate the Equal Protection Clause of the Fourteenth Amendment by Denying the ability to hasten death to those who cannot do so by refusing life sustaining Treatments.

The Supreme Court found that the Second Circuit Court judgment which was overturned was based on a faulty interpretation of New York law as creating a ."Right to hasten death.." Instead, they found that only a right to refuse treatment was supported. The Supreme Court maintained that the distinction between assisting suicide and withdrawing life sustaining treatment is. "Widely recognized and endorsed in the medical profession and in our legal traditions." and is rational, important, and logical.

In their decision, the Supreme Court held that the distinction between refusing treatment and assisting in suicide rests in the principles of causation and intent. When a patient refuses life sustaining treatment, they are killed by the underlying disease; a physician who withdraws treatment. "Purposefully intends, or may so intend, only to respect his patient's wishes.."12 The same is said to be true with the provision of palliative care that may hasten the time of the patient's death. On the other hand, they maintained that a physician who assists in suicide must. "Necessarily and indubitably intend primarily that the patient be made dead.

Furthermore, every competent individual is, regardless of their medical condition, entitled to refuse unwanted life sustaining medical treatment, while no one is permitted

[120] 521 U.S 793

to assist in suicide. Thus, they ruled that a law which applies so. "evenhandedly." to all individuals cannot be thought to lack compliance with the Equal Protection Clause of the Fourteenth Amendment.

Washington v. Glucksberg[121]

On the Moral and Social Implications of Legalized Euthanasia In conjunction with the ruling in ."Vacco v. Quill,." the Supreme Court upheld a law in Washington specifically prohibiting physician assistance in suicide and stated that there was no need to address the more narrow questions as to whether or not: [A] mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death.... [There is] no need to reach that question in the context of the facial challenges to the New York and Washington laws as issue here.... The parties and *amici* agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death....

In this light, even assuming that we would recognize such an interest.... the State's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide.

The Supreme Court found that the constitutionally protected. "Liberty interest." in refusing
Medical care cannot be. "Somehow transmuted." into a right to assistance in committing
Suicide. they also hold that there are a number of legitimate interests that may prompt the State in prohibiting assistance in suicide.

First, the State has an interest in the preservation of human life and a prohibition against assisted suicide, like homicide laws, would promote this interest. Second, the State has an interest in protecting the integrity and ethics of the medical profession that may involve a prohibition against assisted suicide.

Third, the State has an interest in protecting vulnerable groups (which includes the poor, elderly, and disabled persons) from abuse, neglect, and mistakes.

[121] 521 U.S 702 (1997).

Finally, the State may fear that permitting assisted suicide will ."Start it down the path to voluntary and perhaps even involuntary euthanasia.."17

However, despite these fears, the federal government recognizes that it would be problematic to formulate legislation explicitly regulating or prohibiting the practice of euthanasia because it is unclear what effects such legislation might have.

The position which the government has taken, then, is to allow individual states to form their own legislation regarding euthanasia pending information that suggests creating a federal
Stance.

This opinion has been expressed by Supreme Court Justices who maintain that the. "Challenging task of crafting appropriate procedures for safeguarding Liberty interests is entrusted to the. 'laboratory.' of the states.."18 Thus, states are free to form legislation on
either side of the euthanasia debate. Indeed, the rulings of the Supreme Court leave open
."Room for vigorous debate." regarding physician-assisted suicide and voluntary active euthanasia and this is precisely what has been occurring in the last few years.

Recently, the citizens of Oregon voted to approve an Act that legalizes and regulates the Practice of physician-assisted suicide. This legislation has been the subject of substantial Political controversy and has served to advance the level of public and scholarly debate on the timely and important topic of legalized euthanasia.

In the state of New Mexico, a court decision established the legality of Euthanasia as a right in the case of -

Katherine Morris & Aja Riggs v Attorney General of the State of New Mexico[122]

The Plaintiff Aja Riggs was diagnosed with uterine cancer in August 2011. She wanted the "peace of mind" of knowing that aid in dying would be an option available to her if she found her suffering in the terminal stage of her cancer unbearable.

Held: "*Medical practices, medical treatment and medical ethics have changed radically over the past fifty years. Certainly the medical and legal ethical considerations regarding end of life care have changed over the past fifty years... This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and*

[122] No.D-202-CV 2012-02909

happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying... The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution."

CHAPTER 4

QUESTIONNAIRE ANALYSIS

3.3.0 Introduction

Euthanasia and related issues are topics that have drawn a wide range of views and evoked parallel views in support for and against the practice.

In Uganda, mercy killing is a topic still largely shrouded in mystery. I therefore embarked on an academic quest to solicit the opinion of medical professionals, who, given the nature of their occupation, frequently interact with patients likely to harbor a desire to end their life.

I employed the use of questionnaires in gathering the aforementioned data. The questionnaire touched on personal and professional opinions from medical professionals concerning euthanasia and PAS.[123]

The questionnaires included open and tick box questions that addressed the respondents' characteristics, experiences and opinion regarding euthanasia and PAS.

Data was gathered on a small part of the whole sampling frame and used to inform.

I asked the respondents if they had interacted with a terminally ill friend/relative on a personal level.

I also enquired whether they had interacted or handled a terminally ill patient on a professional level.

I further sought to establish each respondent's level of experience working with terminally ill patients.

I framed questions regarding the prognosis of terminally ill patient and the physical, psychological, socio-economic impact their illness general has on them.

Lastly, I sought their approval/disapproval of euthanasia and their involvement in the same.

[123] Physician assisted suicide

3.4.0 Sampling Process

The population concerned comprised of medical practitioners drawn from 8 Counties. The sample frame was obtained from both public and private hospitals. The simple random sampling[124] method was used as the most appropriate.

The sample size included 32 doctors, nurses and other medical professionals participated in the survey.

The total number of doctors was 15, nurses 10, pharmacists 3 other professional services managers, insurance care managers and consultants amounted to 4 individuals.

21 of the respondents sampled were female, 9 were male, 2 were did not disclose their gender. This amounted to 66% female respondents, 28% male and 6 undisclosed.

27 respondents were between the ages of 26-40 while 5 respondents were over 40 years. None of the respondents were between the ages of 18-25.

3.5.0 Data Collection and Findings

The first category of questions dealt with the respondent's personal interaction or involvement with terminally ill patients.

- 14 respondents disclosed having interacted with terminally ill relatives they however denied having terminally ill close friends.
- 14 respondents disclosed having interacted with terminally ill relatives and close friends.
- 4 respondents declined having either terminally ill relatives or close friends.

The second category of questioning sought to enquire the respondent's professional experience working with terminally ill patients

- 14 respondents disclosed having between 0-2 years working with terminally ill patients.
- 8 respondents stated having between 3-5 years experience with terminally ill patients
- 4 respondents disclosed having between 6-10 years' experience with terminally ill patients
- 4 patients stated having over 10 years working with terminally ill patients.
- 2 of the respondents did not disclose their experience level

[124] SRS

Therefore, 69% of the respondents had 0-5 years experience working with terminally ill patients. On the others hand, 26 % of the respondents had over 6 years experience.

5% did not respond to the query.
The third category of questioning was open ended. It sought the professional opinions of the respondents regarding the physical, mental and socio- economic state of the terminally ill patient and as their illness progresses.

There was a consensus among the respondents that the terminally ill patient becomes increasingly vulnerable physically and psychologically.

In addition, the respondents stated terminally ill patients do suffer from fits of depression characterized by anger and denial of their condition.

The fourth category of questioning enquired the respondents' opinion regarding euthanasia and physician assisted suicide

- 17 respondents selected no to terminally ill being allowed to end their life,
- 15respondents chose yes

While responding to their view on euthanasia in general

- 11 respondents were of the opinion that they do not support the practice of all.
- 10 respondents opined that they welcomed the practice
- 11 respondents not to be sure at the moment.

Further, on physician-assisted suicide

- 15 respondents opposed physician-assisted suicide
- 8 respondent's espoused physician assisted suicide
- 9 were unsure at the moment.

3.6.0 Data Presentation and Discussion

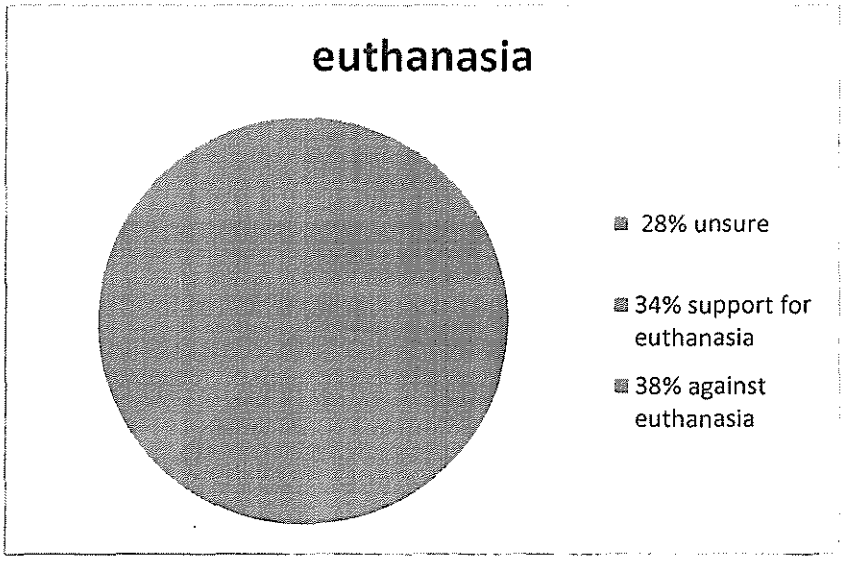
The data collected in the course of the survey was largely positive. Respondents involved in the survey all had interacted and/or handled terminally ill patients both in a personal or intimate capacity by having a friendship or a blood tie with the terminally ill patient, and in a professional capacity in the course of their work. Therefore, each respondent was in a position to draw their opinion regarding Euthanasia and related issues from a position of empathy and technical understanding.

Each respondent had sufficient experience working with a terminally ill patient. In addition, all the respondents shared a common opinion that a terminally ill patient generally deteriorates in health and encounters a significant change in their psychological well-being.

Regarding euthanasia in general, 38% of the respondents were against it, while 34% supported it. 28% had not made their mind on the issue.

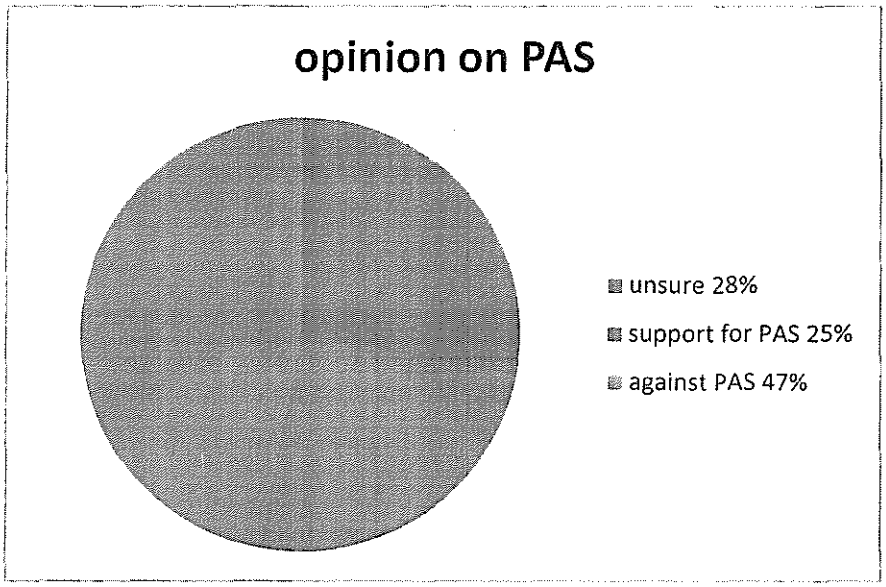
This shows an almost equal for or against with regard to euthanasia as a medical practice.
This data is represented graphically in the pie chart below:

FIGURE 1. Opinion on Euthanasia



On physician assisted suicide, 47% were against it while 25% supported the practice. This result may largely be hinged on euthanasia and physician assisted suicide being illegal in Kenya, further taking into consideration that 28% were unsure.

FIGURE 2. Opinion on PAS



3.7.0 Strengths and limitations

1. Getting respondents to participate in the study was an uphill task. Most hospitals had a rigid and complex procedure for soliciting respondents from their staff by researchers.

2. The general public did not participate in the survey due to time and pecuniary limitations.

3. A diverse sample of the respondents participated from public and private hospitals and health centre's, from a large pool of professionals and geographical locations in Uganda.

This laid the foundation for divergent and unique responses.

3.8.0 Acknowledgements

The author would like to thank each and every respondent who participated in the study and those who played a critical role in soliciting respondents.

3.9.0 Declaration of interests

The author had no conflict of interest and was solely responsible for the content of the questionnaire analysis.

CHAPTER 5

4.1.0 SUMMARY

Throughout the course of my study into the legalization of euthanasia and the justification behind such legalization, I have unearthed a lot of past and contemporary information that as the author, I have applied myself in order to come up with a plausible and persuasive document.

In Chapter 1 of the project, I set the ball rolling by outlining the research topic and the objectives that I wished to achieve with the research. I also give a background to the study to further elucidate on the significance of the study. I delved into the relevant constitutional provisions in an effort to bring out the plight of the terminally ill and looked into the relevant Constitutional provisions. In addition, I highlighted some of the legal and jurisprudential lacunas present in our legal system that can be positively exploited to give a much needed redress to patients suffering from irreversible and complicated illnesses. For instance, Article 26(3) of the Constitution that, when logically and literally interpreted, lends credence to the proposition that written law can allow terminally ill patients to voluntary end their life.

In Chapter 2, I traced and discussed the historical background of euthanasia, from the early times of the Roman Empire to the establishment of a world organization for right to die societies that brought worldwide attention to euthanasia and the rights flowing from it.

I further sought to gain more insight on an already all too familiar phenomena in human existence, death. I explored what exactly constitutes death from both medical and legal perspectives. This was done in an effort to demystify the withdrawal of life support by doctors and the medical and legal parameters regulating such as Act. Further, the criminal culpability of doctors who perform such a procedure as a form of passive euthanasia.

I further proceeded to dissect the concept of euthanasia from a purely legal basis. I looked into the legal definitions of the various forms of euthanasia and the position of the Ugandan constitution and bought out the salient provisions that backed up my research topic.

I also looked into the principle of double effect and its relevance in today's medical practices and development of judicial precedents around the world. I switched focus to emerging and past jurisprudence on euthanasia from different legal systems of the world and the profound impact each court decision had in the respective nations.

In Chapter 3 of the study, I examined and compared the manner in which euthanasia is practiced in countries across the world, I used the Netherlands, India and the U.S.A as case studies.

I explored how each country went about altering their existing laws to accommodate euthanasia and assisted suicide to ultimately provide a solid and responsive procedural framework for conducting mercy killing that would not only serve today's needs but the posterity as well. I unearthed the pitfalls faced by each country in the course of legalizing euthanasia and how they aptly reacted to them.

Chapter 4 of my study encompassed a questionnaire survey and report. I saw it prudent to seek the personal and professional opinion of medical practitioners drawn from all over the country due to the practical nature of the study topic, in that, it is centered on terminally ill patients in different capacities, and as a result, such professionals would be best placed to shed light on the personal and medical state of such patients.

Ultimately, I embarked on this survey to establish whether euthanasia would be a commensurate relief to such patients.

The results of the survey indicated that euthanasia still draws a raft of views as far as Uganda is concerned and as a result, the number of medical practitioners in support of euthanasia and PAS was almost equal to those who oppose the same. However, a considerable number were ambivalent about mercy killing.

4.2.0 RECOMMENDATIONS

Based on this study, I make the following recommendations regarding mercy killing in the Ugandan context without prejudice.

On legalisation of euthanasia in Uganda, the following measures would have to be put in place:

i) A well formulated and laid down legal framework. This should include a legislation stipulating the manner which patients could voluntarily chose to end their lives, the act of parliament would expressly define euthanasia and PAS, provide for procedures to be followed when soliciting and carrying out mercy killing and the role of all parties involved.

From the study, I would recommend a model similar to the Washington death with dignity Act in the U.S.A. this act provides the following key regulations.
a) Who exactly may make a request to end life?

b) A prescribed form within which a patient may make a request to end life with a witness declaration of approval.

c) Rules to be followed by physicians when conducting mercy killing and a mandatory requirement for consultation to eliminate malpractices.

Further, Netherlands also offers a good example on how to lay the procedural groundwork for such a law. The Netherlands termination of life in request Act provides for regional review committees charged with a responsibility to review notifications made by physicians of cases of termination of life on request and register cases of mercy killing. The committee also reports cases of medical malpractices making the physician(s) involved criminally liable.

In Uganda, such a committee would be formed to further make the procedure of mercy killing credible and within the acceptable ethical, moral and legal parameters. As is the case in the Netherlands. These committees would operate independently in a manner akin to Constitutional commissions.

ii) All stakeholders such as doctors, nurses, consultants, lawyers and the general public would have to participate in the law making process and its subsequent implementation. Given the controversial nature of mercy killing, all these aforementioned parties would have to ensure that the noble purpose of the practice is achieved consistently.

Civic education would go a long way in achieving these objectives.
iii) The law would also have to raise the level of criminal culpability for anyone who flouts the procedures for mercy killing put in place. This would however require amendments to our current laws.

For instance, Section 196(d) of the Penal Code of Uganda outlaws aiding death of another. The Section provides that if by any act or omission a person hastens the death of another person suffering under any disease or injury which apart from that act or omission would have caused death has caused death of another and will be liable to death as stated under section 189 of the penal code act.

Section 209 of the penal code outlaws aiding suicide it provides
"Any person who,

a) Procures another to kill himself or herself
b) Counsels another to kill himself or herself and thereby induces him to do so, or
c) Aids another in killing himself or herself

Commits a felony and is liable to imprisonment for life."

Regarding culpability for malpractices relating to mercy killing procedures, and in the interests of justice and integrity, the proposed legislation would also encompass offences such as altering or forging requests to end life, inconsistent and reckless *modus operandi*. Most importantly, the legislation would also impose punishment for each of the offences pursuant to the Latin maxims *nullum crimen sine lege* and *nulla poena sine lege*.

iv) The proposed legislation would also necessitate an amendment of the 1995 constitution. The constitution under article 22(1) provides that " no person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial by a court of competent jurisdiction in respect of a criminal offence under the laws of Uganda and the conviction shall be confirmed by the highest appellate court." This provision would need to provide for the option of euthanasia as well. As another ground for which ones life can be terminated.

The constitution being the supreme law of the land as it expressly states in article 2 requires any amendment providing for the option of euthanasia to start from the supreme law itself

Such a radical and for reaching addition to our body of laws would inevitably come bundled with challenges and potential pitfalls. In order to be as objective and pragmatic as possible in my study, I have identified the most pertinent challenges as follows;

i) Given the pluralistic nature of the Ugandan society today, this change of law would likely generate endless political, moral and religious debates in Uganda.

ii) The constitution of Uganda has created a justice system and a democratic space that paves the way for any concerned citizen or lawful group to challenge legislations in Court and subject them to the test of constitutionality. An Act of parliament Legalising mercy killing would be no exception.

iii) The proposed legislation would also demand a substantial pecuniary investment. The creation of bodies to oversee its implementation, notwithstanding the state machinery needed to enforce some of its provisions would be great.

I would therefore submit that Uganda currently is not ready for such a Law, but nonetheless it is a law that would require much consideration and assessment in future.

The whole study was deeply engaging from an academic, social and philosophical stand point and an immerse source of inspiration. I sincerely hope this study will equally inform and inspire each reader.

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APPENDIX I

SAMPLE QUESTIONNAIRE

STUDY QUESTIONNAIRE

Euthanasia Experiences and Attitudes From a medical Perspective.

The purpose of this study is to assess how your personal experiences of euthanasia affect your attitude towards it. Euthanasia (mercy killing) can be defined as the act of painlessly putting to death a person suffering from an incurable disease or condition.
The research will involve completing this brief questionnaire; the questionnaire will involve questions about your personal experiences with terminally ill patients and will assess your attitudes towards euthanasia.
It is important to remember that you can withdraw from participation of the study at any time during completion of the questionnaire.
Your personal information and opinion in relation to the study may be cited subject to your express consent.
This research is being conducted as a study in pursuit of a Bachelor of laws at Kampala international University Kampala Campus.
As an informed participant of this study I confirm that -

I understand that my participation is voluntary and I may cease to take part in this study at any time.

I am aware of what my participation will involve.

All my questions have been answered about what my participation will involve.

I have read and understood the above and given consent to usage of this information by the author in the study.

YES ☐

NO ☐

PERSONAL INFORMATION

(Please Tick Appropriately)

a) Please state your age

18-25 ☐

26-40 ☐

Over 40 ☐

b) Sex

Male ☐

Female ☐