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A BIOETHICS CRITIQUE OF THE HEALTHCARE SYSTEM IN NIGERIA:
PERSONAL DIGNITY AND HUMAN SOLIDARITY

A Dissertation

Submitted to the McAnulty Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Healthcare Ethics

By

Cyprian C. Duru

May 2022

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2022

A BIOETHICS CRITIQUE OF THE HEALTHCARE SYSTEM IN NIGERIA:

Personal Dignity and Human Solidarity

By

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ABSTRACT

A BIOETHICS CRITIQUE OF THE HEALTHCARE SYSTEM IN NIGERIA: PERSONAL DIGNITY AND HUMAN SOLIDARITY

By

Cyprian Chukwuemeka Duru (Rev. Fr.)

May 2022

Dissertation supervised by Rev. Fr. Peter Osuji, CSsp (Professor in Healthcare Ethics).

Life is a sacred gift, an indivisible good with an inherent dignity and value. Despite its uniqueness, fragility, vulnerability, and limitations, it remains the most interesting, attractive, and exciting thing one can possess. These attributes invoke a deep sense of respect to life. Recently, science and biotechnology have astonished the world, as they continue to disorient human consciousness on new set of ethical issues. In effect, life is seriously exposed to the perspectives of modern science and technology. Thus, President George W. Bush warns that the powers of science are morally neutral, capable for good and bad purposes. In the excitement of scientific discovery, humanity is not defined by intelligence alone, but by conscience. He then cautions that most of noble scientific ends do not necessarily justify every means.

Amidst all the scientific innovations and challenges, a new branch of moral philosophy has emerged, “*Bioethics*”. Bioethics in its multidimensional perspectives is capable to address most of the ethical challenges in modern medicine like decision-making, organ harvesting and transplant, scientific research with human participants, euthanasia, physician-assisted suicide, medical futility, withdrawal and withholding of treatments, death and dying, palliative care for a dignified end-of-life, etc. Therefore, against this background and to ensure that both bio(ethics) and medicine advance along the same pathway toward caring, promoting and safeguarding human life and health, this dissertation is specifically selected to envisage on: ***A Bioethics Critique of the Healthcare System in Nigeria: Personal Dignity and Human Solidarity***. The essence is to establish the need and urgency of the application of bioethical principles in places like Nigeria. This is to keep medicine true to its original moral objectives of curing diseases, caring for life and health, alleviating pains and sufferings, etc. Hence, medicine is a moral endeavor, a human project with discernible (bio)ethical principles and purposes.

Keywords: *Human Life, Bioethics, Critique, Healthcare, Nigeria, Personal Dignity, Human Solidarity*

DEDICATION

In special memory of my beloved parents, Benedict I. Duru (late) and Florence E. Duru, and to all those who with sincere hearts show unconditional love, respect and care to human life and dignity. Posterity has written your names in the golden history page.

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Any sign of an ambivalent attitude towards an act of benevolence can easily be considered as equivalent to insolence. This shows, as far as I am concerned, that expression of sentiments of appreciation to every good act is a noble virtue. Though, I may lack the proper words to articulate my feelings and sentiments, but for realization of this project, I would like to start with, first, to heap much of my praises, appreciations and thanks to God, who is the author of our life. Without my own personal efforts, He granted me this divine privilege to live my life as a human person, created in His own image and likeness, *imago Dei*. Thus, in all circumstances of my life and existence, I am strongly convinced and proud to state that “*God has not yet finished with me!*” I am so grateful to Him, the *Summum Bonum* of my life, the sole ‘Reason’ of my being and existence.

Also, I would not fail to acknowledge and appreciate the procreative roles played by my dear parents, Benedict I. Duru (late) and Florence E. Duru, to give birth to me. All through my life, you thought me how to love God and humans, respect and care for human life. Probably, this could be the major reason why I am studying and directly involved in caring for ‘life’ today. I love you so much, and I pray God to grant you, my dad, an eternal rest, and to my mom, a healthy living till a dignified end-of-life. To you my siblings, Geoffrey and Denis, I wish to let you know that the bond of affinity among us is so strong that no circumstances or vicissitudes of life can break it. You have always advised, encouraged and supported me, even when the chips are down. So, I remain very appreciative and thankful to you.

Equally, I am highly indebted to you, my Lord Bishop, Most Rev. Hilary P.O. Okeke

(Nnaora). Those who know you very closely, especially the knowledge of your personality of ‘who you are’ and ‘what you can do’, would prefer to address you as “*Nnaora*” (Father of all), a name given to you by the non-Catholics at a Parish in Ogbaru, in Onitsha Archdiocese, Nigeria, just immediately after your priestly ordination in 1974. Really, in all ramifications of your priestly and episcopal ministry, you have proved yourself beyond doubt to humanity as ‘Nnaora’. Coincidentally, you will be retiring as our and my Bishop on the 10th of February 2022, the same month (24th February 2022) I will defend my dissertation for a doctoral degree in Healthcare Ethics. You willingly accepted to send me to study Healthcare Ethics at the Duquesne University, Pittsburgh, Pennsylvania, United States. Please, accept my deepest appreciations, thanks and prayers. To me, the opportunity to study in America is just like a dream come true. The name of the human agent whom God used as my sponsor to realize this dream, ***Dr. Godwin O. Maduka MD, PhramD***, (The CEO of Las Vegas Pain Institute and Medical Centers), deserves to be mentioned. For more than two decades now, you have shown that you are a big uncle to me, who entered into my life, and decided to remain with me even when others are leaving me. Though, my words may be insufficient to express myself before you but be rest assured that I will not lack the time and a true God to commit all your petitions before Him, to grant you healthy longevity of life on earth and beyond. Indeed, you are second to none in my life. Thanks a lot, remain ever blessed!

At this point, I want to sincerely express my gratitude and thanks to the entire Duquesne family. History will not forget or omit the vital roles played by the following personalities with regards to my admission, studies and graduation at the Duquesne University: Linda L. Rendulic, Assistant to the Dean of McAnulty Graduate School of Liberal Arts, Michelle

Janosko, Ben Pilcher and Mary Berth Morrison (Office of the International Students), Glory Smith (my course advisor but retired), my professors, Prof. Hen T. Have (retired), Prof. Gerald Magill, Prof. Gielen Joris, and Rev. Fr. Peter Osuji CSsp (Professor in Healthcare Ethics and my Dissertation moderator). Your frenzied hours of diligence, critical analyses, knowledge and skills are proofs of your respective proficiencies in your areas of specializations. Apart from the office and class encounters with you, I learnt some of the most important lessons of life from you: dedication, punctuality, readiness to work, patience, simplicity, humility, humaneness, humorous, cheerfulness, etc. Without any deliberate intention to canonize you people as living saints, I am so confident with facts to say that you people are so wonderful to reshape me to a better personality today. Hence, I will not regret passing through this famous Catholic noble institution, Duquesne University. Of course, Duquesne University is now part of me, my home and family. I am so proud to be a member of Duquesne University as an alumnus!

Of course, simple words of appreciation can melt any heart of stone and can as well brighten someone's mood. Therefore, with immense pleasure and gladness, I would like to extend my gratification to you my mentor, Fr. Theo Ikemefula Iloh, friends like Rev. Frs. Lawrence Nonso Onyegu, and Felix Okeke, Meg Okosi, Ebele Okechukwu, Henrietta A. G. Ahenkorah, all my course mates, well-wishers, etc. Lastly, I want to convey my sincere appreciations and gratitude to those experts, alive or dead, whose works I consulted that served as references toward achieving this project. Even if I fail to remember all your names, both humanity and posterity will not fail to write your names in a golden tablet. To all of you, I have these following words for you: *Appreciation, Thanks and Remian Blessed!* To God be the glory!

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Chapter One

1.0. **Introduction: Meaning, Origin, Scope and Purpose of Bioethics**

An Overview:

Life is a priceless gift! For some decades now, humanity has been experiencing unprecedentedly rapid demographic transitions.¹ This is as result of numerous techno-scientific innovations, especially in the field of medicine. No doubt, the use of the modern scientific technologies has both the positive and negative side effects to human life. Amidst all these scientific developments, the fear of the unknown with regards to human life in the future has made the term “Bioethics” to gain more prominence as it is widely used today. Precisely, its main concerns include the objective appraisal or assessment of how human values, desires and activities are likely to affect human life, other living things and the environment at large. In this respect, I personally agree with Michael W. Fox who is convinced that a healthy humanity ought to be more compassionately concerned on how it acts toward its own kind, to other sentient beings and the Earth itself. Thus, it should show respect for all life, avoid any actions that can harm itself or destroy the entire human society. He then concludes that, it is possible within the field of Bioethics to engage into a kind of ‘self-investigation’ and ‘enlightened self-interest’, in order to provide a foundation to establish proper meaning and protection to human life.²

1. 1. *Meaning and Origin of the Term “Bioethics”*

Etymologically, the term *Bioethics* is derived from two Greek words, ‘bios – life’ and ‘ethos – behavior, habit or custom’. Literally, it means life ethics. Historically, in the year 1926, Fritz Jahr used the term ‘Bioethics’ in the article on “bioethical imperative” that focuses more on the use of animals and plants in scientific research.³ Similarly, Van Rensselaer Potter borrowed

the term in 1970, to make some clarifications on the relationship between the biosphere and the growing human populations. It was this Potter's work that laid the foundation for what is known today as 'global ethics' – a new discipline that makes connections between biology, ecology, medicine, and human values.⁴ However, another opinion from Robert Martensen has attributed the invention of the term to Sargent Shriver. According to him, Shriver claims that he had invented the word "bioethics" in his living room, precisely in Bethesda, Maryland in 1970. Hence, it was after a discussion at Georgetown University with other experts, a possible Kennedy family sponsorship of an institute, he reflected on the term that would suggest the application of science and moral values to real concrete medical dilemmas.⁵ Therefore, bioethics for me, is the intersection between science and ethics.

Besides, there is no consensus on the meaning of the term 'Bioethics'. It is still fraught with a lot of ambiguities as it is always criticized of the insatiability of definitions, scope and purpose. According to Warren T. Reich, bioethics is defined as a systematic study of human "conduct in relation to the life sciences and health care. Indeed, such a study should be evaluated and reviewed in the light of moral values and principle."⁶ For people like Van R. Potter, an ethics that inspires moral actions ought not ignore facts that are established through biological knowledge. Thus, he conceives Bioethics as a discipline that builds bridges, i.e., a link from the present culture to new or future cultures, between facts and values. Also, it can be considered as a discipline that appears as inter- or multidisciplinary. This is because it is more particularly broad both in range and scope of ethical issues it addresses and the resources it uses to do so.⁷ Moreover, with his apocalyptic conception, Potter refers to 'Bioethics' as the "Science of Survival." In this light, he identifies Bioethics as a wisdom that brings "knowledge of the use of other knowledge," or a kind of meta-science of the good use of science and biotechnology.

Automatically, its good applications would ensure the survival of human species and the improvement of quality of life in general⁸, for both the present and future generations.⁹

Furthermore, Potter never lacks words to see in Bioethics as a “new ethics,” and “interdisciplinary ethics.” With its “interdisciplinary” nature, Bioethics can easily include other sciences and humanity within its scope of activities.¹⁰ Moreover, Potter combines these aspects “meta-, inter- and multi-” as wisdom of “scientific knowledge to balance ethical relations with other knowledge”.¹¹ He rightly noted that, such a profound knowledge of Bioethics is needed since human ethics cannot easily be separated from a realistic understanding of ecology in the broadest sense. Likewise, ethical values cannot be separated from biological facts. Therefore, there is a great need for Land Ethic, Wildlife Ethic, Population Ethic, Consumption Ethic, an Urban Ethic, an International Ethic, a Geriatric Ethic, etc. With due respect to personal dignity and human solidarity, all these call for actions that are based on moral or ethical values and biological facts.¹² As a life ethics, Bioethics is still a holistic philosophy, that gives equal and fair consideration to the concerns, interests and rights of humankind, animal kind and the environment. It can as well provide an objective, a compassionate and an empathetic basis for humans to live in the society in terms of public policy, corporate responsibility and professional integrity. Basically, Bioethics can be said to embrace two major ethical principles. The first principle is known as ‘ahimsa’ or nonmaleficence, i.e., the avoidance of causing harm to life and environment. Also, the second principle refers to transgenerational equity, i.e., the concern for future generations.¹³

1. 2. *Scope and Purpose of Bioethics:*

With regards to the scope and purpose of Bioethics, Albert Jonsen succinctly indicates five major topics which deserved preferential attention in the

contemporary bioethics. They include, research with human subjects, genetics, transplantation of organs, reproduction, the concept of death and dying, etc.¹⁴ He equally notes that it is as result of accumulation of concerns related to the ambiguities of modern science which gave birth to the new ways of bioethics.¹⁵ This then leads to broaden its scope of responsibilities by incorporating concern for all life, modern scientific activities and environment.¹⁶ For some scholars like Daniel Callahan, Bioethics represents a shift or radical transformation within the domain of medical ethics. It is not just an intersection of ethics and the life sciences, but also an academic discipline, a political force in medicine, biology, environmental studies and their related side effects.¹⁷ Thus, the advent of bioethics stands as principal response to ethical challenges related to the innovations in scientific medicine.¹⁸ In other words, the field of scientific research with human subjects constitutes the primary condition for the emergence of bioethics. However, its mains objectives are not far from guiding proper justifiable paths toward where technoscientific developments may tend to lead the modern world.¹⁹ Today, with its scope and objective as a discipline, Bioethics is highly appreciated not only by the scientists, but also by the physicians and other experts from different fields of study.²⁰

Relying on its meaning, scope and objective, it becomes very glaring that Bioethics is closely related to Medical Ethics, but still with much of differences in scope and purpose. In this sense, Stephen Holland succinctly remarks that the latter falls within the field or branch of the former. According to him, therefore, Bioethics is much broader both in its scope and objectives. Though, it is still mainly within the domain of philosophy, and its development will continue to influence the new medical ethics.²¹ It then suffices to add that Bioethics generally deals with theoretical ethical issues and concepts surrounding all biomedical technologies, such as cloning,

stem cell therapy, xenotransplantation, research with humans and animals, etc. As an interdisciplinary ethics with a diverse range of professional backgrounds, Jeffrey Spike insists that the fields of bioethics need to include other experts like scientists, philosophers, doctors, sociologists, lawyers, theologians, etc.²² With these experts, Bioethicists will be able to address a broad swathe of human inquiry, ranging from debates over the boundaries of life like the issues of abortion, euthanasia, withdrawal and withholding of treatments, palliative care, death and dying, ecology, etc. Other issues include surrogacy, the allocation of scarce health care resources (e.g., organ donation, health care rationing) and the right to refuse medical cares.²³

Besides, the term “medical ethics” is often used to refer to the deontology of the medical profession, which emphasizes more on moral values, rules of etiquette and professional conduct. The word “deontology” is derived from the Greek root “deon” which simply means to a kind of duty or an obligation. So, medical ethics can be understood as the study of moral values and judgments as they apply precisely to medical or clinical practices. At the same time, it can boast of the four main moral commitments or ethical principles which include: *autonomy*, *beneficence*, *nonmaleficence*, and *justice*. According to Raanan Gillon, these principles are of paramount importance to guide and assist physicians to make justifiable ethical decisions in clinical settings.²⁴ In effect, medical ethics is more specific and focuses on the medical treatment of the sick. Thus, it is nothing but ‘patient-oriented’ or ‘patient-centeredness’.

With the above analysis, the study of Medical Ethics should focus more on the analysis of concepts such as the models of doctor-patient relationship, competence, autonomy, beneficence, compassion, personhood, quality, dignity and sanctity of life, best interests, just resource allocation, etc. This is because the preservation of human dignity and the prevention of indignity are obligations built into the ends of medicine. Of course, these ends that center on

patient's well-being are ultimate, intermediate, and proximate. Ultimately, medicine aims to restore health; and intermediately, its aim is to cure, ameliorate, or prevent illness, pains and suffering. Most proximately, it aims at making right and good ethical decisions in critical ill situations.²⁵ Therefore, the work of the contemporary Medical Ethics is believed to build on that of Bioethics to ensure good and proper medical practices in order to eliminate avoidable medical malpractices or errors. At the same time, Bioethics is richly improved scientifically, clinically, legally, theologically and philosophically well informed.

1. 3. *Application of Bioethics: Personal Dignity and Human Solidarity:*

Suffice it to affirm that the emergence of bioethics is never out of surprise. This is because the concept of personal dignity and the principle of human or social solidarity play major roles in the contemporary bioethics.²⁶ Speaking on the personal dignity, David A. Jones refers to the Latin *dignitas*, which is related to *decus* (decent, decorous), and it also connotes fame, honor, or glory.²⁷ This dignity has its divine origin from God, since each person is created in the God's own image and likeness, *imago Dei*.²⁸ Worthy of note is that, there are five major paradigms of personal dignity – moral, spiritual, rational, social and human dignity in the strict sense. Each of these paradigms has contributed, directly or indirectly, to shape the irreducible worth of the dignity of human person. Of course, the ideas of dignity and respect for persons are inherently related. Thus, dignity is an inalienable or essential intrinsic quality that can never be separated from human personality. It can as well be conceived that the intrinsic value of human dignity is the foundation of all human rights. As such, the Catholic social teaching principles and any other moral obligations that can influence the new Bioethics and health care activities.²⁹ So, it is not by chance that the acknowledged “dehumanization” of contemporary medicine reigned

the initial drive toward the birth of bioethics. Hence, Bioethics is introduced as a response to legitimate concerns regarding the future of human life or entire humanity in general.

Similarly, the principle of solidarity has recently been gaining more prominence in bioethical theory and practices, especially in the area of public health and global health debates. According to the UNESCO Declaration, this principle is used in terms of mutual cooperation among different peoples at all levels, both locally and globally.³⁰ In other words, solidarity among human beings demands absolute co-operations.³¹ Within the context of bioethics, solidarity ought to be understood, not only as social concept, but also as a moral value. As a moral concept, it implies a sense of non-calculating cooperation based on the identification with a common cause or backgrounds. Also, in the thoughts of Rahel Jaeggi, solidarity remains one of the three ‘moral patterns of recognition’ which are very essential to self-realization: love, rights, and solidarity.³² This suggests a kind of group-oriented moral to act toward obligations in taking proper care of the weak, aged, sick or vulnerable persons in the society. Hence, solidarity means not only a vertical and episodic interventions, but genuinely it also represents more of cooperative relationships that may contribute to effective improvement of the life of individuals, groups and nations.³³

Just as all humans share the same identity as persons of the same collectivity, then, they ought to feel a mutual sense of belonging and responsibility.³⁴ Logically, solidarity in this sense is nothing but a ‘humanitarian solidarity’. Thus, it is a true expression of an ethics of conscious responsibility or commitment, a sense of responsibility towards the most vulnerable in the society. As such, it is not based on self-interest but on the interest of others which motivates the mutual cooperation among peoples and nations.³⁵ Acting out of solidarity means ‘standing up for each other, because one is conditioned to recognize one’s own fate in the fate of the other.’³⁶ Very

interestingly, the Universal Declaration on Bioethics for Human Rights (UDBHR) has succeeded to connect the concept of personal dignity to the principle of human solidarity.³⁷ In this regard, the fundamental objective of the UDBHR is ‘to provide a universal framework of principles’, in order to promote respect for human dignity in all activities related to human life.³⁸ At this juncture, Henk Ten Have rightly opines that, solidarity is more or less something ‘among and between’ human beings. This assertion indicates that wherever solidarity is found, a positive expression is at the same time given to human dignity. It then follows that, wherever these principles or norms are respected, therefore, people ought to be treated with an unreserved respect for personal dignity.³⁹

Reflecting on Bioethical issues, Gabriel Tordjman referred to certain revelations of unethical experiments with humans like the Nazi experiments and the impending danger of recent scientific innovations, as a propelling force that enabled the growth of bioethics.⁴⁰ Affirming this position, Edmund Pellegrino then alludes that what is known today as ‘Bioethics’ started just some years after the end of World War II. At the early stage of Bioethics, it all began as a movement, but its primary objective is aimed at “humanizing” all the scientific research activities with humans, medical education and clinical practices.⁴¹ As it continues to gain more prominence in the recent decades, bioethics is now challenged to deal with the ethical issues or implications of biological and medical practices, research with humans and new technologies. In other words, it suggests the application of ethical reasoning or “wisdom” on moral values to the ethical dilemmas, questions and other issues related to biological and medical science.⁴² Therefore, the drafting work of the Universal Declaration of Human Rights was largely inspired by the discovery of the horror of concentration camps, where prisoners were used for brutal medical experiments. As George J. Annas points out that, the

World War II was “the crucible in which both human rights and bioethics were forged, and they have been related by blood ever since”.⁴³

Furthermore, this idea of human dignity in this context cannot be compatible with the instrumentalization of human beings. This kind of instrumentalization involves illegal and unethical commodification of the human parts or organ sales, and surrogate motherhood. Though, in varied contexts, it is not surprising that the term “dignity” could be used to support different and even opposed views on euthanasia or assisted suicide.⁴⁴ Faced with such controversial ethical dilemmas, the roles of Bioethics and morality become very imperative. In relation to their proper roles, Margalit Avishai makes the distinction between *Bioethics* and *morality*. According to him, while ‘Bioethics’ may be so much concerned about *thick* relations between persons, i.e., the relations that call for justifiable ethical actions, ‘morality’ then regulates the *thin* relations which express great concerns for humanity. So, providing proper care for the vulnerable individuals in need is a more of a moral obligation that will not only support their health and other needs, but will also keep them included in the society. Such cares for them should be properly and ethically justifiable. This is what Margalit conceives as *shared humanity*.⁴⁵

At the center of traditional African morality is the respect to human life which is a priceless divine gift. Thus, the sacredness of human life and human worth form the fundamental values and pillar of bioethical thinking in Africa, especially in Nigeria.⁴⁶ In effect, any ‘African bioethics’ in this context should attempt to revolve around harmonious coexistence with the cosmos and the promotion, defense and protection of life. This implies collaborative efforts to maintain the integrity of the human species, protecting the dignity of each person, protecting nature and its diversities.⁴⁷ As earlier noted, it is this respect for personal dignity supported with

the principle of human solidarity that triggered for the emergence of bioethics due to series of public revelations of gross abuses on human life. Just like in any other developing nations, the rise of bioethics in places like Nigeria is not far from a product of great concerns to life.

Today, the Nigerian health sector is currently and seriously facing significant bioethical challenges that continue to pose a big threat to life, health and environment. These challenges range from the decisions at the beginning and end-of-life in the clinical settings, the use of modern scientific equipment to alter the course of life, the issues regarding research with human beings, too much of terrorism, body injuries due to accidents, mental disorders, poverty, high rate of disease outbreaks, morbidity and untimely mortality, etc.⁴⁸ All these, no doubt, can directly or indirectly, devalue the dignity and value of life of a human person. As Nigeria is currently working towards achieving the Millennium Development Goals and Sustainable Developmental Goals respectively, it is very necessary to address them using Bioethical principles to ensure support of stability in this part of the globe.⁴⁹ In other words, it beholds on Bioethics to address these challenges that pose great threat to life and environment, especially in Nigeria. Hence, there is an urgent need to provide the proper bioethical procedures that will respect the autonomy and rights of patients both in clinical practices and in scientific research with humans in Nigeria.⁵⁰

Nevertheless, it is against the backdrop of the above Bioethical issues with special reference to Nigeria, that prompted this dissertation to focus on: ***A Bioethics Critique of the Healthcare System in Nigeria: Personal Dignity and Human Solidarity***. Also, it is very necessary to note that, the term ‘critique’ in this context should not only be conceived within the realm of negativity. Instead, its usage portrays a sense of ‘ethical review’ of the nation’s health care system. Such a critical review is intended to provide the best opportunity to make certain

ethical recommendations towards improving the country's healthcare system, for better clinical practices, research with human participants, etc. Suffice it to note that, for the objective of this dissertation, the term "Healthcare system" is not just about the monumental structures or hospital complex edifices in bricks. Rather, it simply refers to the western-style medicine, to the exclusion of African Traditional Medicines. According to Potter, it is high time to apply bioethical reasoning or "wisdom" and moral values to dilemmas in clinical medicine, questions and issues raised by the multiple innovations in biological and medical science.⁵¹

To Actualize the dream of this academic adventure, the entire corpus of this dissertation is divided into seven major chapters with subsequent sections and subsections, respectively. Chronologically, chapter one which is the introductory section of this work focused more on the term "Bioethics". So, the introductory section delves into providing the meaning, origin, scope, purpose and application of Bioethics, in relation to the concepts of personal dignity and the principle of human solidarity. More details on these two concepts (including African / Nigerian perspectives) will be provided in the subsequent chapters, precisely in chapters two and five respectively, just to satisfy certain curiosity. Standing solidly on the arguments provided in the introduction, the focus in chapter two (2. 0) is more on 'Human Life' and 'Clinical Medicine'. Of course, the concept of 'dignity' of human life is the pivotal point of discussion in this research. This is because, life is a sacred gift, of great intrinsic value and dignity,⁵² and should be respected and cherished as well.⁵³ In this light, section (2A. 0.) engages on the 'Explication of terms', while its subsections will expatiate on the following notions: (2A. 1. 0.) – 'Human life: Origin, Meaning, Dignity and Rights'; then (2A. 2. 0.) – 'Human Person in the Multicultural society'; and lastly, (2A. 3. 0.) – Medicine: Fundamental Goals and Ethics. Again, section (2B. 0) deals on the need of 'Clinical medicine for human life'. Thus, subsections of (2B.

0) is dedicated to reflecting on the following issues: (2B. 1. 0.) – ‘Human life and frailty’; (2B. 2. 0) – ‘Sickness and Medical decisions at the End-of-life’; and lastly in (2B. 3. 0) – ‘Basic ethical requirements for Decision-Making’.

In chapter three, the expectations center on the possibility of (3. 0) ‘Medical Care in a Multicultural Society’, using Nigeria as a case study. Of course, any pluralistic society is likely to be characterized with intense ethnic polarizations, tensions, struggles and endless strife among the peoples.⁵⁴ In effect, section (3A. 0.) of this chapter is very much concerned to focus on: ‘Nigeria: A multicultural and ethnic Pluralism’. At the same time, its subsections did well to deliberate on the following points: (3A. 1. 0.) – ‘Nigeria as an Independent nation’; (3A. 2. 0) – ‘Nigeria: A nation with multiple Ethnic Tribes’; and then, in (3A. 3. 0) – ‘Nigeria and Medical Practice’. Similarly, (section 3B. 0) preoccupies itself with the review of actual situation in the ‘Nigerian Health Care System’. The main objective is to boost every harmonized effort towards reviving the entire health sector, to ensure proper quality care for all the citizens in Nigeria.⁵⁵ As the emphasis is primarily limited to the western-style medicine, subsections will endeavor to make an ethical critique on: (3B. 1. 0) – ‘The Existence of Health Care System in Nigeria’; (3B. 2. 0) – ‘The Major Challenges in the Nigerian Health System’; and lastly, in (3B. 3. 0) ‘Ethical Solutions and Recommendations’ to promote the patient safety.

Likewise, chapter four of this dissertation makes a kind of connexion between theory and praxis. Thus, it will attempt to engage on deliberating on: (4. 0) ‘The Principle of Autonomy and Abortion Dilemma in Clinical Medicine’. According to the principle of autonomy, a competent patient in good mental and cognitive state or sound mind, has the right and responsibility to make medical decisions concerning his or her own treatment options.⁵⁶ Even at that, a qualified physician still has the moral obligation not to trespass or go beyond the ethics of

medicine.⁵⁷ In other words, a physician should not always yield to the patient's requests, especially when such requests are not medically indicated, ethically justifiable, or not compatible with the principles of biomedical ethics. Theoretically, (section 4A. 0.) will concentrate on "The concept of Autonomy in Physician – Patient Relationship". This is the sole reason while its subsections presented some details on the principle of autonomy thus: (4A. 1. 0.) – "Autonomy: General notion, Scope and Ethical conflicts"; (4A. 2. 0.) – "Autonomy and Models of Physician – Patient Relationship", and then, in (4A. 3. 0.) it discusses on the possibilities "Towards Balancing the Patient-Physician Relationship". Absolutely, I concur with the ethicists like Edmund D. Pellegrino, who see the urgency and a great need to balance such relationships, since both the personal and professional ethics are always inseparable in clinical medicines.⁵⁸

In more practical terms, (section 4B. 0.) presents the main points of discussion on: "The Abortion Dilemma: Legal and Religious Perspectives". Worthy of note is the concept of abortion which is one of the controversial ethical issues for hot ethical debates that keep on dividing peoples, today. This is because, life is at stake, and it involves, according to Charles C. Ryie, a deliberate act of expulsion of the human fetus incapable of self-dependency or survival outside the mother's womb,⁵⁹ or without any possible viability as a qualifier.⁶⁰ It then becomes very necessary that its subsections would approach the same term thus: (4B. 1. 0.) – "Abortion: The meaning, Brief History and Basic Factors of the Concept"; (4B. 2. 0.) – "Ethical Controversies and Indications for the Legalization of Abortion"; and (4B. 3. 0.) – "Abortion: Religious Perspectives and Ethical Review".

Besides, every medical activity is to ensure proper care to human life. This can be realized once there is a great respect for 'personal dignity' and acting with the spirit of 'human solidarity' in medicine. To this effect, chapter five (5.0) of this dissertation considers the

“Dignity and Solidarity in Medicine”. In section (5A. 0.), the major ethical issue or topic to deliberate upon is “Medical Genetics and Research with Human Subjects”. Based on the ethical principles, genetic services like other medical services, can realize its objective provided all procedures are in accord with the peoples’ best interests, wishes, values, preferences, etc.⁶¹ Therefore, its sub-sections concentrated more on (5A. 1. 0) – “Genetic Testing and New Eugenics”; (5A. 2. 0.) – “The Meaning and Purpose of Research with Humans”; and finally, in (5A. 3. 0.) – “Scientific Medical Research: The Relevant Ethical Principles”. Still on the concept of dignity and solidarity in medicine, section (5B. 0.) pays a great deal of attention on the principle of “Beneficence and Compassion” as the moral imperatives in clinical medicine. These concepts can place moral obligations on caregivers to engage in those activities that will benefit or respect the best interest of the patients.⁶² Therefore, in more details, the subsections of (5B. 0) basically argue thus, in (5B. 1. 0.) – “The Principle of Beneficence” as the basis for patient safety and quality care; in (5B. 2. 0.) – “The Role of Compassion and Solidarity in Care Ethics”; and lastly, in (5B. 3. 0.) – “The Professional Moral Obligations and Duty for ‘Patient’s best interest”.

Evidently, Bioethics will always refer to the personal dignity of each person and human solidarity in medicine practice, especially while caring for others. As such, chapter six (6.0.) of this work deals with an ethical critique on the: “Ethical Tensions between Individual Dignity and Human Solidarity”. The objective is to elucidate some possible inhuman and unethical collaborative activities in medicine and inhuman conditions in the area of public health that can raise some doubts or create ethical tensions on the respect to personal dignity. For instance, as I reason with Kelly A. Keller who remarks that, the unethical inhuman activities related to organ trade, donations and transplantation can lead to effecting pains and injustice, or violation of life, rights and dignity.⁶³ In effect, section (6A. 0) reflects on the issue of “Organ Commercialization

and Ethical issues of Public Health”. Moreover, the followings are the major ethical issues discussed in subsections of (6A. 1. 0.) – “Organ Trade: An affront to Human Life, Dignity and Rights”; (6A. 2. 0.) – “Public health crisis and health security: Nigeria as a case study”; and in (6A. 3. 0.) – “Recommended Ethical Solutions”. Following the same trend, section (6B. 0.) attempts to make ethical clarifications on “The issue of unjust Mortality and Medical Futility in Clinical Practice”. Meanwhile, subsections consider some salient ethical issues in their respective titles thus: (6B. 1. 0.) “The Concept of Death and Dying”; (6B. 2. 0.) – “Clinical Deaths” as in the practice of euthanasia and physician-assisted suicide, and in (6B. 3. 0.), the issue of “Medical Futility” in relation to enhancement of palliative care with the application of the ‘Tronto Models’ of care, for a dignified end-of-life.

Lastly, chapter seven (7.0) of the entire work of this dissertation is the “Conclusion”. In the final analysis, this section continues to lay more emphasis on the intrinsic value of human life and dignity of each person, as a being created in the image of God. Automatically, a good understanding of this position is likely to influence every bioethical activity that can promote and show great concern, care and respect to life, especially in Nigeria. Reflecting on the moral obligations in bioethics as human enterprise, Charles Kammer rightly notes that moral values are more basic than all other values. This is because moral values can touch, not just on what human beings can do, experience or possess, but on their ontological ‘essence-of-being’ as rational beings.⁶⁴ In effect, as far as *human life* is at stake, I have it as a moral obligation to emphasize that the *dignity* of human person should be highly recognized in all bioethical practices that relate to life, health and environment. Lastly, cognizant of the fundamental roles of principle of human solidarity in biomedicine, I also dedicate this section to proffer some basic ethical solutions or recommendations to address some of the bioethical challenges related to human life

and care, especially in a pluralistic setting. Hence, this is objective of the dissertation: “A

***Bioethics Critique of the healthcare system in Nigeria: Personal Dignity and Human Solidarity*”.**

Endnotes

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Introduction

A critical mind may not be so fast to discuss about ‘human life’ without first attempting to understand the concept of life on a broad sense. The concept of life, which stands for “*ndu*” (Igbo), “*aye*” (Yoruba), or “*rayuwa*” (Hausa), is conceived by Michael Mautner as a process rather than a substance.⁶⁵ Life can be defined depending on the aspect one views it, and the purpose the definition tends to satisfy, as in the decision to declare a human being dead, either clinically or legally. In this light, I would easily agree with Alexander M. Capron who is convinced that such definitions may serve as proofs in all legal ramifications in the court of law.⁶⁶ Likewise, some experts from various fields have come to the conclusions on the meaning of life, which may patch with the following convictions that: Life is a matter, system, chemical (metabolism), complexity (information), (self-)reproduction, evolution (change), environment, energy, ability, etc.⁶⁷

Although, multiple definitions of life are abounded, but people like Edward N. Trifonov is very much comfortable with just one of them. Thus, life is simply defined as a ‘matter’ with the potentialities to reproduce itself and evolve as survival dictates. In other words, life may be understood as a characteristic of something that preserves, develops or reinforces its existence in any possible lively environment.⁶⁸ By using the terms like ‘matter’ and ‘characteristics’ to define life, makes people like me to have a rethink that ‘life as an intangible thing’ can only be found or expressed in a thing. In effect, every living thing is expected to exhibit the following living characteristics or traits:

- i. *Homeostasis*: This refers to ability to regulate its internal temperature with the outside to maintain a constant state, e.g., ability to sweat for temperature control.

- ii. *Organization*: Each living is structurally composed with a least one or more cells – as the basic units of life.
- iii. *Metabolism*: It suggests the capacity to undergo transformations of energy by converting chemicals and energy into cellular components (anabolism) and decomposition, otherwise known as ‘catabolism’.⁶⁹
- iv. *Growth*: This is very essential in every living thing to maintenance of a higher rate of anabolism than catabolism.
- v. *Adaptation*: This implies that a living thing is not so static in nature but has a dynamic capacity to change over time in response to the environment. It invokes the process of evolution that can be determined by heredity, food consumptions, and external factors.
- vi. *Response to stimuli*: Each living organism has the capacity to stimuli depending on the senses of reaction (as in unicellular organism, it is contraction), but multicellular organisms, it is complex). Most often, such responses are expressed by all kinds of motion, e.g., the leaves of a plant turning toward the sun (phototropism) and chemotaxis.
- vii. *Reproduction*: To ensure the continuity of its existence, each living organism is capable to produce younger ones, either asexually from a single parent organism or sexually from two parent organisms.⁷⁰

Most people still favor the definition that life is an intangible thing or matter with the potentialities to reproduce itself and evolve as survival dictates in the environment.⁷¹ It is very necessary to reaffirm that the discussions in this dissertation will be limited mainly in reference to human life, dignity and its relationship to human solidarity in medicine.

2A. 0. Explication of Terms

2A. 1. 0. *Human Life: Origin, Meaning, Dignity and Rights*

The life of a human person is highly regarded and valued as being exceptional when compared to other creatures. This is because, according to the creationism, which is strongly influenced by the ‘Intelligent Design Theory’, there is a supernatural being known as Supreme God or “Chi-ukwu” (Igbo), “Olodumare” (Yoruba) that is responsible for all lives.⁷² So, the destiny of each person depends on his or her personal relationship with the creator and giver of life – God. Also, Rojas holds that each species is predetermined and immutable, this implies that evolutionism is an illusion.⁷³ Most importantly, it is this notion of intrinsic worth and dignity of life that makes it to be the pivotal point of focus in the caring relationships and dependencies among humans. This is because, according to the above popular opinion and belief, David F. Kelly et al., establish that ‘human life’ bears its divine origin to God. Indeed, it is a sacred gift, of great intrinsic value and dignity.⁷⁴ Hence, a wider critical analysis of these assertions is highly recommended toward better understanding of human life in this context.

2A. 1. 2. *Life is a sacred gift*

Life is a sacred gift from God. According to the Christian Holy Bible, man became a living being by the breath of God.⁷⁵ Hence, each person is a being created in God’s own image and likeness. This divine image is ever present in every person, and it continues to shine forth in communion with others, in the likeness of the unity of the divine persons among themselves.⁷⁶ In addition, since each person is endowed with a spiritual and immortal soul,⁷⁷ man is seen as the only creature in the universe that God has willed for its own sake. Theologically, Austin Flanery concludes that from conception, man is destined for eternal beatitude.⁷⁸ The concept of life for a

traditional African person is not different from the above belief. Life in the African cosmology is summarized by Francis Njoku with just few points. Firstly, he affirms that God is the originator of life, the creator of man, the universe and the sustainer of creation.⁷⁹ Secondly, he rightly points to the fact that the ancestors play a very important role in man's communal life with others. According to him, there is a strong bond between the living and the dead. Such a bond is possible due to the social interactions of dependency and communal aspects of the peoples' ways of life.⁸⁰ This shows that the latter are not cut off from the living, as they continue to reveal themselves even in dreams, visions, or can appear to their living relatives for sustenance, guide or corrections.⁸¹ Thirdly, just as already noted, life is a communal or social affair. It involves an interrelationship or communion between God, man, ancestors, divinities, other persons and the land itself. Such a bond, according to Francis Njoku is based on the already established relationships that are based on certain cultural rules and regulations for it to exist.⁸²

Suffice it to add that Africa as a whole and Nigeria in particular, have a good understanding of the concept of life. Metaphysically, life is a mysterious divine gift, with special intrinsic dignity, value and respect.⁸³ This is because, each person is a composite of soul and body. Among the Yorubas, Akans and Igbos, this personality soul, otherwise known as 'chi' (Igbo) is derived from the Supreme Being, God. In Igbo cosmology, the concept of 'chi' has many connotations. The word 'chi' can be used to refer to 'day or daylight' or those transitional periods between day and night or night and day like 'chi *ofufo*' meaning daybreak or 'chi *ojiji*' that stands for nightfall. In this context, the term 'chi' is better understood as an 'an operative principle, a personal god, guardian angel, soul, personal spirit, spirit-double, etc., in each person, which has some effects on one's psyche and self-actualization.'⁸⁴ This is what Ralph O. Madu believes to be a personal god – *divine afflatus* – the animating spirit of each individual being.⁸⁵

Also, notable scholars like Theophilus Okere remark that “chi” is a personal god or “a unique life force”⁸⁶ that is infused by the Supreme God into every living person.⁸⁷ This is continuous in the creative process, but the ‘chi’ can be recalled back to ‘Chi-ukwu’ at death.⁸⁸ This justifies the Igbo principle of individualization, as each person is unique and irreplaceable.⁸⁹ Within the African worldview, nothing as such happens in the physical realm by mere chance, i.e., the philosophy of *entelechy*. In addition, Patrick Iroegbu buys the same idea that it is the spiritual (metaphysical) that holds as the bedrock of the physical world.⁹⁰ Amidst the plethora of determinism, it is believed that this metaphysical determinism is the foundation for human ‘destiny’, which is the life-line pattern of each person. Among the Igbo people, thus, it writes “akaraka onye na-edu ya” (one’s destiny is his or her guide). The people also believe that “akaraka anaghi eme nhicha” which means one’s destiny is immutable or cannot be wiped off”.⁹¹ With the above explications on the term ‘chi’, I can boldly aver that some Igbo names bear different expressions for different persons. For instance, ‘Chika’ (*chi* is supreme); ‘Chibuzo’ (*chi* leads or goes before humans); ‘Lebechi’ (look unto *chi*), etc. Thus, each personal ‘chi’ is very unique and cannot be duplicated, as there are no two persons that can possess the same “chi”, because no two persons are identical. This justifies the Igbo principle of individualization, as each person is unique and irreplaceable.⁹² All these beliefs confirm the general primacy of *chi* over other things, and it is believed that this ‘chi’ is responsible for human destiny or one’s trajectory of existence to the realm of the ‘unknown’ or world beyond.⁹³

Even at the point of death, Africans believe that life is not yet terminated. Hence, death becomes an entry into the community of the departed, and finally an entry into the world of the spirits.⁹⁴ This implies that, God created humans with the potentialities of passing through all these stages of life with varying degrees according to cultures, time and place. As a social being,

Kofi Opoku strongly holds that a person exists in the context of others, and to live is to be in union or in togetherness with others. He then notes that, a life that advocates for any form of isolation or absolute individuality is not only against the human nature but may seem as an unimaginable reality or animalistic.⁹⁵ This implies that, God created each person as a social being with the potentialities of passing through all the developmental stages in life. Every human being is expected to pass through them, although they may vary according to cultures, time and place. Thus, an ‘individual’ person cannot achieve much or realize one’s full potentials in life without the support of others.⁹⁶ By my own logical conclusion, Theophilus Okere’s understanding of an ‘individual’ as a ‘social being’ highlights in the context of this dissertation, the concept of ‘human solidarity’ or ‘interdependency among peoples. Therefore, the life that begins at conception, celebrated at birth, lived among others, always comes to an end at death.⁹⁷

With the above analyses, it is now so glaring that life belongs to God. As such, every created person, whether acting as an individual or in group, is a steward or custodian to God-given life. This implies that, in every human activity, especially bioethical activities, each person should uphold and respect the sanctity of human life at all stages. In effect, any voluntary termination of life, either with the reason to relieve pains, sufferings or other inconveniences, it is not only ethically unjustifiable and unacceptable but a serious profanatory of the sacredness of life. Such act violates God’s clearly defined natural law and its moral orders. In this light, suffering should not be a reason to end one’s life, deliberately. Even in critical human conditions or illness, each person’s life still belongs to the owner of life, God.⁹⁸ Indeed, no human person has absolute power or authorization, autonomy or control over one’s own life. All lives should be respected, cared for, cherished, defended and promoted. At this juncture, I still maintain that any deliberate termination of life, either with the reason to relieve pains, sufferings or other

uncomfortable inconveniences in life, does not stand the test of any ethical, legal or moral reasons and justifications. Such is a mortal sin against God, extreme evil or wickedness against fellow humans, and a serious crime against humanity or society. In this light, some people should have a rethink and be convinced that suffering should not be considered as a major reason to end one's life, deliberately. No matter the condition or state of life, each person's life still belongs to the author of life, God.⁹⁹ Indeed, no human person has absolute authority, autonomy or control over one's own life. All lives, both one's life and other peoples' lives, are to be respected, cared for, cherished, defended and promoted at all costs.

The above position on human life is equally appreciated by the United States Conference of Catholic Bishops. Indeed, these hierarchical Church leaders are of the opinion that all human beings are 'ends' in themselves, that need to be cared for and served, but not just as 'means' to be exploited and whose lives can be deliberately terminated regardless of the objectives.¹⁰⁰ As such, personalism grew up as a reaction against the intellectual and social trends that never considered, neither the sanctity nor the dignity of man. Most of which were perceived as inhumane or dehumanizing. Therefore, this suggests that in dealing with other human persons, a sense of sacredness and respect in the quality of each person, should highly be emphasized.¹⁰¹

2A. 1. 3. *Life is of great intrinsic value:*

Life is an irreplaceable value. The intrinsic nature of human life is traceable to its divine origin. According to Donald Winnicott, lack of proper meaning and the loss of the feeling for human life are the beginning of a destructive process in which the awareness of the value of life is disrupted. He rightly remarks that life is a process. This implies that, at all stages of human

existence, each person should always bear in mind that life has an irreplaceable intrinsic dignity and value because it is the product of creation by God. So, any life that is devoid of such profound knowledge and understanding is not worth living.¹⁰² With regard to what makes life worth living, Bernard Stiegler stresses that due to its intrinsic dignity, value and fragility, life needs much attentive care. All these provide the key to value and show of respect to human life.¹⁰³ In relation to recent developments in modern science and technology, Stiegler notes that both are capable to improve and destroy human life at same time.¹⁰⁴

Among all the known values in the world, either collective or personal, Emil Visnovsky insists that human life is the most valuable thing a person can possess in life. For him, life remains the most valuable, interesting, attractive, and exciting thing. Despite its vulnerability, fragility, uniqueness and limitedness, life remains the only one and ultimate thing.¹⁰⁵ Meanwhile, for the objective and best interest of this dissertation, the focus will be on the intrinsic value of human life at the expense of other values. This intrinsic value of life is considered as a fundamental concept of axiology, which refers to the philosophical study of value and worth of things. In this respect, George E. Moore reasons that, if a value is intrinsic, then it must be objective.¹⁰⁶ Likewise, Ronald Dworkin argues that the value of human life is sacred once it exists.¹⁰⁷ Therefore, Rosalind Hursthouse argues and concludes that since God is the author of life, then every fetus is intrinsically valuable and should not be terminated, unjustly and unethically.¹⁰⁸ This provides a strong argument to object any deliberate violent attack against human life, and it forms strong basis for bioethics. So, some ethical issues like in the cases of abortion, euthanasia and patient-assisted suicide may be considered as are morally wrong, because they disregard and insult the intrinsic dignity, value or the sacred character of human life. It is, therefore, morally wrong and a matter of a “cosmic shame” to destroy the sacredness of

any human entity once it has existence.¹⁰⁹ A good understanding of this position is highly recommended to moderate excesses in bioethical or medical activities.

2A. 1. 4. *Human life: Dignity and Rights:*

In line with the Catholic traditional teachings, St. John Paul II explicitly maintains that all human persons are willed and created by God. As such, they are imprinted in the likeness and image of God, '*imago Dei*'. In relation to the intrinsic value or worth of life, each person's dignity is rooted from his person, not necessarily from his actions.¹¹⁰ This forms the basis on the transcendent worth of the sacredness, great intrinsic value and dignity of human life.¹¹¹ Suffice it to note that this inherent dignity is inseparable from the human nature, which cannot be gained or lost. Even the worst criminal cannot be stripped of his or her inherent dignity, and as a result, he or she has the right not to be subjected to all kinds of inhuman degradations, treatments or punishments.¹¹² Then, it is good to note that the term "inherent" refers to being involved in the constitution or essential character of something. It simply suggests an "intrinsic" or "permanent" quality, a characteristic attribute of a thing. Relating it to human person, it shows that dignity is inseparable from the human condition. Thus, dignity is not an accidental quality in human person, nor a value derived from some circumstances, regardless of age, gender or condition. Rather, it is something that all human beings possess by the fact of being human,¹¹³ with a permanent and inherent existence.¹¹⁴

Today, the concept of intrinsic human dignity operates in this contemporary time as the bedrock of the international human rights, especially in bioethics since after of the World War II. Ever since then till date, it continues to play major positive roles both in the international policy documents relating to bioethics and in modern medicine. According to Noel Lenoir and Bertrand Mathieu, 'human dignity' can be characterized as the "shaping principle" of

international bioethics.¹¹⁵ In other words, it has become an “overarching principle” of the global norms governing biomedical issues or activities.¹¹⁶ Far from representing a shift merely in style, the higher profile accorded to human dignity in bioethics is seen as a true shift in substance that deserves to be carefully considered.¹¹⁷ With this notion of dignity, some ancient Greek philosophers had argued that, human beings are capable of spiritual activities, because they are essentially spiritual beings.¹¹⁸ Precisely, due to their spiritual components, human beings are regarded as radically unique among living beings and were thought to share in the divine nature. So, the concept of dignity suggests an intrinsic and universal worthiness of human beings.¹¹⁹

Today, the concept of intrinsic human dignity operates in this contemporary time as the bedrock of the international human rights, especially in bioethics since after of the World War II. Ever since then till date, it continues to play a positive role both in the international policy documents relating to bioethics and in modern medicine. According to Noel Lenoir and Bertrand Mathieu, ‘human dignity’ can be characterized as the “shaping principle” of international bioethics.¹²⁰ This concept has become an “overarching principle” of the global norms governing biomedical issues or activities.¹²¹ Far from representing a shift merely in style, the higher profile accorded to human dignity in bioethics is seen as a true shift in substance that deserves to be carefully considered.¹²² With this notion of dignity, some ancient Greek philosophers had argued that human beings are capable of spiritual activities, because they are essentially spiritual beings. So, the concept of dignity suggests an intrinsic and universal worthiness of human beings.¹²³

During the period of Renaissance, emphasis on human dignity became more persistent more exclusive, and ultimately more systematic than in the previous centuries. It was Immanuel Kant who developed one of the most influential accounts of human dignity in the history of philosophy. He affirms that the intrinsic human worthiness is grounded on the capacity for

practical rationality. This capacity is for autonomous self-legislation under the categorical imperative. Thus, it states that “autonomy is then the ground of the dignity of human nature and every rational nature”.¹²⁴ This Kantian approach lays more emphasis on man’s freedom that should be in accord with the moral law. This is the only condition by which human dignity and acts can be justified. Few years after the horrible experiences against human life during the World War II, the international community felt it is necessary to strongly address and emphasize insistently on the notion of human dignity. The objective is to prevent any further occurrences of certain barbarous acts against human dignity and violation of human rights. This is because, if such is not addressed urgently, any deliberate act of dehumanization is likely to engender more of public outrages in the future.

Accordingly, the Universal Declaration of Human Rights of 1948, explicitly declares that: “all human beings are born free and equal in dignity, value and rights”.¹²⁵ This Declaration should serve as the cornerstone or guiding principle of the new international human rights system. Basically, the emphasis is on the recognition of the inherent dignity and equal inalienable rights of all members of the entire human family. Ever since 1948 till date, this notion of human dignity operates not only as a central organizing principle of the international human rights system, but also moderates and the answers questions on certain activities in the field of bioethics. The recourse to dignity in this specific area reflects a real ethical concern about the need to promote the respect for the intrinsic worth of each person, regardless of color, age, gender, etc. As a matter of fact, the UDHR has succeeded to provoke an urgency of thought and collaborative efforts to preserve the identity and integrity of the human species against any potentially harmful biotechnological developments.¹²⁶ So, the inhuman experiments of the World

War II that reflect ‘the crucibles’ that crossed the red boundaries of both human rights and bioethical laws, should not be allowed to repeat again.¹²⁷

The recognition of the dignity of human person present a more pragmatic reason for casting the bioethical standards into human rights terms.¹²⁸ In this vein, Jonathan Mann adds that human rights framework provides a more useful approach for analyzing and responding to public health challenges than any other framework in the biomedical tradition.¹²⁹ By applying this ‘human rights strategy’, there is every possibility to arrive at a consensus, or common language and systematic institutional practice with bioethics.¹³⁰ This increasing use of a human rights framework to deal with bioethical issues does not mean that “human rights will subsume bioethics”,¹³¹ or render bioethical discussions at the academic and professional levels, useless. Insofar as bioethics is a part of the ethics, it cannot be entirely encapsulated into legal form. Though, ethics and law may interact in various ways, and may significantly overlap with one another, but they are still two different normative systems. So, in dealing with human life, all bioethical activities should consider the intrinsic nature of human beings and human rights. Life deserves more respect, to be nurtured, promoted, protected and cared for.

2A. 1. 5. *The Concept of Dignity in African / Nigerian Perspectives:*

Like most of the abstract concepts, the meaning of the term ‘dignity’ may not be so comprehensive if it is not expressed or seen as an inherent attribute of someone else. According to Augustine B. Onwubiko, the term ‘dignity’ is one of the words that can be so easily pronounced, but its meaning is still fraught with contestable and unclear ambiguities. For instance, the advocates for the respect to human dignity may find it very difficult to discuss about it without referring to the fundamental inalienable human rights.¹³² Meanwhile, my studies of the concept in the African *cum* Nigerian perspectives, convince me that this intrinsic value

‘dignity’ or “ugwu” (Igbo) can be better expressed in the contexts of communal life. So, for the Igbo people, it is ‘ugwu na nsopuru’ which means ‘dignity and respect’ that is the hallmark in the communal existence with others. Logically, the dignity of each person can only be respected only when it is morally and responsibly expressed in communal life with others. Likewise, Onwubiko B., rightly points out that, it is communal life that gives meaning to the dignity of human person. For him then, an authentic African (Nigerian) believes that “Ndu bu isi” which means life is supreme and paramount above other things. So, in the placement of priorities or order of values, an African, especially an Igbo person in the South-East of Nigeria, believes that ‘life is dignity’. Due to some elements of individualistic lifestyle, a Westerner may agree that the reverse is the case, i.e., ‘dignity is life’. From this African perspective, therefore, human dignity is more of a socio-anthropological construct, which can be realized by social integration, and maturity through a harmonious communal cohabitation with others. As for me then, this African notion of dignity invokes a deep sense of human solidarity in the contexts of interdependency or interrelationships among peoples.¹³³

Ontologically, it is already stated that the intrinsic dignity of human person emanates as a divine product, *imago Dei* (in the likeness of God). For Stephen Nnamdi Ani, as this dignity transcends all forms of conventional realities or social orders, it implies that it should not be neglected, undermined, violated or trampled upon, in any form of pretense of saving human life.¹³⁴ Thus, in reference to all medical activities, Ani N., upholds that each person ought to be treated with respect as a subject, but not as a mere object, in such manners that would recognize his or her inherent dignity. So, in this context of bioethics critique, any activities that may reduce human being as a mere object of scientific investigations are ethically condemned.¹³⁵ The respect for humanity dignity among the Igbo people is clearly expressed with the peoples’ love for life,

children, family, harmony, hospitality, community. Among all these, a traditional African believes that ‘community’ is much more than a mere social grouping of people who are united due to natural origin, common interests, values, etc. Within the community setting, the Igbo principle of “Onye aghana nwanne ya” (as an active solidarity in being your brother’s keeper) will always insist that the dignity of each person is well recognized, respected and ensured.¹³⁶

It is very interesting to note that in the Igbo ethnic group, the “life-wire” or “vital force” of the communal existence and living is the ‘umunna’ (kinsmen). Though, this ‘umunna’ comprise of all the members of a given kindred in the community, but most of the decisions with regards to caring for the weak or sick members, financial contributions or levies, administration of justice, settlement of cases, marriages rites, community projects, environmental sanitations, etc., are made by the male elders of each Umunna.¹³⁷ This ‘kinsmen’ (umunna) mentality pervades in the African philosophy of life and existence. For instance, it resonates strongly the Mbiti’s maxim that states thus: ‘I am because we are and since we are therefore, I am’. Such names as “Igwebuike” (strength in unity), or “mmadu ka eji aka” (we prevail by other’s support) confirms the belief in communality among the Igbos.¹³⁸ Therefore, as far as I am concerned, the concept of human dignity is inseparable from the community life. This position is equally affirmed by Ani N. Stephen, when he notes that the only way each person is dignified is by being in good rapport with the “Umunna”.¹³⁹

In further analysis, the relationships between the following terms ‘person’, ‘personhood’ and ‘community’ in the African context, indicate that each man is a social being. For the sociologists, life is communitarian that involves a cyclic process and continuous struggle. As a person, Ifeanyi Menkiti notes that all the natural attributes each person possesses is shared by all human beings because they are from the same common natural source, ‘born of the same

human seed'.¹⁴⁰ According to Elochukwu E. Uzuoku, in this cyclic process, 'relationship' is a very essential element in personhood. This shows that personhood is shaped and upheld in ongoing relationships with others, as such, a person becomes human for others, with others and through others.¹⁴¹ To achieve a perfect personhood in any given community, one must struggle to imbibe with a set of ultimate communal character of ideals, responsibility, norms and moral virtues. Such list of moral actions provided by Gyekye includes love, generosity, kindness, compassion, benevolence, respect and concern for others, or any other acts that can promote the welfare of others.¹⁴² In this respect, Polycarp Ikuenobe adds that 'personhood' invokes a set of rights and responsibilities that is acquired developmentally by participating in communal life before becoming a full person in the eyes of the community for social recognition.¹⁴³

Based on the intrinsic value and dignity of human life, Balogun J., then opines that all human beings should be treated with utmost respect, especially in reference to all medical activities with humans.¹⁴⁴ Likewise, Paul C. Ezenwa adds that the value for the dignity of the human person also forms a natural part of Igbo ontology that would insist on the respect for life. As for him, Africans live in a cultural setting that values and respects the dignity of the human person. This notion of dignity suggests a kind of new humanism, that places each person in a position of discharging his or her ethical responsibilities for the good and edification of the entire human society.¹⁴⁵ To further buttress this point, Steven Biko opines that the new ethical principles that should be operative in the African healthcare system, Nigeria not exempted, must be newly 'African-inspired ethical' mantra of *respect for persons* (instead of autonomy that seems to be more individualistic), *beneficence*, *non-maleficence*, and *harmony* (rich in meaning than justice). This is perhaps, as he maintains, one of the ways Africa (Nigeria) can contribute toward enriching the *principlism* of global biomedical ethics.¹⁴⁶ In relation to these ethical

principles as applied in medicine, Immanuel Kant admonishes that, in all human acts, each rational agent (or individual person) ought to abide by the dictates of a categorical imperative which concerns and grounds the dignity of human person. Hence, this imperative obliges each rational competent moral person to act ethically by using the ‘humanity’ that is in the person to always consider others as ‘end-in-themselves’ rather than as a pure means.¹⁴⁷

2A. 2. 0. Human Person in the Multicultural Society

The ontological, normative and ethical reflections of the human nature indicate that each person is a social being. As such, no person can easily exist in isolation, as everyone can realize his or her potentials only in the contexts of inter-relationship with others. For Desmond Tutu, each human being can realize his or her full personality or potentialities through communal interactions with other peoples. Since no person comes into the world as a fully formed individual, each person depends on others to grow into maturity.¹⁴⁸ For St. John Paul II (Pope), human person is a being for others in this inter-personal relationship. He then adds that to think of a ‘person’ in his self-giving dimension is a question of principle.¹⁴⁹ Therefore, interdependence is not optional to human person but the hallmark of human existence.¹⁵⁰ All these accounts justify the reason why ‘human person’ is the central focus in caring relationships, especially in the area of bioethics.

To reiterate that ‘no person is an island’ simply means that each individual person is a contextual being, who lives in the society, within a given time and space. Indeed, every human being is capable to create his own values in order to make his life very meaningful.¹⁵¹ This is what Heidegger considers as a being ‘thrown’ into a sociocultural world regardless of his choice and consent.¹⁵² Each person is called to exist not only for himself, but also offers himself or herself as a gift to others in the inter-relationships.¹⁵³ Existing “for” others entails much more

than just “co-existing” with them, rather it implies loving, caring and serving those in need, especially the most vulnerable ones in the society. It really demands both personal and collective efforts (human solidarity) to develop and keep this network of a social system. Though, the social nature of human species does not automatically guarantee authentic relations among persons. Due to pride and selfishness, the unpredictable humans can exhibit certain traits or impulses that can mislead them to close their respective individuality, and then tend to dominate others.¹⁵⁴ Against this background, the notion of the principle of personalism then grew up as a reaction to such unethical intellectual and social trends, perceived as dehumanizing. In effect, the principle of personalism, which affirms the primacy of human person with a conscious rational mind, tends to reaffirm the absolute dignity and inter-relationality of the human persons.¹⁵⁵

Moreover, it is this bonding, communion and fellowship which are the inescapable hallmark of community in Igbo thoughts and culture. The community provides each individual person with the necessary resources to lead a minimally meaningful, normal and dignified life.¹⁵⁶ In this perspective, Christopher O. Agulana refers to the Igbo maxim, “otu onye abughi osisi” which means that ‘no one is an island unto his or herself’. This expresses the idea that no person, no matter how strong, is capable of surviving alone in the world.¹⁵⁷ The emphasis on the idea about the impossibility of human persons or individuals in the world to exist or subsist without human fellowship is captured in the modern existentialist dictum that each person is a ‘being-in-the-world’ or a ‘being-with-others’.¹⁵⁸ Besides, this notion of human dignity as expressed and respected in the context of mutual existence in the communal life helps one to differentiate between a ‘human being’ and a ‘human person’ in the African worldview. In most of the African cultures, especially in Igbo cosmology, a ‘person’ can be understood from two major perspectives: *ontological* and *ethical* perspectives. Ontologically, a person is composite of body

(ahu) and soul (mkpuruobi), which is the life principle of every human being. Ethically, a person is defined in one's personal relationship with God, spirit world, and with the human society.¹⁵⁹

As such, John Menkiti argues that a 'human person' is different from a 'human being'.

According to him, the possession of body and soul by each human being does not qualify one to be a 'human person', since personhood is processual, or procedural with social complex and sacred ritual incorporation at different stages in life. So, a person is only defined by the community, but not by the possession of qualities like nationality, will, memory, etc. Hence, only mature adults of good moral reputation can attain the personhood; it is not yet to be fully attained by children 'umuaka' or youths 'ndi-na-eto-eto' (Igbo), respectively.¹⁶⁰

In further analysis, the relationships between the following terms 'person', 'personhood' and 'community' in the African context, indicate that each man is a social being. For the sociologists, life is communitarian that involves a cyclic process and continuous struggle. As a person, Ifeanyi Menkiti notes that all the natural attributes each person possesses is shared by all human beings because they are from the common natural source, 'born of the same human seed'.¹⁶¹ According to Elochukwu E. Uzukwu, in this cyclic process, 'relationship' is a very essential element in personhood. This shows that personhood is shaped and upheld in ongoing relationships with others, as such, a person becomes a full human for others, with others and through others.¹⁶² Therefore, to achieve a perfect personhood in any given African community, I strongly believe that one must struggle to imbibe with a set of ultimate communal character of ideals, responsibility, norms, cultural and moral virtues.

Based on the intrinsic value and dignity of human life, Balogun J., then opines that all human beings should be treated with utmost respect, especially in reference to all medical activities with humans.¹⁶³ Likewise, Paul C. Ezenwa adds that the value for the dignity of the

human person also forms a natural part of Igbo ontology that would insist on the respect for life. As for him, as a core African traditionalist, Africans live in a cultural setting that values and respects the dignity of the human person. This notion of dignity suggests a kind of new humanism, that places each person in a position of discharging his or her ethical responsibilities for the good and edification of the entire human society.¹⁶⁴ To further buttress this point, Steven Biko opines that the new ethical principles that should be operative in the African healthcare system, Nigeria not exempted, should be newly ‘African-inspired ethical’ mantra of: *respect for persons* (instead of autonomy that seems to be more individualistic), *beneficence*, *non-maleficence*, and *harmony* (rich in meaning than justice). This is perhaps, as he maintains, one of the ways Africa (Nigeria) can contribute toward enriching the *principlism* of global biomedical ethics.¹⁶⁵ In relation to these ethical principles as applied in medicine, Immanuel Kant admonishes that, in all human acts, each rational agent (or individual person) ought to abide by the dictates of a categorical imperative which concerns and grounds the dignity of human person. Hence, this imperative obliges each rational competent moral person to act ethically by using the ‘humanity’ that is in the person to always consider others as ‘end-in-themselves’ rather than as a pure means.¹⁶⁶

Besides, the concept ‘multiculturalism, refers to situations in which people of different ethnic groups, customs, traditions, languages and/or religions co-exist in the same social space and context. At the same time, each group of persons must be ready to maintain relevant aspects of their own uniqueness and to have it publicly recognized. Though, in bioethical context, multiculturalism invokes a positive evaluation of cultural diversities and the commitment to respect each of them. In this respect, Julie A. Brow remarks that (bio)medical ethics and culture are interconnected as different cultures attempt to implement ethical values differently. This

leads to an increasing need for culturally sensitive or competent physicians or healthcare givers, including the ethics committees in hospitals and in other healthcare settings.¹⁶⁷ For Enzo Colombo, a proper recognition of cultural diversity is a necessary step towards revaluing disrespected identities. Such can modify dominant patterns of representation and communication that marginalize certain groups, especially within the healthcare system.¹⁶⁸ In reference to Nigeria as a multicultural nation, it might interest you to know that this most populous black nation on earth is made up of multi-ethnic backgrounds. Therefore, to think of applying bioethics in such multi-pluralistic settings, it calls for ‘cultural competency’ to play major roles in addressing ethical issues related to disparities, language barriers, sickness and treatments options, patients’ values, wishes, preferences, beliefs, equal privileges, etc. This involves a readjustment of unequal relations and exploitations between the poor and the rich in its health system.¹⁶⁹

2A. 3. 0. Medicine: Fundamental Goals and Ethics

While seeking for the entire well-being of the patient, medicine is still consistent with its fundamental objectives to heal, relieve pains and suffering. To achieve these goals, medicine must rely on certain ethical principles like autonomy, beneficence, non-maleficence and justice. As earlier indicated in the Hippocratic Oath of medicine, these principles ethically oblige physicians or healthcare purveyors not to engage in any foul plays with their patients. With love and compassion, they should not deliberately attempt to harm or inflict pains and suffering on the patients.¹⁷⁰ As for me, I would expect them to always endeavor to participate in those medical activities that will always benefit or seek for the well-being. Again, Daniel Callahan would insist that physicians, as worthy moral agents, should endeavor to provide care, comfort and compassion to the suffering patients without exceeding the limits of medical goals.¹⁷¹

It is a clear fact that medicine cannot alleviate all the problems related to human life and health. Despite all the recent scientific innovations in medicine, it cannot offer absolute solutions to human sickness and mortality. Reflecting on the objectives of medicine, Linda L. Ezekiel et al., note that the much medicine can do is to provide any possible cures, improve the quality of health and life expectancy, relieve of pains and suffering. All these goals are the same, and none should be considered more important than others.¹⁷² So, by respecting the dignity of human persons and acting in solidarity with others, I am very optimistic that physicians can achieve the expected maximum results in the treatment of patients, provided the ethics of medicine are properly applied. In the patient-physician relationships, Bart Criel et al., would insist on a kind of holistic approach in order to foster ‘patient-centered health system’. Such approach would require more optimal and less distortive interactions between the patients and physicians.¹⁷³

Meanwhile, it is worthy of note that the Nigerian health system in its efforts to ensure a healthy patient-doctor encounters, will always refer to the Code of Medical Ethics to ensure good results. But any lack of profound knowledge of biomedical ethics and its application can create some ethical issues in dealing with the patients and their families.¹⁷⁴ There is great need to get rid of any serious violation of human dignity, rights and abuse of medical goals while caring for others. Such is possible with the applications of biomedical ethics. Then, Callahan would advise all physicians and other caregivers to always act with integrity in accordance with medical goals.¹⁷⁵ A ‘clinical relationship’ based on trust is the essence of good caring relationship. So, it beholds on all the parties involved in this relationship to cement good personal relationships among themselves. As such, bioethics will always assist them to know how to identify features of a case, interpret and apply justifiable ethical guidelines,¹⁷⁶ both in the contexts of clinical practices or in scientific research with human beings.¹⁷⁷

In addition, both Beauchamp and his colleagues conceive ‘bioethics’ as a system of moral principles that applies values in the practice of medicine. As such, bioethics is based on a set of values that medical professionals can always refer to, especially in situation of divergent opinions in the decision-makings. It becomes so obvious to me that these values ought to be in accord with the respect for autonomy, non-maleficence, beneficence, and justice, to ensure that the objectives of medicine are achieved.¹⁷⁸ Agreeing with this position, Mary Weis then adds that, these bioethical principles form the bedrock or guidelines for the health care givers to create justifiable treatment options to realize the expected medical goals devoid of any conflicts.¹⁷⁹

Besides, a reference to history would reveal that medical ethics is traceable to the Hippocratic Oath that focused more on the basic ethical principles of medical profession. Precisely in 1803, Thomas Percival published a document that outlined the requirements and expectations of medical professionals. In a sense, it became more of ‘guild-like’ in nature for clinical practices.¹⁸⁰ This document was later in 1847 updated and adapted as the ‘Code of Ethics’.¹⁸¹ Following the same trend, the Code underwent a series of revisions, precisely in 1903, 1912, 1947 (Nuremberg Code) and 1964 (Helsinki Declaration), respectively. Today, medical ethics has been widely acknowledged, and it has been globally accepted as ‘Bioethics’ to be practically applied in almost serious clinical cases and research activities around the universe.¹⁸² As such, bioethics is a system of moral principles that will always apply values in the practice of clinical medicine and in scientific research.¹⁸³

As the guiding principles of biomedical ethics, Tom L. Beauchamp and James F. Childress make critical emphasis on the followings principles: autonomy, non-maleficence, beneficence, and justice.¹⁸⁴ By applying these principles, Mary Weis is convinced that they will always help doctors, care providers and even the surrogates to create a good treatment plan to

achieve the same common goal (i.e. patients' well-being).¹⁸⁵ It is important to note that these four values or ethical principles are not ranked in order of importance or relevance. As earlier note, none of them is superior to others, but they altogether encompass the values pertaining to medical ethics. They can only assist health caregivers in the making of ethical decisions in the health system. In such situations, Gilbert Berdine believes that some moral obligations can overrule others with the purpose of applying the best of moral judgements to difficult medical situations.¹⁸⁶ Of course, brief discussions and understanding of these principles can assist one to resolve some ethical issues in medical practices.

2A. 3. 1. The Respect for Autonomy:

The term "autonomy" is derived from the two Latin words 'autos' (self) and 'nomos' (rule). It then refers to 'self-rule' that advocates for an individual's self-determination.¹⁸⁷ Viewed from this perspective, this concept is equally considered as an underline principle of human dignity. This is because, its emphasis is mainly on the recognition of respect for each person's ability to make deliberate rational informed decisions freely on the issues that concern the person.¹⁸⁸ Thus, autonomy can be noted as a general indicator of a healthy mind and body. Though, the concept can present a negative duty not to interfere with the decisions of competent adults. Also, it can as well offer a positive duty to empower the surrogates to take decisions for the incompetent persons. Today, autonomy is regarded as a social value that focuses on medical outcomes that benefit the patient and their family rather than medical professionals, only. Its increasing importance is seen as a social reaction against the old traditional medical paternalism.¹⁸⁹ This shift from the 'excessive' paternalism that favors the patients seems to be replaced with a kind of 'soft paternalism' to the detriment of outcomes for some patients.¹⁹⁰ Its corollary principles are respect, sincerity, trust and the obligation to keep promises.

Equally, the principle of autonomy is considered as a ‘virtue’. While describing the concept as dealing with a state of character, John Benson indicates its reliance on one’s own powers in acting, choosing, and forming opinions. As a virtue then, it stands as a ‘mean’ between the deficiency of heteronomy in which one is excessively influenced by others and excessive arrogance of self-sufficiency known as solipsism.¹⁹¹ Moreover, Raanan Gillon opines that autonomy connotes the capacity to think, decide and act, based on deliberate uncoerced thoughts and decisions.¹⁹² With this understanding of the concept, he is able to make classifications of the term into *autonomy of action*, *autonomy of will* and *autonomy of thought*. In relation to the *autonomy of action*, he noted that specific actions may be autonomous even though they do not reflect the immediate or direct results of the person’s thought process. For instance, in a habitual action, a person may be driving to a destination perfectly and autonomously without thinking where he is going. But once proper reasoning is applied, he may suddenly remember that he is on wrong directions, and then, he may decide to turn back. On the contrary, the *autonomy of thought* embraces a very wide range of mental processes that can be subjectively viewed as “thinking for oneself”. It involves taking decisions, believing things, having aesthetic preferences and making moral assessments by oneself.¹⁹³

The last in this category is the *autonomy of will*, also known as ‘autonomy of intention’. This kind of autonomy suggests a freedom to decide to do things based on one’s personal deliberations. Even in the physician – patient relationship, there is every possibility that there is a human capacity corresponding to the idea of will power to make decisions accordingly, despite a powerful contrary desire to do so.¹⁹⁴ Again, there is little doubt that some people have more of such autonomy of will than others. However, Gillon then concludes that all the three kinds of autonomy – *of thought*, *of will (or intention)* and *of action* – require some elements of rationality

to function well.¹⁹⁵ Applying practical reason to the principle of autonomy, Immanuel Kant advises that each person ought to act in such a way that will consider other fellow human beings, not simply as a “means”, but necessarily as “ends-in-themselves”. Logically, I can strongly affirm that the respect for autonomy is a necessary feature for all competent human beings as rational agents. As such, it should be applied in relation to every rational agent, without excluding the mentally incapacitated people in the society.¹⁹⁶

2A. 3. 2. *The Principle of Beneficence:*

Although, the principle of beneficence is widely recognized and applied in medicine, but it is difficult to define it with some precisions. Some erudite scholars like Tom L. Beauchamp, in his book titled “Medical Ethics: The Moral Responsibilities of Physicians”, he explains the word ‘beneficence’ to mean the followings: ‘the doing of good’, ‘the active promotion of good’, ‘kindness and charity’.¹⁹⁷ In a sense, it simply means performing any obligatory actions in view of benefitting others. From this perspective, the acts of beneficence are morally tied with obligation, which can be suggestive of altruism, humanity, unconditional love and non-obligatory optional moral ideals. Within the context of bioethics, the principle of beneficence morally obliges physicians or researchers to provide within the best of their capabilities, positive benefits such as good health, prevent and remove harmful conditions from patients. In other words, it asserts an ethical obligation on both physicians and others to care for patients’ best interest, values, preferences or wishes.¹⁹⁸

With regards to the patient-physician encounter, the role of ‘beneficence model’ indicates that the end of medicine is directly on the patient’s best interests, not mainly on the physician’s interest. It is important to say that the central theme in this ‘model’ of relationship is

the physician's obligation to benefit the patients. As a matter of fact, the moral obligation to confer benefits and actively prevent or eliminate potential harms from patients is very necessary in biomedical ethics. It also goes on with the obligation to assess or weigh and balance potential goods against any possible harms of every medical procedure. At this point, it is very imperative to make a clarification on two principles under the general principle of beneficence – the principle of 'positive beneficence' and the principle of 'utility'.¹⁹⁹ In the principle of positive beneficence, the obligation focuses more on the provision of benefits including the prevention and removal of harm from patients. As such, it seeks to promote the welfare of others. While in the principle of utility, it requires weighing and balancing benefits and harms in moral life. So, it beholds on physicians and other health workers to carefully analyze, evaluate and promote those actions that bring more benefits to the patients or to the general public. This suggests, in my own opinion, the maximization of potential benefits and minimization of harms or risks in dealing with others, including animals.²⁰⁰

In addition, experts like Tom L. Beauchamp and group are very comfortable to identify beneficence as one of the core values of healthcare ethics. Likewise, Edmund Pellegrino continues to assert that beneficence is the 'sole' fundamental principle of medical ethics. Relying heavily on the principle of beneficence, they unanimously argue that 'healing' should be the sole purpose or top priority of medicine. Moreover, David Hume had in the past contended that 'benevolence' is the "ultimate foundation of morals." This is because, while *benevolence* refers to the morally valuable character trait – or virtue – a disposition to act to benefit others, *beneficence* then refers to actions or rules intended to benefit them. Therefore, beneficence should not be disassociated with acts of mercy, charity, compassion and love that are primarily intended to benefit other persons.²⁰¹ Some beneficent actions are morally required, and others

may be morally discretionary.²⁰² Its corollary principle implies maximization of benefits and minimization of harm. By adopting this corollary principle, I would suggest that ‘beneficence’ ought to be applied together with the respect for autonomy to ensure better outcomes.

2A. 3. 3. *The Principle of Non-maleficence:*

Evidently, much of the avoidable harms, pains and suffering have been inflicted unto numerous patients, and some have resulted into the untimely death of many of them. The reports of such medical malpractices or errors may be presented thus: “Though, the treatment was very successful, but the patient later, died”. The ethical question would be, ‘how can ‘death’ as the ‘end’ result of a patient justify the success of such treatment?’ To provide solutions to eliminate such malpractices or harms in medical system, renowned experts like Tom L. Beauchamp et al., have proposed the application of the ‘Principle of Non-maleficence’. This is because, this principle has its fundamental embodiment in the phrase, “first, do no harm”, and its Latin equivalent is ‘primum non nocere’. According to Jotterand Fabrice, the consideration of the term ‘first’ or ‘primum’ suggests that it is more important to the notion not to harm a patient first, than to perform good any act to them. Hence, this consideration forms a part of the Hippocratic oath for physicians.²⁰³

Reflecting on the principle of non-maleficence, David C. Thomasma and group highlighted that, it not only relates to, but also revolves around the concept of harm. In their critical analysis, they clearly indicate that pain is the product of harm, and worse still, pain engenders distress. The most interesting in this critical analysis is the classification of harm into *incidental*, *intended* and *intrinsic harms*.²⁰⁴ A further explanation shows that, ‘incidental harm’ can be avoided but it is as result of carelessness and negligence. In the case of ‘intended harm’, it is as result of deliberate, thoughtful or well calculated in view to inflict unnecessary pain on

others or patients. Lastly, an ‘intrinsic harm’ refers to any act that is capable to produce harm, directly and immediately. For instance, ‘killing’ or to kill a person deliberately has the intrinsic effect of harming (the patient). Thus, ‘killing’ is intrinsically evil, harmful, and it violates the negative duty not to harm.²⁰⁵ This notion of physicians’ obligation not to harm is reflected in various codes and declarations of medical ethics.

Furthermore, Albert Jonsen in his work ‘*Do no Harm*’ comes up with more details that further explain the concept of non-maleficence. With the obligation and duty on the physicians attached to this concept, he admonishes that they ought: (a) To dedicate themselves to the well-being (not to harm) of patients; (b) Be able to dispose themselves to provide adequate care to patients; (c) Also, they should properly assess the situation, with regard to the risk/benefit involved; and (d) lastly, they are to make proper detriment-benefit assessments before deciding on any medical options.²⁰⁶ Obviously, if these Jonsen’s propositions on the principle of *non-maleficence* are respected and applied in clinical settings, likely a lot of foreseen harms could be avoided. Basically, this principle as embedded in common morality, recognizes that an intentionally or negligently causing harm is a fundamental moral wrong. Though, it does not exclude the possibility of balancing potential harms or risks against potential benefits. It then becomes very necessary to weigh the risks and potential harms of medical and public health interventions against possible benefits for patients, research participants and the entire public.²⁰⁷

In the final analysis, while applying the principle of non-maleficence, each caregiver must always bear in mind the obligation of preserving life. Again, it is not the same with ‘non-malefeasance’, which is a technical legal term; nor ‘non-malevolence’, which refers to the notion that one does not intend to cause harm. At this point, I will not hesitate to say that its ‘corollary principles’ include: First, it is morally obligatory to minimize harm, whether such harm could be

avoided or not. Second, it is mandatory not to increase harm or risks to others. Third, it is not advisable or justifiable to waste resources that could be used for greater good. Lastly, if beneficence and nonmaleficence are joined together, every action is expected to produce more positive results than harm.²⁰⁸ This is the reason why Hippocrates advised the ancient physicians to respect and apply the medical regimens within the best of their knowledge and capacities. Hence, all their medical activities should aim at benefitting the patients without causing unnecessary harms to them.²⁰⁹

2A. 3. 4. *The Principle of Justice:*

The fourth ‘prima facie’ moral principle of biomedical ethics is ‘justice’. There is no single term that can be sufficiently enough to portray the full meanings of justice. Though, it is fraught with a lot of ambiguities, but it refers to moral obligation to act based on fair adjudication between competing claims or issues. As such, the principle of justice can easily be defined in relation to fairness, entitlement, equality and equity. Within the context of bioethics, Raanan Gillon classifies the concept into different categories. First, with the notion of distributive justice, he insists on fair distribution of available or scarce resources. Second, considering the notion of the dignity of each person, or rights-based justice, he then proposes due respect for human rights. Lastly, from the legal perspective of justice, he equally insists on the respect for morally acceptable laws.²¹⁰ Meanwhile, the two elements of the principle of justice are ‘equality’ and ‘equity’.

Still on the notion of ‘equality’, Aristotle hinted in the past that justice is more than mere equality. This is because, in critical evaluation of resource control, people can be treated unjustly even if they seem to be treated equally. Based on what he conceived as ‘horizontal equity’, he suggested that it is very important to treat equals equally, but with ‘vertical equity’,

he opined to treat ‘unequals’ unequally in proportion to the morally relevant inequalities.²¹¹ As earlier noted, there are possibilities of witnessing some kinds of disparity and inequality in the Nigerian healthcare system. This refers to situations where some people may not be treated with the same degree of respect given to others due to ethnic background, indifference, unfriendliness, lack of concern or rudeness, etc. Such inequality and discrimination in the healthcare system, according to Mahajan et al., may be based on structural violence such as racism, ethnic background, power, sexism and poverty.²¹² In this light, Beauchamp et al., will always appeal to the principle of justice with regards to the distribution of goods and services, including medical goods and services, fairly. So, it is expected that healthcare directors, practitioners and the entire human society in general should endeavor to treat every case or equal, equally and equitably.²¹³

According to Tom Beauchamp et al., distributive justice in the healthcare system may be determined by variety of factors as criteria. This implies granting to each person an equal share; according to one’s need; depending on one’s effort or contributions; or according to one’s merit; and lastly, base on to free-market exchanges, etc.²¹⁴ The problem is that the principle of justice does not clearly indicate what a patient might actually need, nor which needs are most important for a person. In effect, the American Medical Association AMA, in the *Code of Medical Ethics*, listed the criteria for medical needs. Thus, any medical needs: should be beneficial to the patient, reflect the urgency of need, are likely to change the quality of life, and should indicate lasting durability of such benefits. So, this Code insists that ‘non-medical’ criteria for limits should not be used, i.e., the ability to pay, social worth, obstacles to treatment, patient contribution to illness, and use of past resources.²¹⁵ It is very important to note that, the corollary principle of justice is not in any form compatible with the imposition of unfair burdens to others. Rather, it imposes a moral obligation to treat each person with dignity, equally,

equitably, fairly, and impartially. Hence, I would suggest that ‘beneficence’ should be applied in relation to ‘justice’, to ensure that all medical activities are channeled towards benefitting those in need, or who are unfairly treated.

2A. 3. 5. *The Critique of Principlism:*

The introduction of the term ‘principlism’ by Tom L Beauchamp et al., in their book titled “Principles of Biomedical Ethics” published in 1979 has continued to receive much of appreciations as well as a lot of criticisms. As an advocate of principlism, Raanan Gillon would think that the application of these four ethical principles – *respect for autonomy, beneficence, non-maleficence* and *justice* – are sufficient enough to explain and justify all the substantive moral claims in medical ethics. Again, he is of the opinion that these principles can as well provide a transcultural, transnational, trans-religious, and trans-philosophical framework for ethical analysis. Though, Raanan concludes that these principles do not provide a set of ordered rules or regulations.²¹⁶ This implies that they are judged insufficient. However, both Danner Clouser and Bernard Gert are not comfortable with the approach of these principles due to lack of theoretical unity. In other words, they see in these principles as lacking a kind of systematic relationship. So, since they are drawn from conflicting moral theories, they are capable of misleading people to conflicting conclusions.²¹⁷ Further criticisms by Danner K. Clouser reveal that the sources of principlism are from ‘pick and mix’ selection of other theories and principles. Therefore, they will likely indicate different competing ethical theories like Kantianism, deontology, utilitarianism, consequentialism, etc. As a result, one may be confused to apply any of the competing theories, maxims, principles or rules that seem to suit for a given case.²¹⁸

Other criticisms levelled on principlism are: First, with its little content, any of the principles can mean anything depending on the person applying them. Second, if judged as having too much content, there is every tendency that one may be compelled into an exclusively system of values. Third, it is needless to divide them into too many principles, as nonmaleficence and beneficence could be fused together as a principle of utility. Lastly, it is insufficient to function with only four principles, hence, there is need to include other principles like solidarity, fidelity, the virtues of care, friendliness, charity, etc. Again, Matti Hayry points out that since these principles lack representation of moral, religious or virtue ethics, they do not truly represent typical European values, not to talk of other cultures in the world. With the omission of ideal nature of a good or virtuous human being, exposes the tenets of principlism to accusations of short-sighted hedonism, excessive individualism and sneaking nihilism.²¹⁹

Similarly, another school of thought emanating from the African background bemoans the lack of ‘Africanness’ in the contemporary bioethical principles. Thus, Godfrey B. Tangwa criticizes the present bioethics as focusing more on the Western and American cultures that claim to be highly rational and universally valid. At the end, it has little or no considerations for other world cultures, especially the African cultures and beliefs.²²⁰ In the same vein, Edmund D. Pellegrino expresses a kind of discomfort with the fact that ‘medical science and technology, and the ethics designed to deal with their impacts, are all Western in origin. Consequently, such values are often perceived as alien and antipathetic to many non-Western worldviews.²²¹ Worse still, I can imagine the effects of ‘prima facie’ of the dark history of colonization that resulted into the persisting traces of racial mistrusts, biases and the threat of exploitation. With all these inhibitions in the mind, it will be very difficult for an average African to easily embrace anything Western or American, including the bioethical principles.

So, to accept ‘principlism’ that promotes individualism at the expense of communalism which is the African spirit and way of life is just like treading on the realm of impossibility. For another group of critics, if *principlism* is a mistrust in error, then it is better to err on the side of caution. This refers to the purported justification of mistrust which seems to ignore the very atmosphere in which existing bioethical principles arose as – *reek of racism* – the Tuskegee Syphilis study, the Nazi experiments on the Jews and Romany peoples.²²² However, despite all the criticisms or shortcomings of the principlists’ approaches in bioethical analysis, I would still appreciate the perceived benefits which have been significantly evident by their pervasive application in medicine. Today, Principlism is by far the most dominant approach to ethical analysis in healthcare system across the globe, and the book titled ‘Principles of Biomedical Ethics’ by Beauchamp and Childress remains the most influential book in modern bioethics.

2A. 3. 6. *The Principle of Fidelity:*

A lot of people are very skeptical with regards to building trust or confidence in physician-patient relationships. This is because, principlism as discussed above is not only judged insufficient as ethical principles, but it also very silent on the issue of building trust or confidence in the clinician-patient encounters. In effect, as a kind of the principle of beneficence, it is the principle of fidelity which captures the quality of commitment that may exist between the healthcare professionals and the patients. The principle of fidelity proposes that each person should try to keep his or her promises to others, just to maintain the trust which is so necessary to retain any given human relationships that are likely to bind people together. This principle captures the element of trust which must exist between persons who are mutually bound to each other by circumstances or choice. A reference is made to the ancient Hippocratic traditional

medicine, which is known with regards to confidentiality, pledging to keep the patient from harm, and the patient upholding a pledge of trust towards the physicians. Today, as humanity continues to experience evolutions in science and technology, but there is nothing more important than the mutual relationship of trust that ought to exist between a caregiver and a patient. It is this relationship which is the medium for genuine healing, and fidelity is the glue which holds it together. Hence, this answers the question of trust or faithfulness in human interactions, especially in the medical field.²²³

Etymologically, the term ‘fidelity’ is from the Latin ‘*fidelitatem*’ (nominative *fidelitas*) which refers to faithfulness, adherence, trustiness, or from ‘*fidelis*’ i.e., faithful, true, trusty, sincere, and from ‘*fides*’ which stands for ‘faith’. Within the context of biomedicine, the ethical obligations of fidelity may be different in research ethics or clinical ethics, but still trustworthiness and loyalty are morally central virtues in them. Thus, the principle of fidelity suggests a kind of faithfully living up to one’s commitments. For instance, in the field of research with human beings and clinical settings, fidelity obliges experts to keep promises to collaborate respectfully with research participants or patients, seek benefits for individuals and for society. Fidelity ensures that every medical activity is fair, non-exploitative, truthful,²²⁴ and then promotes professional integrity.²²⁵ To conclude, as the search for the “Universal Common Morality” continues, I would suggest that bioethics should be more flexible and inclusive in nature to recognize other cultures. This is one of the best ways it can be globally accepted and applied to ensure that the objectives of medicine are achieved worldwide.

2B. 0. Clinical Medicine for Human Life

2B. 1. 0. Human Life and Frailty

Introduction:

Human life is always in need of medicine. It is an indubitable fact that human life, with all its unquantifiable essential intrinsic values and qualities, is still fragile and can be rendered vulnerable by sickness, old age, accidents, etc. This notion of ‘fragility’ with regards to life is the main reason for each person to rely so much with unquestionable dependence on medicine for various kinds of lifestyle diseases and treatments. In this respect, both Benjamin Goldberg and his colleagues, refer to medicine as the science of healing which involves the treatment and prevention of diseases, etc. According to this group, almost all human cultures and traditions, Nigeria not excluded, have respective medical beliefs that offer explanations for diseases, illness, birth, death, etc.²²⁶ Faced with multiple challenges due to fragility and vulnerability of life, human beings have no other better options than to depend on the ultimate goals of medicine. Emphasizing on these ultimate goals of medicine, Balaji Moore believes that they are intended to improve life expectancy of human beings, make them functional and satisfactory, relieve pains and provide a life free of symptoms.²²⁷ At all stages in life, according to World Health Organization, each individual person deserves a quality medical care. Such quality of care refers to the degree to which healthcare services for individuals and populations are likely to increase the health benefits and desired outcomes. This implies that, it must be consistent with the trajectory of the current medical knowledge and skills to ensure effective, safe and patient-centered cares.²²⁸

Moreover, it is very important to note that the WHO highlights that each person possesses the right to quality medical care and health. In effect, in its declaration of 1948, the

WHO attempted to define the right to health as ‘the enjoyment of the highest attainable standard of health’. A critical analysis of this assertion would include a healthy human development from birth, equitable dissemination of medical knowledge and benefits, etc. Above all, each person is entitled without discrimination or disparity of services, to appropriate medical care.²²⁹ So, it is expected that constituted government like Nigeria must abide by this fundamental inalienable right by providing all the essential measures to ensure adequate good healthcare for all. By so doing, Talcott Parson sees in medicine to be capable to maintain, sustain, safeguard, promote and increase the life expectancy of the people in each society.²³⁰ Personally, I can also assume that any healthcare system that is committed to universal patient-centered excellence, will always insist on the patients receiving the best quality cares. On this issue, Karen E. Steinhauser et al., maintain that any healthcare system that understands and can meet with the above medical goals will always be fundamentally recognized as *life-affirming*, even when the end-of-life is very imminent, as in the case of frail older adults.²³¹

2B. 1. 1. *Clinical Care for Frail Older Adults:*

From the moment of conception to death, medicine continues to play vital roles towards caring, protecting and promoting human life and health. Since the trajectory of human life is associated with the concept of ‘frailty’, it becomes very imperative at this point to consider the term in relation to medical assistances, especially in the older adults. The term ‘frailty’ is associated with ageing in human life. It refers to a wide range of health complications that may result from accidents, chronic illnesses and old age, which can cause general debility and cognitive impairments. Frailty is more common in older adults and in those with multiple comorbidities, but it can occur independent of advanced age, disability, or specific diseases.²³² The adverse outcomes in frailty are frequent falls, delirium or dementia, and other forms of

disability.²³³ Subsequently, Cynthia M. Boyd et al., identify frailty as being strongly and independently associated with the onset of dependence in activities of daily living.²³⁴ From medical perspective, there are certain criteria in health conditions that can suggest a state of frailty. The phenotype of frailty normally identifies with the elderly persons who may be suffering from at least three or more criteria. The determining criteria for frailty in adults are as follows: slow walking speed, weak grip strength, exhaustion, low physical activity level, and unintentional weight loss.²³⁵ Though, a combination of inactivity and weight loss seems to be the most predictive of mortality.²³⁶ The hallmark of frail conditions can manifest as a kind of progressive irreversible decline marked by loss of cognitive function, loss of physiological reserve, increased risk for falls, etc. Worse still, there are no signs of hope to recover from illness, due to more frequent and longer stay hospitalization, and mortality.²³⁷

For the existentialists, everything that has a beginning, also has an end. This is the sole reason why Martin Heidegger qualifies ‘all human beings’ as ‘Beings – in – time’. So, as human life begins at conception, it is highly appreciated at birth, and then comes to an end at point of death. This implies that, within the interval between birth and death, each person’s life journeys on its steady pathway to frailty. This is to say that the life of each human person experiences two major stages: *rise* and *fall*. With this notion of frailty, the focus here will be on the latter stage of life. At the stage of “fall” or “evening of life” which is an integral part of human nature, life itself is conceived to decline progressively.²³⁸ So, in frailty, this decline is more accelerated due to some complications or failings of the bodily systems in the older adults.²³⁹ With my own understanding of ‘dignity’, such decline in the physical body does not mean that ‘personal dignity’ is lost in the face of frailty. As earlier noted, at such critical stage of life, frail adult patients are likely to experience multiple complications.²⁴⁰ As Douglas A. Wolf puts it, any

medical or palliative care would demand a lot of time, energy and money, to provide quality cares to the vulnerable and dependent frail adults.²⁴¹

Most often, both comorbidity or disability has been considered and often treated as synonymous with frailty. Even though it may result from comorbidity, frailty should not be conceived as the same as disability.²⁴² Nevertheless, in order to ensure optimal clinical cares for frail older adults, the physicians or caregivers should always bear in mind the concept of *dignity* of human persons, no matter their critical health conditions in life. Also, it is pertinent that they should endeavor to recognize the range of signs, symptoms and adverse outcomes associated with frailty syndrome. Due to the recurrent susceptibility to acute illness and poor ability to recover from acute stress, David Hamerman calls for a strong ‘solidarity’ of persons while caring for the vulnerable frail patients to ensure a dignified end-of-life.²⁴³

With regards to ethical and legal issues in the treatment of the frail persons, the bioethical principle, *respect for autonomy*, will insist that competent ones should be allowed to participate in the decision-making processes concerning their illness. However, even the incompetent frail patients should not be neglected or taken for granted. Instead, they should be represented by their respective surrogates in the decision-making. Again, the power of attorney or advance directives, if previously prepared, should provide guidance if the patients later in life are unable to understand and communicate their preferences, values, interest, wishes, etc. So, geriatricians are ethically obliged to respect the frail patients’ privacy, ensure that they receive quality services. To get rid of any unnecessary abuses on the frail adults, Travis Labrum insists on the application of the ethics of care. For him, this is the best means for health professionals or caregivers to seek for the well-being of patients, eliminate malpractices and abuses on the vulnerable elderly patients.²⁴⁴ Therefore, it is now so evident that medicine is meant for human

life at all stages, but if it is applied in respect to the bioethical principles, it will go a long way to improve health outcomes, including the frail candidates.²⁴⁵

2B. 2. 0. Sickness and Medical Decisions at the End-of-Life

Life is an indivisible good! As earlier noted, each human life is not only unique, but it is also an unrepeatable gift, created in the image and likeness of God. As an unquantifiable gift from God with intrinsic value and inherent dignity, the Catholic Bishops of the state of New York, unanimously hold that human life deserves to be cherished, respected, preserved, cared for and promoted under a morally obligatory stewardship.²⁴⁶ Though, serious sickness or illness in relation to certain of diseases, can pose as a big threat to life itself. Most often, the concept trilogy of ‘illness’, ‘disease’ and ‘sickness’ have been used to capture different aspects of ill health or sickness. Even at that, there is need to make little clarifications of these terms.

According to Ellen L. Idler and Yael Benyamini, ‘illness’ is defined as the ill health a patient suffers, which can be easily identified with some kinds of mental or physical symptoms, minor or temporary problems, acute pains and sufferings. It may include health conditions that limit the person’s ability to live a normal life. Thus, illness can be controlled or managed, and it includes feelings of pain, discomfort, distress, weakness, fatigue, etc.²⁴⁷

Similarly, a ‘disease’ can be defined as a condition that can be diagnosed by qualified physicians or healthcare professionals, with the specific conditions known as biomedical cause, with proper treatments and cures. In the scientific paradigm of modern medicine, it simply refers to some kinds of abnormality both in the function, structure of body organs and systems. So, on the one hand, while the patients can be said to suffer from “illness” or “sickness”, on the other hand, doctors are expected to diagnose and treat “diseases” due to infection, injury, toxic exposure, cell degeneration, etc. This shows that since ‘illness’ is abstract, it cannot be cured but

can only be managed, while the term ‘sickness or disease’ is real, it can be cured or managed.²⁴⁸

The fact remains that, in such critical ill conditions, a substantial portion of patients have a very good understanding of morbidity and the inevitable mortality of life. At such critical moments in life, some patients can easily realize that medical interventions are not absolute solutions to human life and death. Evidently, this group of patients is likely to have different goals for care, if the sickness has a poor prognosis and death is so imminent. Such goals of care at this point, as listed by Lauris C. Kaldjian et al., may include: (1) to be cured; (2) to live longer; (3) to improve or maintain bodily functions, quality of life and independence; (4) to be comfortable; (5) to achieve life goals; and (6) to provide support for the family/caregiver.²⁴⁹

Most often, some of the ‘routine’ medical interventions performed in the clinical settings may have repercussions for the comfort of the patients. This suggests that the decisions to carry out certain medical options should depend on the health conditions of the patient, especially in the case of a terminal phase or end-of-life. This is because, patients approaching the end-of-life have terrible experiences that are marked with, not only by the symptoms suffered, but also by the actions and decisions taken by their respective physicians.²⁵⁰ For this reason, Nicholas A. Christakis et al., add that the identification of a patient’s critical or terminal status should represent an inflection point to reflect upon, to avoid any further unnecessary pains and suffering for the patient.²⁵¹

Obviously, once sickness has attained its advanced conditions of health, patients are exposed to life-sustaining interventions and practices. Such extraordinary medical interventions are mechanical ventilation, transfusions, parenteral nutrition, extrarenal purification, that may last until the end of life. So, in relation to the medical decisions at the end-of-life, the ethical topics for discussions or debates are likely to revolve around crucial clinical measures such as

sedation, withholding or withdrawal of medications, refusal of admission to the intensive care unit (ICU), etc.²⁵² Of course, a shared decision-making that will involve both parties – physician(s) and patient or surrogate(s) – in an active deliberation is considered as the ideal model of communication. Such is ethically recommended for decision-making on serious illness, especially when optimal treatments are uncertain, and risks of treatment are also high. Automatically, this ideal of health care communication is intended to elevate patient autonomy when the stake is so high, moving beyond advance care planning to define quality communication for real-time decisions.²⁵³

Very interestingly, as the principle of autonomy continues to gain more prominence, likewise the ‘decision theory’ has become a specialized topic of interest and study within several disciplines, especially in biomedical ethics. Within the clinical settings, it is to be noted that ‘decision-making’ is a very complex process. It is particularly challenging to make decisions, because life is at stake, and death may be so imminent. Granted that, out of deep respect for the dignity of life, the provisions for the ordinary medical means of preserving life is ethically justified and acceptable. This is because, with the ‘ordinary means’ there is a reasonable hope of benefits, the chance of survival is high, and it will not entail excessive burden both on the patient and family. So, to withhold ordinary cares with the intention of causing an easy death as in passive euthanasia, is morally judged as an evil, and gravely contrary to God’s will. Hence, the ordinary means of medical treatment are morally obligatory.²⁵⁴ The treatments that are considered “extraordinary” are not morally obligatory. This is because its burdens and consequences are likely to be out of proportion to benefit the patient.

So, medical decisions can become much more complex or difficult, especially when it concerns issues related to ‘extraordinary care’ like the withdrawal or withholding of medical

treatments. In a very critical sick situation, it would be ethically permissible for to forego any aggressive and expensive treatments, provided the survival rate is too low, as the pains pose a great burden to the sick. To allow a natural death to occur in such ill cases is not the same as killing. Then, to make decisions either to accept or refuse a treatment, it is necessary to consider the type of treatment options involved. There is need to weigh and balance the benefits and risks of these options, in relation to their likelihood to enhance the life of the patient.²⁵⁵

The important distinction between what is morally obligatory and morally optional extends even to food and water when it is medically recommended or not. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally.²⁵⁶ Since such decisions are often sensitive and complex, there is a great need to seek for guidance from experts who regularly make judgments on these matters, such as a physician, an ethicist, priest or chaplain.²⁵⁷ In most cases, the physician is usually the first to recommend for a particular course of action, or a kind of ‘decisional priority’, a phrase that is meant to imply antecedence but not superiority. Though, a competent adult patient, who reaps the rewards or suffers the consequences of any medical interventions, retains the final decisional authority. Such an authority can also be strictly reserved or delegated to the family or surrogate when the patient can no longer make decisions.²⁵⁸ The patient’s participation in clinical decisions is fostered by the legal doctrines of informed consent and by the ethical process of shared decision-making.²⁵⁹

Above all, even in the special cases of those whose lives are diminished or weakened by serious illness, they still deserve utmost respect and preferential cares.²⁶⁰ Thus, the notion of ‘*quality of life*’ – which refers to how a certain ailment affects a patient – should not be a criterion to determine how the patient ought to be treated or not. Besides, the quality of life is

defined as the degree to which each person is capable to enjoy his or her life, probably without suffering from sickness and treatment.²⁶¹ No matter the deteriorating health conditions of the patient, still they do not diminish the intrinsic quality, dignity and value of the patient's life. Therefore, every sick candidate deserves to be treated with much respect, caution, and compassion in order to provide possible cure, or even palliative care when cure is not possible. Thus, the basic ethical requirements for the decision-making ought to be satisfied to ensure ethically justifiable options in the treatment of patients.

2B. 3. 0. Basic Ethical Requirements for Decision-Making

To engage in making any ethical decisions, especially in clinical situations, it involves a process of evaluating and choosing among the available alternatives. Thus, such decisions are to be consistent only with ethical and legal standards or principles. This requires a commitment to do the right thing with moral consciousness, competency to know the potential benefits and risks involved. This is to ensure that a decision in serious ill case is ethical and effective. In every effective ethical decision, there should be demonstration of respect for 'dignity', elements of trust, fairness, responsibility, proper caring and accomplishment of the expected goal. Therefore, the process of decision-making demands basic ethical requirements to make justifiable and effective decisions for clinical matters. Such basic ethical requirements include:

2B. 3. 1. *Informed Consent*

As far back as in 1994, the European Consultation in Amsterdam made an official "Declaration on the Promotion of Patient's rights in Europe". This declaration in clear terms, strongly emphasizes on the 'patient's rights to information. Enshrined with the spirit for self-determination, this ethical imperative authorizes the patients to seek for comprehensive

information of his or her treatments procedures before making any autonomous choices. It is expected that during the process of making decisive choices, only relevant information that would be beneficial to the patient should be provided by the caregivers.²⁶² This is because, the concept of ‘informed consent’ implies the ethical principle of respect for the personal ‘dignity’ of each autonomous being, which is considered as the cornerstone of patient autonomy. The concept of informed consent is an element of autonomy. Both are not different as such; instead, they are closely related, and may overlap, especially in areas of definition. In effect, it is the principle of autonomy that provides the patient with fundamental right to always seek for necessary medical information in order to consent any medical options or not.²⁶³ Still in this view, Patricia A. Staten rightly indicates that the patients have the inalienable right to be involved in all aspects of their medical cares, including giving informed consent to the health care provider.²⁶⁴ Of course, it is only the autonomous competent persons are regarded as capable candidates to deliberate on the issues concerning personal goals and acting under this direction of deliberation.²⁶⁵

According to Habiba Marwan, the concept of informed consent as used in biomedical ethics suggests a voluntary uncoerced medical decisions made by a competent autonomous individual.²⁶⁶ In addition, to obtain an informed consent demands an ethical process that would provide the best opportunity for the patient to play active roles as an informed participant in his or her health care decisions. It serves as an invitation to engage in the healthcare decisions. As far as patients have the right to obtain necessary details related to their treatments, they also have the right to accept or reject any suggested options. Effectively, I agree with Kimberly J. Strom Gottfried who argues that such an ethical process would consider and guarantee the patient’s freedom, privacy and safety in clinical situations.²⁶⁷ The reason for this is to promote and keep

intact the existing trust between healthcare professionals and patients. This is because, most of the difficulties in the clinical practices today are related to certain factors impinging on the physician-patient relationship. However, it is mutual trust that stands out as fundamental basis for good relationship between a doctor and a patient. Still, there are still some occasions where patients may or may not be well informed about their ill situations. To obtain a valid informed consent from a patient, relevant information must be disclosed before any decision-making.²⁶⁸

Although, in critical ill cases, Bernard Lo holds that competent patients are not obliged to accept all the physicians' recommendations, even when the goals of care and benefits are very clear to them, with little or no potential risks as such.²⁶⁹ No matter what, patients still possess ethical and legal rights to refuse any unwanted medical interventions or bodily invasions. Though, the physician is not expected to act against the patient's objection, but it still beholds on him or her to inform the patient on the potential implications of such refusal. Seeking for the patient's 'informed consent', is just a kind of respect to the patient's autonomy, which indicates the central features in the patient – physician encounter. On this point, Albert Jonsen et al., would advise that there is need to get proper permission before engaging in any healthcare intervention on a patient, including disclosing of treatment information.²⁷⁰ Again, healthcare professionals should evaluate the mental capacity or competence of the patient to be treated, in order to affectively transmit information that might have effect on their informed choices.²⁷¹

Furthermore, in the doctor-patient encounters, all parties involved should actively participate in the informative process in order to execute informed consent, because 'dignity' is at stake. On this point, Theresa Arnold warns that such encounters should not be an occasion to increase unnecessary anxiety on the patients at the expense of losing confidence on the physician.²⁷² So, the terms to be used in passing the message across should be concise, clear and

simple, devoid of ambiguous medical terminologies or technical expressions. Thus, they need to be adjusted to suit the patient's language, level of maturity and competence. This will not only help the patient to understand fully the nature of his or her illness, but equally allows the patient to weigh and balance the relevant factors involved before consenting on any decisions. To this effect, the patients should be encouraged to ask relevant questions to better grasp the situation at hand.²⁷³ The patient needs enough time to digest and discern the information, before voluntarily deciding on the therapy to continue with. But in the state of emergency, such protocols may not be respected, instead every decision should be based on the patient's best-interest, values, preferences, wishes, etc.²⁷⁴

The doctors or caregivers only play the role as 'facilitators' in patient's decision-making. The legal requirements of informed consent, by Edward Etchells et al., indicate the type of information – nature, purpose, risks and benefits of treatments – a physician may disclose to the patients, and how such consent can be obtained.²⁷⁵ To obtain an informed consent then, it must be voluntary and free from coercion or manipulation that undermines the patients' free choices.²⁷⁶ Consequently, any consent given under fear, intimidation, misconception or misrepresentation of facts, are better held as invalid. Equally, Bernard Lo, highlights other issues that may render an informed consent invalid. They include: (a) The patient's inability to understand and communicate: (b) If the physician fails to communicate the relevant information to the patient; (c) If a 'competent' patient does not want to be involved the decision-making; (d) If the decision is unilaterally made by the physician; (e) If the patient is so rigid to his or her earlier position even when things get worse in the future; (f) Lastly, if the patient makes decisions that are against medical goals.²⁷⁷

From the legal and ethical perspectives, no person has the right to touch, let alone treat a patient without the patient's authorization. Once such an act is performed without the patient's full permission, it violates personal dignity and the autonomy of the patient. Legally, it is regarded as "battery", and it is a punishable offense.²⁷⁸ This was so evident in the incident that led to the suit filed by Mary Schloendorff, also known as Mary Gamble, against the Society of the New York Hospital. In the said incident, it is to be recalled that Ms. Schloendorff was admitted into the above hospital, precisely in January 1908 for just a stomach disorder that demanded subsequent medical examinations and treatments. Some weeks later, she was diagnosed of a fibroid tumor. At this point, a surgery was recommended by the physician, but she adamantly declined it, though she only consented to a medical examination with ether anesthesia. Even against her wish, the doctors proceeded with the surgery that made her suffer gangrene in the left arm, which later resulted into the amputation of some of her fingers. Hence, the legal suit against the hospital institution in 1914 at the New York Court of Appeals.²⁷⁹

During the legal proceedings, the Appeal Court explicitly noted that the surgery on the plaintiff, Mary Schloendorff, not only violated the principles of informed consent, but it also constituted ethically what is termed as a 'medical battery'. Ruling on the case, the presiding Justice, Benjamin Cardozo remarked that, any competent person of adult age in good mental and cognitive state, has the right to decide on his or her treatment options. Thus, any act of violation of the person's consent in this respect is regarded as a medical assault or malpractice, and the violator is liable for compensable damages. He equally added that except in the situations of emergency where the patient is incompetent or unconscious, then, the medical actors can proceed with treatments based on the 'patient's best interest'. Another interesting aspect of this case is that it has succeeded in the recodification of the laws of informed consent in most states in the

United States of America that are now applicable across the globe, today. Therefore, from the above case, it is clear to me that, even if a medical procedure is indicated and done properly, though the potential risks may develop, the patients still have a right to decline to those known risks, otherwise they may become compensable events. Also, this litigation battle has proven that obtaining a consent is very imperative than just mere physical routine examinations. To obtain consent is not only an ethical obligation, but it is legally recommended and mandatory.

2B. 3. 2. *Decision – Making Capacity*

Another component of the principle of autonomy is the concept of “Decision-Making Capacity” (DMC). Arguably, this doctrine is intended to promote and protect the autonomy of healthcare subjects. Following the same line of thought, a competent patient must be properly informed before making a free decision, in order to be deemed legally and ethically valid consent. In effect, such a person must possess the decisional capacity or competence, which can be referred to as the ability to perform an ethical task of decision-making in critical clinical situations.²⁸⁰ As the concept of informed consent is based on the principle that allows patients to make decisions for themselves, the decision-making capacity serves as a ‘gatekeeper’ concept in the process. Some experts like Helena Hermanna conceive ‘decision-making capacity’ (DMC) as an indispensable prerequisite for patients to make informed consent. This is because it directly relates to the patient’s right to self-determination.²⁸¹ Ethically, the DMC judgements suggest the moral duty to respect the autonomy of competent patients, and the great need to protect the incompetent patients in the decision-making as well. This implies critical ethical evaluations of DMC that can balance every moral concern, to ensure proper and responsible course of action. According to Manuel Trachsel et al., critical ill cases that signal the patients’ end-of-life are likely to invoke existential and medical-ethical decisions.²⁸² At this point, it becomes very

imperative to delve into the clarifications of both the meaning and constitutive elements of DMC, to be able to assess the validity of DMC in vulnerable cases.

The exegetical issues surrounding the concept of “decisional capacity,” show that the two concepts “decisional capacity” and “mental competence” are inter-changeably used without any precisions. These two concepts continue to divide experts and causing more confusions with regards to the appropriate term to be used to refer to this element of informed consent. To resolve this confusion, Linda Ganzini et al., affirm that the word ‘competency’ is exclusively a legal concept determined by a court of law, and its twin concept ‘capacity’ is coined with the physician clinical assessment of patient for the decision-making.²⁸³ For instance, in relation to prisoners, though, they are legally incompetent does not mean that they lack the capacity for decision – making. According to Albert R. Jonsen, ‘decisional capacity’ in the clinical setting refers to the patient’s ability to understand, evaluate and then make choices on his or her treatments options.²⁸⁴ Even John Bellhouse affirms that the concept of decision-making capacity is central to clinical practice. It helps to identify and weigh different medical options in respect to patient’s best interests.²⁸⁵ Meanwhile, in most common-law jurisdictions, there is a ‘presumption of capacity’. With these clarifications, I can now deduce that only a competent adult is considered to possess the ‘capacity’ to give or withhold consent to the treatment options, until the contrary is proven.

In some places like Britain, Alec Buchanan further clarifies that the term “capacity” is usually applied within legal jurisdictions, but on the contrary, precisely in the United States, it is the term “competence” that bears legal connotations and authority.²⁸⁶ Obviously, the legal assessments of capacity should be situated within the context of ‘case-specific’ and responsive to ‘situational variations’ in demands. It is the responsibility of the physicians to make assessments

of the patient's capacity that may effectively carry the weight of legal judgments, even though the courts may not be directly involved. This is because, the law has a backing to promote "prospective autonomy," or the right to control before losing decision-making capacity in one's future medical treatments.²⁸⁷ Also, with the mechanism of 'proxy directive' or 'durable power of attorney' for health care, a person can be designated as a 'surrogate' to direct the course of medical treatments on behalf of an incapacitated candidate.²⁸⁸

There are five basic elements or sub-capacities of decisional-making capacity, namely:

i. *Understanding*: It will be very difficult and unethical to give one's consent to certain issues without proper understanding of the basic facts that ought to be known. In this light, most people consider the concept of 'understanding' as most basic element of capacity. So, a patient needs to be fully aware of the diagnosis and prognosis, including the potential benefits or risks involved in his or her treatment options, before being capable to consent to any of them or not.²⁸⁹ Though, another school of thought still argue that this level of mental ability may not be substantially enough for generating the sort of health care decisions.

ii. *Appreciation*: It is expected that the patients express appreciation on the nature and significance of the decisions already made. This is the only way to show that 'alternative' treatment options serve the expected goal in the decision-making. According to Kathleen C. Glass, this element of capacity is held as a legal requirement that a patient should not only have an 'insight' into the circumstances of a given decision, but ought to show appreciation of the entire process.²⁹⁰ By showing an 'appreciation' it means that the patient is in accord with the decisions taken, which can be expressed facially with smiles, gestures or signs, etc.

iii. *Reasoning*: The power of rationality is also an essential element of capacity. In effect, one must be in good state of mental and cognitive capacity in order to be able to understand and appreciate any medical decision made on one's behalf. Without sound mental ability to engage in *reasoning* and manipulate information rationally, I would believe and equally agree with the school of thoughts led by Alec E. Buchanan that, it is impossible for one to have a full grasp of the details involved in the decision-making.²⁹¹ At times, the concept of reasoning is often left vague in the discussions concerning decisional capacity. This is because, in critical ill conditions, the patients' reasoning faculty may not be so active. Also, I would think that the issue of subjecting a seriously sick candidate into too much of mental processes can render him or her more vulnerable. Judging from the normative standards of reasoning, if the patient is consistent, able to weigh the benefits and risks, and if he or she is able to derive conclusions from premises, then such a person is considered capable for decision-making.²⁹² The patient's application of sound reason without any influence to make deliberates choices, is highly recommended.²⁹³ So, I would propose that all the parties involved in the decision-making should be just to respect the autonomous choices of patients, unless the decision-making capacity is questionable.

iv. *Choice*: Evidence shows that in serious health scenarios, the subject may be able to understand, appreciate and rationalize perfectly in a decision process, but at the same time, he or she cannot make choices between alternative treatment options. For instance, this is likely to occur mainly in the cases with stroke victims. Such victims, in their critical conditions they may possess high level of active mental capacity that can help them to understand and reason well, but may not be able to express their choices, either verbally or through gestures (e.g., blinking the eyes, lifting a finger, etc.). So, the ability to express choices by the subjects during decision-making in clinical issues can be considered as one of the elements that prove capacity.²⁹⁴

v. *Values*: It is very interesting that ‘value’ is also included among the elements of capacity. In this case, with the evolution of sickness, the value of a patient is likely to change at any given time. Thinking ahead on such situations occurring, Allen E. Buchanan and his colleague, suggest that a patient is not expected to function with a fixed, immutable, stable or rigid value. By allowing a flexible value, the patient should clearly indicate it, especially in the Advanced Directive using the words like ‘best interest’ or ‘a conception of what is good’ for the patient as the sickness evolves. To weigh the risks and benefits of the alternative choices in critical cases requires flexible values.²⁹⁵

Therefore, the ability to make medical decisions is a continuum, with no natural starting point for adequate decision-making capacity. It requires a cluster of abilities that should be subjected to high level of scrutiny in different contextual situations. With all these elements of capacity present, a competent patient will be able to understand in clear terms: (a) The nature of the intervention; (b) The purpose of the intervention; (c) The risks and benefits of the intervention; (d) The risks of not carrying out the intervention; and (e) The risks and benefits of alternative interventions.²⁹⁶ It is only when a patient is judged incapable or incompetent to proceed in the decision-making will the role of the surrogate be appreciated. Lastly, every decision should be consistent with the patient’s values, interest, wishes, goals and preferences.

2B. 3. 3. *The Role of Surrogate in the Decision – Making*

The primary purpose of seeking for medical treatments is mainly to provide cure or overall well-being of the patients. At the initial stage of an illness, a patient may be fully conscious of everything about the illness, and the hope of recovery is always so high at that point in time. Gradually, as the health situation gets worse, it can render the patient more vulnerable,

unconscious, incapable to participate in the decision-making of the treatment options. In such events when ‘things are falling apart’ with regards to the patient’s critical situation, then the role of the ‘surrogate’ becomes very imperative. The term ‘surrogate’ refers to as a decision-maker, an agent, a healthcare proxy, who is chosen to advocate on behalf of an incompetent patient. Acting as an ‘extension of the patient’, Lawrence A. Frolik believes that a surrogate is morally obligated to play important ethical roles for the best interest of the patient, just like the way the patient would have decided for himself or herself, if he or she were to be competent.²⁹⁷

Meanwhile, there are at least four types of surrogates, namely:

- (i). *Patient-designated surrogates*: They are also known as proxies, agents and attorneys-in-fact. Legally, they can be officially or formally appointed as advanced directive or a durable power of attorney for health care. Though, a patient can informally or orally, designate a surrogate directly to the supervising provider in the presence of a witness. Once designated, the provider then confirms it on the medical record and has that signed by a witness as well.²⁹⁸
- (ii). *Court-designated surrogates*: If a petition is filed by a relative or by the administrator of a long-term care facility where the patient resides, the court can designate a surrogate as ‘guardian’ or ‘conservator’, who may be a family member, friend, dis-interested stranger, non-profit or for-profit agency, etc. It is also referred to as “displaced decision- maker”, because the surrogate is not chosen directly by the patient.²⁹⁹
- (iii). *Physician-designated surrogates*: In the absence of any of the above designated surrogates, the healthcare provider has the power to select someone as the ‘default surrogate’ for the patient. Based on the circumstance of the appointment, it is sometimes referred to as “devolved decision-making.” A default designated surrogate should be a relative, the patient’s spouse, adult child, parent, adult sibling, etc.³⁰⁰

(iv). *Surrogates for un-befriended patients*: This simply refers to a situation whereby, a patient has no known family or friends to make health-care decisions on their behalf, a decision-maker may be chosen to decide on behalf of ‘un-befriended’ patients. These decision makers include temporary guardians, social workers, clergy, ethics committees, and regional surrogate decision-making committees.³⁰¹

Basically, the major roles of a surrogate are to implement the three ethical standards in the decision-making for an incompetent or incapacitated candidate. Sequentially, James L. Bernat presents these standards thus: *subjective standard*, *substituted judgement*, and *best-interest standard*.³⁰²

(a). *Subjective Standard*: This ethical standard is primarily intended to implement the patient’s expressed wishes, values, preferences, etc. Some patients who are in critical health conditions might have already planned ahead of time concerning their treatment options in the future. So, once it is clearly stated in the advance directives or living will, the surrogate may not have much role to play regarding decision-making. However, if the incapacitated patient had expressly confided on the surrogate the modalities of his or her preferred future medical therapies, then the surrogate, as the subjective first-hand evidence, should insist on the implementation of the ‘expressed wishes’ of the patient.³⁰³

(b). *Substituted Judgment*: Such judgment must be in accord with the patient’s preferences and values. When a situation calls for the application of ‘substituted judgement’ standard, by inference or speculation on the patient’s earlier wishes, the surrogate may step up to ensure that they are respected in the course of decision-making. Taking into the cognizance of the patient’s background, belief or affiliations, all the decisions should closely conform as much as possible to

what the patient would have done or intended under the circumstances, if he or she were capable to do so.³⁰⁴

(c). *Best-Interests Standard*: Any decision that is based on the ‘best interests standard’ is expected to promote the patient’s welfare. Granted that, a situation may arise, where there is no reliable evidence of the patient’s expressed wishes, values, or preferences. Or, worse still, a legal appointed surrogate may not know any information about the patient. In such situation, it is needless to refer to the subjective nor to the substituted judgment standards. Rather, since the autonomy of the patient, in my own view, has hit its limitations, then the surrogate should decide based on the standard of patient’s best interest.³⁰⁵

To draw the curtain closed at this juncture, I will still reaffirm that medicine is meant to care for human life, and not vice versa. With special respect to ‘dignity’ of human person, and with the notion of human solidarity in medical practice, it then becomes very imperative to lay more emphasis on the application of bioethical principles, especially in Nigerian healthcare system, to ensure that this ‘dignity’ is not undermined, violated or lost in all medical activities. Nevertheless, the situations for informed and shared decisions do not just happen by chance. Such situations suggest clinical scenarios that involve different parties, the patient and family on one side, and the medical team on the other side. So, I would suggest here that all the parties involved in the decision-making should be very clear on the right decisions to make, and then match them with positive action plans. Therefore, the fundamental role of the surrogates in the decision-making is to safeguard prospective autonomy of the patient at the expense of the traditional medical paternalism. Such roles can spring up once the patient loses capacity, and it vanishes when the patient regains capacity or competency.

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Chapter Three

3.0 Medical Care in Multicultural Society: Nigeria as a case study

Introduction:

Diversity is an undeniable reality in a multicultural setting. The recent world population is estimated to be around 7.8 billion peoples co-existing in about 200 different independent states with over 6000 languages.³⁰⁶ Being affiliated to number of social, religious, spiritual, cultural traditions, etc., there is every possibility for all forms of diversities to exist among peoples and nations. Besides, ‘culture’ is an embodiment or representation of peoples’ way of life. So, *cultural diversity* as conceived by the UNESCO declaration in Paris 2002 is nothing but a common heritage of the entire human family. This declaration also indicates that diversity in cultures is very necessary just as biodiversity is for natural ecology. Therefore, any defense of cultural diversity supposed to be considered as an ethical imperative that cannot be separated from the respect for the dignity of human persons.³⁰⁷ In the context of clinical practices in a heterogenous settings like in Nigeria, there are some circumstances that can lead to some ethical conflict of opinions in the decision-making while caring for patients. The issues like a patient refusing treatments due to cultural or religious views, or requesting for futile treatments, withdrawal and withholding of treatments, euthanasia, physician assisted – suicide etc., all these are enough to provide an atmosphere for ethical conflicts. Therefore, cultural diversity in this sense, as remarked by Tomislav Bracanovic, is something that every frontline healthcare giver should understand and respect, especially while making any treatment decisions for the patients.³⁰⁸

Granted that bioethics is of western origin, but most of the bioethical issues are of

great global concerns. Thus, the application of bioethics, according to Subrata Chattopadhyay and his friend, Raymond De Vries, should be suited within the local cultures.³⁰⁹ In multicultural settings, different opinions are bound to exist with distinctive understandings of what constitutes moral conduct.³¹⁰ However, to solve any global ethical problems with coordinated efforts (human solidarity) is ethically justified and acceptable. Though, any form of imposition on peoples' cultures can be regarded as a western imposition of bioethics as a new form of ethical imperialism.³¹¹ For people like Ten Have and Gordijn, taking seriously the bioethical questions in multicultural milieu, are against the imposition of any normative framework on others. Rather, they suggest a kind of normative considerations and respect to other exiting cultural norms in different contexts, especially in Nigeria.³¹² Therefore, since this dissertation makes a bioethics critique on the Nigerian healthcare system, it would be necessary to discuss on the nation as a multicultural and ethnic pluralistic state. This will help one to know how bioethics could easily be applied in such a multicultural state while respecting the 'dignity' of each person and the peoples' cultures as well. This affirms what Henk T. Have means that bioethical ideas though developed in the West can also be applied elsewhere around the world.³¹³

3A. 0. Nigeria: A multicultural and ethnic Pluralism

3A. 1. 0. *Nigeria as an Independent Nation*

It would seem as an incomplete academic adventure to engage into a bioethics critique on the health system in Nigeria to the exclusion of its brief historical background as an independent nation. Indeed, the primary objective to delve into the historical aspect of Nigeria is to present a clear view to an avid reader the possible challenges associated with the application of biomedical ethics in such a multi-ethnic nation. In effect, the history of the afore-mentioned autonomous

nation ranges from the pre-colonial, colonial to post-colonial eras. The pre-colonial Nigeria shows that the country had been in existence in the form of different multi-ethnic groups before the advent of colonialism. With firm respect to their respective cultures, customs, religions, norms, values, traditional medicine, trade relations, etc., the people of Nigeria had been in constant mutual relationships with one another for ages before the arrival of the so-called white masters.³¹⁴ Perhaps, just as Cecil R. Niven articulates that, the people might have begun the remotest processes of instituting a federation of multi-ethnic cultures before the colonial invasion. Though, during this epoch, there was no official known name like “Nigeria”. The word ‘Nigeria’ is of a modern nomenclature used by the Europeans for “Negroland”, at one time it was almost officially called “Nigritia”, which at the extreme, it represents the black people living along the coast of River Niger.³¹⁵

It was in 1914, during the regime of Sir Frederick Lugard as colonial governor, that the northern and southern protectorates of Nigeria were amalgamated, without any due consultations or consents from the different ethnic groups that make up the country.³¹⁶ Besides, it was since after World War II that most of the progressive constitutions provided an increasing representation and electoral government of Nigeria as an independent nation. While setting the record straight, it can be said that the colonial period properly lasted in Nigeria from 1900 to 1960, after which Nigeria gained its ‘so-called’ independence on the 1st of October 1960. Of course, most experts are still divergent in opinion on whether the British conquest of Nigeria was as result of disguised benevolent motives that ended up with inhuman slavery, or it was more of instrumental motives for quest for wealth and power. All these remain topics of controversial dispute between African and European historians, yet to be settled.³¹⁷ The fact remains that the

forceful amalgamation of different ethnic and religious groups into one federation, known as 'Nigeria,' today without due consultations, is the root causes of internal tensions till date.³¹⁸

3A. 2. 0. *Nigeria: A nation with multiple Ethnic Groups*

As an independent state, Nigeria is culturally a heterogeneous nation that is characterized with multi-ethnic diversities. The cultural ethnic diversities range from the linguistic, norms, religious and other modes of differences that reflect the number of different ethnic groups that constitute the nation known as Nigeria today.³¹⁹ The term 'culture' as defined by Alfred L. Kroeber et al., simply refers to the totality of people's ways of life, including, behaviors, knowledge, beliefs, traditions, customs, religion, music, art and craft, dressing, food, and any other capabilities. In other words, it consists of explicit and implicit patterns of behaviors acquired and transmitted by symbols that reflect the distinctive achievements of human groups, including their embodiment in artifacts. The essential core of culture consists of traditions that are historically derived, and selected ideas especially their attached values.³²⁰

Both society and culture are interdependent, none of them can exist without the other.³²¹ Moreover, the Cultural Policy of Nigeria (1988) articulates the concept of culture as the totality of the way of life evolved by a people over a long period of time. People are enshrined in their respective cultures in order to meet up with the challenges of their daily activities, and then to provide orderliness and fundamental meanings in their different aspects of existence like in the social, political, economic, aesthetic and religious spheres. Very interesting is that the norms and mode of organization in every culture are what distinguish a particular people as being unique from others.³²² In the same light, 'ethnicity' though related to culture, but they are not the same. It simply refers to as the awareness on the part of a group of people having a separate identity based on common history, race, language, religion, culture and territory.³²³

Logically, an ethnic group represents a community of people who share the same cultural and linguistic characteristics including history, tradition, myth, origin, etc. So, ethnic pluralism suggests a heterogeneous society that consists of larger and smaller ethnic groups with multiple diverse cultures, multi-lingualism, different socio-political affinity, etc.³²⁴ Reasoning in the same direction, Gabriel C. J. Okpalike confirms that Nigeria is a perfect example of multi-ethnic nation. Today, its population is estimated to be over one hundred and eighty million (180,000,000) inhabitants, with more than 300 different ethnic groups, with about 420 different languages, and more than 830 dialects.³²⁵ Again, it is recognized as the most populous country in Africa and among the 10 most populous countries of the world. Unfortunately, the concept of ethnicity is most often used interchangeably with tribalism in Nigeria to portray some negative connotations. Reacting to this assertion, Chinua Achebe remarks that ‘ethnicity’ is used as a discriminatory tool against the concept of citizenry in Nigeria because of one’s place of birth or background.³²⁶

The ethnic compositions of Nigeria are broadly classified into ethnic majorities and ethnic minorities. This classification continues to influence every aspect of the nation’s life, including the health sector. For instance, in the Nigerian politics, issues regarding power, allocation of resources or benefits, including major political appointments, all depend on the numerical strength of each of the ethnic groups. However, the major or dominant ethnic groups comprise of the Hausa-Fulani in the north, the Yoruba in the southwest, and the Igbo in the southeast. The rest of ethnicities constitute different degrees of minority status. So, under the umbrella of large minorities are other different ethnic groups like the Ijaw, Kanuri, Edo, Ibibio, Nupe, and the Tiv. All of them put together constitute about the 27.9% of the entire population of the country.³²⁷

Such co-habitation of these multicultural ethnic groups is always characterized with intense ethnic polarizations, struggles and endless strife among the people of Nigeria.³²⁸ This is because, as remarked by Patrick A. Edewor et al., the colonialists autocratically and undemocratically amalgamated the Northern and Southern Protectorates of Nigeria without due consultations of all the peoples involved from different ethnic groups. This is one of the major causes of the ethnic conflicts in our nation.³²⁹ Even Oliver A. Onwubiko, in his book titled “African Thought, Religion and Culture” published in 1991, is of the opinion that such an atmosphere of co-existence that continues to affect every aspect of the nation’s life needs to be addressed, urgently. To buttress the reason to address this issue, he equally noted for instance that, allocation of resources or benefits, especially in the health sector depend on the numerical strength of the ethnic groups.³³⁰ Evidently, with such intense ethnic polarizations in Nigeria, there is every tendency to always be in incessant conflicts and disagreements among these ethnic groups. Affirming this, Adiele E. Afigbo remarks that the struggle for ‘inter-ethnic rivalry for domination’ has become a ‘fatal affliction’ of the country’s quest for development.³³¹ Hence, the practice of inequalities and fight for superiority are real between the northerners and the southerners of the country, including other minority groups.³³²

In an atmosphere with much ethnic chauvinisms, the application of bioethics in such multicultural milieu like Nigeria is likely to face multiple challenges due to cultural influences from different ethnic compositions. Reflecting on these challenges of ethnic groups in Nigeria, Oliver A. Onwubiko again advocates for re-evaluation of the terms like ethnicity, tribalism, etc., to avoid more negative consequences of ethnocide in the country’s harmonious existence, especially in the health sector.³³³ Hence, it calls for national integration and cultural competency in the health system. This can be achieved by setting aside major differences without neglecting

the original identity or backgrounds of each group. It also requires ‘human solidarity’ with good coordinated and concerted efforts based on equity and justice towards unified value system in the healthcare system.³³⁴

3A. 3. 0. Nigeria and Medical Practice

There are two kinds of medical practices in Nigeria: *traditional* and *western* styles of medicine. Though, this dissertation focuses more on the western style of medicine, but it will be also nice to say brief things about the traditional medicine, since it stands as the cradle of medical care in Nigeria. Before the western colonization, African Traditional Medicine (ATM), had already existed in this part of the globe, especially in Nigeria, which had continued to sustain the people for ages till date. The people still patronize it, because it is always very available, accessible and affordable, and it relies so much on the cultural norms.³³⁵ One of the most interesting aspects of the African traditional medicine is that it functions with a kind of area of specialization. So, African medical specialists include the traditional herbalists who are concerned with different kinds of medical cares to patients. Applauding the natural endowments or gifts of the African herbalists, Udoabata Onunwa remarks that such profound knowledge of healing powers with roots and herbs, is so amazing.³³⁶ Evidently, for centuries now such knowledge continues to play a big significant role in the healthcare systems in Nigeria and in other countries of the African Region and beyond.³³⁷

Another group is the traditional spiritualists or diviners, who strongly believe that some of the illnesses or diseases do not pertain to natural or physiological causes but are traceable to the spiritual or meta-physical realm. In effect, to apply any effective medical remedies to such spiritual ailments, the attention of traditional spiritualists or diviners must be highly solicited to ascertain their remote and esoteric causes before providing proper cures to them. Even without

despising the achievements of Western medicine, this group of traditionalists still believes that there are some ailments which the western medicine may not easily provide their cures.³³⁸ Also, there are specialists among the traditionalists who have proven to be very resourceful in rendering effective services to patients with mental, psychological or psychiatric cases, etc. There is also a group of traditional midwives who endeavor to provide prenatal cares to expecting mothers, attend to the birth delivery and provide post-partum care to the mother and her infant.³³⁹ Also in the list is the group of specialists who focuses on bone setting services. Thus, before the emergence of western chiropractors, osteopaths, physical therapist and even establishment of orthopedic hospitals, traditional bone setters were the main providers of such treatments. With their expertise, they are capable to treat joint dislocations and re-set bone fractures.³⁴⁰ Today, some physiotherapists attest to the fact that on several occasions they can refer some cases to the traditional bone setters for proper treatments.³⁴¹ Although, the traditional practitioners and their practices may vary, but the few common features among them are: a personal involvement in the healing process; protection of the therapeutic knowledge by keeping it a secret; and being rewarded or paid in return, which can be done in different forms, for their services to the patients.

It is a basic truth that the African traditional medicine also forms part of the global overall traditional medicine from which most of the new age western scientific medicine has evolved.³⁴² According to Ishaq I. Omoleke, the relevance of traditional medical practice in Nigeria is very pivotal to the acceptance of western-styled of medicine. He still maintains that it is very difficult or impossible to separate one from other.³⁴³ Today, the western-styled of medicine is observed to have had an overbearing influence on the African traditional medicine, especially since the arrival of white folks in Africa, particularly in Nigeria. In this respect, David

Arnold is convinced that the introduction of western-styled form of medicine in places like Nigeria still forms part of the colonization agenda. He then remarks that the intention behind the practice of western medicine in this region is very symbolic to civilization and modernity. Though, such may be understood as being antithetical to the African traditional medicine, which has been criticized as being uncivilized, unscientific and undocumented by the forerunners of the western healthcare system.³⁴⁴

The introduction of the western medicine in the first half of the 19th century is noted as a new era that marked the beginning of transformation in the healthcare system in Nigeria. Precisely, it was during the period of explorations, expeditions and colonization by the Europeans that brought about the first western-styled of healthcare services in Nigeria. Initially, the European explorers and traders came into Nigeria with few white doctors who were primarily intended to cater for their well-being without any medical consideration for the welfare of the indigenous people. It was the arrival of the different early Christian missionaries from the Roman Catholic Mission (RCM), the Church Missionary Society (CMS for the Anglicans), Methodist and the Baptist that opened the door for the infiltration of western medical system in Nigeria.³⁴⁵ This innovation in the medical system was appreciated as an alternative to the existing indigenous medical services in the country. Though, at a point, the colonialists had tried to neglect and push the African traditional medicine to the background. The worse is that the practitioners of the ATM were always derided and labelled as ‘witch-doctors’. Despite all the attacks, neglects, rejection and derision of the indigenous healing practices, the ATM is not yet extinct. Even though it has survived the tests of times, Toyin Adefolaju hints that much of efforts are still needed for it to be fully harmonized and integrated with the global system of health care delivery.³⁴⁶ In sum, there are two kinds of medical services in Nigeria, but this is not to conclude

that in practice, both share similarities in all forms and practices. Whatever be the case, I still believe that the fundamental objective of both styles of medicine (traditional and western) is to provide proper care to all the inhabitants in Nigeria.³⁴⁷

3B. 0. Nigeria and Health Care System

Introduction:

Having briefly discussed on the African traditional medicine, it is time to focus more on the existence of healthcare system that bears its origin from the western-styled of medicine. Besides, to be in the state of good health is the most significant ingredient of human life. This is because, “health is wealth”, and it remains the greatest asset of human existence and life. The concept of ‘health’ as defined by the World Health Organization refers to a state of being absolutely in good physical, mental and social well-being. Though, it does not necessarily imply living in the absence of illness or bodily disorders that are associated with pains and sufferings.³⁴⁸ In addition, Innocent O. Eme et al., explicitly noted that the term ‘health’ exclusively refers only to the living persons. As such, neither death nor a dead person has something to do with health, whether bad or good, no matter the state. This definition invokes a kind of moral obligation to always strive for a conducive viable climate that would ensure the total well-being of each person. It is only in such a state of good health will one be able to aspire to attain their highest human aspirations, maturity or developments and self-realizations.³⁴⁹

The above definition on the concept of health, makes it very easy to understand a ‘health system’ or ‘healthcare system’, as an organized group of medical personnel, institutions and resources that work to deliver proper medical cares for the targeted sick vulnerable human populations. Each independent nation is expected to design and develop a unique kind of health

system according to their needs and resources, in order to meet up with the goals of the primary healthcare and public health of the people.³⁵⁰ In support of this clarion call, the World Health Organization (WHO) adds that all the goals of the healthcare systems are expected to promote the good health of the citizens, be responsive to the expectations of the masses including fair means of funding operations. These goals revolve around the four vital functions of the United Nations, which include the provision of adequate health care services, resource generation, financing and stewardship.³⁵¹ So, reflecting on the efforts to realize the goals of healthcare system, it is necessary to delve into the existence healthcare system in Nigeria.

3B. 1. 0. The Existence of Health Care System in Nigeria

According to Richard I. Cook, every health care system should be evaluated based on the quality, efficiency, acceptability and equity of its services. He equally notes that a healthcare system can as well be evaluated based on the efficient management of the 5Cs: Cost, Coverage, Consistency, Complexity and Chronic illness. This is the best means to ensure efficiency and continuity of the healthcare services.³⁵² Very interestingly, Nigeria is seriously making a lot of efforts to meet up with the goals of the healthcare system to ensure the good health of her citizens. In this respect, the provision of health cares in Nigeria, which comprise of – *primary, secondary and tertiary cares* – remains the functions of the three tiers of government: local, state and federal government levels, respectively. Therefore, a brief analysis of each of the three levels of health institutions in Nigeria will make this discussion more comprehensive to an interested reader.

3B. 1. 1. *Primary Health Care at Local Government Level:*

The primary healthcare system which is considered as the cornerstones of the universal health systems of the people is managed within the local government areas in Nigeria.³⁵³ Also, it

is boosted with the effective support from the respective state ministries of health and with the collaborations from the private medical owners.³⁵⁴ So, primary healthcare (PHC) system covers all the issues related to health in the rural localities, villages, towns and districts. It is also good to add that the primary health care is the essential health care that is based on scientifically sound and acceptable methods of medical services. Hence, it is one of the surest ways, according to Starfield Barbara, to make proper health care accessible to all individuals and families in a local communities.³⁵⁵ Even in the Declaration of Alma-Ata in Kazakhstan of 1978, the World Health Organization clearly states the goals of PHC. The main objective is geared towards making provision of “healthcare for all!” By making provisions for ‘healthcare for all’ is a means to empower the people and their respective communities. So, in the context of daily increase of the world populations, the WHO reaffirms the need to put up more efforts on the primary care services both in the developed and developing nations like Nigeria. Again, to meet up with the goal of providing “healthcare for all”, such medical services can be provided in different settings like in urgent care centers which can provide same day appointments, or services on a walk-in basis and frequent home visits.³⁵⁶

Nevertheless, health care at the primary level is regarded as the lowest level and the entry point to medical services to provide basic primary care services, spanning with promotive, preventive, curative and rehabilitative services. The primary healthcare centers are mainly located within the Nigerian political wards – which are known as the smallest political units or structures. Each political ward covers a geographical area with at least a population range of 10 000 to 30 000 people. Every political ward in Nigeria is considered as an operational area for delivering minimum health care packages.³⁵⁷ Some of the health facilities at this level are either static or mobile structures where different types of health services are provided by various

categories of health workers. These healthcare posts are known with the terminologies like dispensaries, health clinics, health centers, primary health centers, maternities, health posts and comprehensive health centers. They are either owned by the government or by the private for-profit and not-for-profit organizations like the religious institutions, charity organizations, NGOs, etc.³⁵⁸

With regards to the administration at this level of healthcare delivery, the PHC services have been jointly managed by the state ministries of health, ministries of local government affairs, the Local Government Service Commission, and other related health ministries. It is the primary responsibility of each Local Government Area in Nigeria, with the support of state ministry of health, to provide funds exclusively to all the government owned primary healthcare centers.³⁵⁹ In conclusion, the primary healthcare system consists of a set of health interventions and services that address health and health-related problems that would result in substantial health gains at low cost to both the government and its partners. The minimum health care package at this level includes the following interventions: (a) control of communicable diseases (malaria and sexually transmitted infections, including HIV/AIDS); (b) maternal and newborn care; (c) child survival; (d) nutrition; (e) prevention of noncommunicable diseases; and (f) health education and community mobilization. At this level, Benjamin S.C. Uzochukwu reflects on the strategies for the provision and sustainability of these six listed interventions which include service provisions like essential drugs; improved quality and quantity of human resources for health; and health infrastructural developments.³⁶⁰

3B. 1. 2. *Secondary Health Care at State Level:*

In this context, the terms “secondary care” are equivalents to “hospital care”. It is expected that at this level good medical services are provided to both the in-patients and out-

patients, including the patients that are referred from PHC facilities, by different medical experts. All the secondary care hospitals follow the state medical directives or guidelines and are equally managed and supervised by the state ministry of health.³⁶¹ It is clearly stated in the Code of Medical Ethics in Nigeria, that every secondary health institution should be well equipped in order to provide a full complement of curative cares. Such an institution like a General Hospital is expected to possess in its capacity the basic hospital units with a minimum of at least three doctors to ensure provision of adequate medical treatments at this level.³⁶² With their level of expertise, the doctors will be able to cover host of medical emergencies in rotations, even though each practitioner may develop an interest in one specialty or the other.³⁶³ Every secondary health institution is expected to possess in its full capacity the followings:

- i. Accident and emergency unit
- ii. Diagnosis unit comprising radiology and health pathology services
- iii. Out-patient consultation unit
- iii. Different Medical Wards (which include, surgical ward, medical ward, pediatric ward, antenatal ward labor ward and post-natal ward, etc.)
- iv. Treatment facilities (operating theater, pharmacy department with shop or market, physiotherapy and diet kitchen or restaurant).

In collaboration with the primary healthcare system, the secondary health system at the state levels plays major roles to offer basic maternal-child health, immunization, nutrition, first aid treatments and other referral services. Most of the acute medical cares for a brief but serious illness, injury, or other health conditions can as well be properly treated at the different General Hospitals in Nigeria, especially at the emergency departments. Other acute care settings may include intensive cares, coronary care, cardiology, neonatal intensive care, etc., but the

patients need to be stabilized first at this level before being transferred to another higher dependency unit for further treatments.³⁶⁴ In collaboration with the primary healthcare system, the secondary health system at the state levels plays major roles to offer basic maternal-child health, immunization, nutrition, first aid treatments and other referral services. If the secondary health care system is well equipped, James Pfeiffer believes that it can as well play vital roles for the prevention and control of diseases based on evidence of prevalence, reduce morbidity and mortality, and can equally ensure feasibility control of cost-effectiveness.³⁶⁵

3B. 1. 3. *Tertiary Health Care at the Federal Level:*

A tertiary medical care refers to a more scientific specialized consultative kind of healthcare services with qualified medical professionals. Relying on the advanced scientific medical technologies, this level of healthcare delivery can offer effective quality medical treatments to both the in-patients, out-patients and other patients on referrals from the primary and secondary level.³⁶⁶ Very similar to the secondary health institutions, the tertiary medical institutions are equivalent to specialist hospitals, and the scope of medical coverage at this level includes the following major components:

- a). Accident and emergency unit
- b). Diagnostic and radiology unit
- c). Out-patient consultation unit
- d). Ward units
- e). Treatment unit

With more sophisticated medical technologies, all the facilities of the tertiary institution are devoted to the practice of one or more specific disciplines of medicine, e.g., pediatrics,

orthopedics, psychiatry, surgeries, dentistry, obstetrics and gynecology, etc. Other specialties include: cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, etc. The tertiary medical institutions in Nigeria work in conjunction with the different Teaching Hospitals to render medical services in the following departments of anesthesiology, dental surgery, general medical practice like family medicine, internal medicine, public health and primary health care.³⁶⁷ All the tertiary healthcare services in Nigeria are provided predominately at the federal government established medical institutions like the Teaching Hospitals and Specialist Hospitals. Today, there about 54 federal tertiary hospitals comprising of 20 teaching hospitals, 22 federal medical centers, 3 national orthopedic hospitals, 1 National Eye Centre, 1 National Department for Ear, Nose and Throat Centre, and 7 psychiatric hospitals. Administratively, they are under the supervisions of the Hospital Services Department of the Federal Ministry of Health (FMOH). Though, it is the primary responsibility of the federal government of Nigeria, in collaboration with the state government, to make necessary provisions for the smooth running of these tertiary medical centers.³⁶⁸

It is important to add that health care services in Nigeria are provided by a multiplicity of health care providers in the public and private sectors. Recent report shows that there are more 35000 health facilities located at different places within the 36 states and the Federal Capital Territory (Abuja) of Nigeria. Out of the total number of these health facilities, about (88%) are PHC facilities, (12%) are secondary-level facilities, while only (1%) are tertiary-level facilities. More than 66% of the facilities are public or government owned, while the rest are privately owned by individuals or institutions.³⁶⁹ The main categories of human resources for the healthcare services in Nigeria are doctors, nurses, midwives, laboratory staff, public health

nurses, public health nutritionists, community health and nutrition workers, including the community healthcare officers, community health extension workers and community health assistants.³⁷⁰

3B. 1. 4. *The Regulatory Policies for the Healthcare System in Nigeria:*

In accord with the World Health Organization (WHO) of 2005 Resolution that emphasizes on the “right to health for all”, the government of Nigeria had set up several statutory and policy frameworks that will govern health and healthcare services of her citizens. The few most crucial of them are: Nigerian National Health Policy (NNHP) 1988, National Agency for Food and Drug Administration and Control (NAFDAC) 1993, Code of Medical Ethics in Nigeria (1995), National Health Insurance Scheme (NHIS) 1999, and National Health Act (NHA) 2014. All these statutory and policy frameworks are established with specific goals to achieve. For instance, the objective of NNHP is meant to strengthen the Nigeria’s health system in view to deliver effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to the people. In other words, this policy reaffirms the right to ‘health care for all’ as one of its underlying principles.³⁷¹ By implication of this right to medical cares, every Nigerian should be accorded with an inalienable entitlement to medical therapies or interventions in the event of illness or medical emergencies, regardless of ability to pay.

Another turning point of the statutory and policy frameworks is the codification of laws and medical ethics, otherwise known as Code of Medical Ethics in Nigeria (1993), to guide and regulate the medical practices in the country’s healthcare system. This is as result of the Law of the Federal Republic of Nigeria 1990 (Decree No. 23 of 1988) that demands for a review of medical practices in order to formulate the Code of Conduct that is desirable for the practice of

the medical professions in Nigeria. Thus, the Medical and Dental Council of Nigeria was constituted in accordance with the provisions of the law. The last of which was revised in January 1995, and it is known as the “Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria”.³⁷² Following the same pattern, it is the latest revised edition of the “Rules of Professional Conduct for Medical and Dental Practitioners” that finally gives birth to the long expected “Code of Medical Ethics in Nigeria”, in consonance with its legal status. A strict adherence to the application of this Code of Ethics, is likely to bring the incidence of ethical violations to the barest minimum, enhance the image of the profession, increase the patients’ confidence in the physicians and then offer legal and ethical protections to the conscientious practitioners.³⁷³

Worthy of note is that the NHA is considered as the first comprehensive domestic legal framework statute on health policy that accords explicit recognition of the peoples’ right to health care. In effect, this National Health Act makes provisions for social inclusion, addresses the issues of equity in Health and the high costs of medical expenditures.³⁷⁴ The policies of the NHA of 2014 in the nation’s health system are articulated to make provisions of the best possible health services within the limits of available resources for the masses. This is fundamentally intended to protect, promote and fulfill the right of all the citizens to have equal access to health care.³⁷⁵ Similarly, the introduction of National Health Insurance Scheme (NHIS) of 1999 by the Nigerian health system is to strengthen the clarion call for the Universal Health Coverage (UHC). In this respect, the goals of the Scheme include, inter alia, is not only ensuring the provision of quality health care services for the masses, but it can as well assist individuals or groups in terms of making payments to medical bills.³⁷⁶

These policies and legal frameworks are formulated to develop an institutional arrangement that ensures that the onset of illness would no longer hold catastrophic consequences, particularly for the poor vulnerable populations in the country. So, it is the responsibility of the Federal Ministry of Health to direct on the good management of all activities, both in the internal and external affairs related to health services.³⁷⁷ Though, one may be tempted to applaud the theoretical organization of the health system in Nigeria that seems to be well coordinated. This is because, the goal of the national health policy is to guarantee at least the minimum health care package for all Nigerians.³⁷⁸ Unfortunately, in reality one can easily notice signs of weakness in the coordination that may give room for the collapse of the entire health system, if not checked urgently. Therefore, with the notion of ‘human solidarity’ as articulated in the title of this dissertation, both the government authorities, private sectors, groups, individuals or other stakeholders should collaborate to ensure quality health deliveries in Nigeria.³⁷⁹ To engage on such difficult projects to ensure proper administrative coordination, it is needful to delve first into the major challenges in the nation’s healthcare system.

3B. 2. 0. The Major Challenges in the Nigerian Health System

Emphatically, the above presentation confirms the existence of healthcare system in Nigeria with its regulatory policies. This is enough to attract much of admirations and applauds from different peoples that both the federal government and stakeholders in Nigeria have good visions and plans to care for the lives and health of the citizens. Though, it is an indubitable fact that, the existence of health facilities in the sense of bricks and mortars do not necessarily imply that they are very functional or free from numerous challenges.³⁸⁰ Besides, I would like to state that any critiques on the major challenges in the nation’s healthcare system is far from undermining all the previous efforts made in the past to improve the entire health system.

Instead, such critiques are intended to provide practical solutions to the problems in order to meet up with the Sustainable Development Goals (SDGs3), which is geared towards achieving better sustainable healthy lives and promote well-being of all.³⁸¹ Globally, there is no country in the world that has absolutely achieved this (SDGs3) objective, or otherwise free from one or multiple challenges in its healthcare system. Such challenges may vary depending on the place, people and time. Considering on how to improve the healthcare systems globally, the World Health Organization (WHO) in 2007 proposed a universal framework that should address the following six core components or “building blocks”: i) service delivery; ii) healthcare workforce; iii) healthcare information systems; iv) medicines and technologies; v) financing; and vi) leadership/governance.³⁸²

Likewise, healthcare system in Nigeria is fraught with complex challenges. In the studies carried out by Petersen and group, they affirm that healthcare system in countries like Nigeria suffers mainly from ‘man-made’ issues which cut across institutional, human resources, financial, technical and political developments. Even till date, Nigeria is yet to meet up with the basic requirements for good healthcare systems. Thus, they concluded that due to indifference or poor governance by some people in authority and human resource challenges are linked to ineffective integration of services in resource-limited nations.³⁸³ Another research carried out by Federico Roncarolo et al., in relation to the perspective of the six WHO pillars of the healthcare system, they equally observed that most of the leading problems still revolve around leadership and governance, healthcare workforce, health service delivery and poor financing. Although this categorization may seem to overshadow the individual issues that make up these categories, but it enables prioritization of the segments of the healthcare system most affected or requiring

urgent attention.³⁸⁴ For the purpose of this dissertation, it is important to indicate the few major challenges in the Nigerian health system as follows:

3B. 2. 1. *Inadequate Human Resources in the healthcare:*

The notion of Human Resources (HR) as defined by Van Olmen and group, refers to the medical personnel who dedicate themselves, time and energy primarily to care, protect and improve the quality of human life and health. They can be classified as healthcare providers or purveyors, health managers and support workers who operate in both private and public health institutions.³⁸⁵ In other words, HR are regarded as agents as effective competent health workers that possess enough of technical knowledge and interpersonal skills required to provide quality care, able to engage in patient-centeredness and professional cares. Any signs of lack of commitment or excessive workload among them can consequently pose a big challenge to the outcome of the health services.³⁸⁶ In his investigation, Francis Omaswa confirms that inadequate human resource is one of the foremost leading challenges in the health sector in the developing countries like Nigeria.³⁸⁷

As such, the challenges related to Human Resources in health system can either be overt or covert in nature, which reflect their respective complexities. Overtly, there is inadequate number of qualified healthcare workers to compare to the population of people in Nigeria.³⁸⁸ It is as result of incessant brain drainage to Europe, America and Asia of some medical personnel seeking for greener pastures. Even some of the unfavorable governmental policies are factors that can mitigate employment into the medical services.³⁸⁹ Covertly, there is poor availability of engaged or dedicated caregivers to deliver quality services. Other covert reasons that can lead to the shortage of medical purveyors include too much of strike actions, prioritization of more attendance at the private than public hospitals, migration of healthcare providers to big cities,

poor attitude to work, etc.³⁹⁰ This is a serious trend perceived by Eyitayo Lambo as a threat to a sustainable health care delivery in Nigeria.³⁹¹ Reacting to this, Prof. Abubakar Rasheed notes that the current doctor-patient ratio in the country stands at 1: 3,500. This implies that the nation needs not less than 300,000 doctors more to meet up with the World Health Organization's recommendation of doctor-patient ratio of 1:600.³⁹²

3B. 2. 2. *Poor Financing of healthcare system:*

It may seem laudable to say that the federal government of Nigeria has over the years invested huge funds towards improving the healthcare system. The report released by the Central Bank of Nigeria shows that the federal government health spending increased from the equivalent of US\$141 million in 1998 to the equivalent of US\$228 million in 2003. Though, most of the federal health spending goes to teaching hospitals, specialist hospitals and federal medical centers.³⁹³ Be it as it may, despite the laudable contributions of the health sector to the economic development, the Nigerian health sector is still experiencing a kind of turbulence that has negatively revised the progress recorded at various times.³⁹⁴ Despite the Abuja Declaration (2001) signed by the African Leaders, that insist on the allocation 15% of government annual budget to health, it is so disheartening that many hospitals in Nigeria are still poorly equipped, lacking essential supplies and qualified staff.³⁹⁵ These prevailing problems then are still persistent and are yet to be fully addressed due to Nigeria's socio-economic situation and leadership crises.³⁹⁶

3B. 2. 3. *Ineffective Administration and Management:*

Another area of major concern is identified with administrative inefficiency, otherwise known as poor leadership and management in healthcare system. Foreseeing this challenge long ago, both Carson F. Dye and Andrew N. Garman remark that any health system that fails to select and develop efficient leaders who are well trained and prepared for leadership in

increasingly complex healthcare systems is heading for a doom.³⁹⁷ According to Obinna O. Oleribe et al., Nigerian health system is suffering from poor leadership techniques and management.³⁹⁸ Both Dye and Garman opine that poor leadership could lead to increased healthcare costs, reduced efficiency and effectiveness, increase dissatisfaction among staff and ultimately resulting in lower patient satisfaction and poor healthcare outcomes.³⁹⁹ I strongly agree that such is typical to the Nigerian health sector.

3B. 2. 4. *Corruption in the Healthcare System:*

The term ‘corruption’ as defined by famous American political scientist, Michael Johnston, simply refers to “the abuse” of power or responsibility, in order to promote one’s personal gains rather than for public interests.⁴⁰⁰ It is not an over-statement to say that the issue of corruption is still prevalent in the Nigerian health system. Both Adeyemi Kamorudeen et al., equally affirm that corruption in the nation’s health sector has rendered various health institutions in the country ineffective. It still exists because some healthcare administrators are not interested in adhering to the rules of law, coupled with lack of transparency and trust. The result of such practices are misappropriation of property or funds officially entrusted to them as trustworthy agents or guardians of health institutions.⁴⁰¹ To substantiate the above claim on the existence of corruption in the healthcare system, a former minister of health, Adenike Grange was relieved of her duty in 2008 for her complacency in the sharing over N300 million unallocated budgeted health sector fund.⁴⁰² Thus, the social media reports state that corruption deprives the nation’s economy in general and the health sector in particular of vitally needed funds.⁴⁰³ Also, it was reported that there was a consignment of ‘vitamin A’ supplement by the Canadian government through its bilateral assistance to Nigeria which was diverted in 2008. According to UNICEF report, this product was later found on sales in most itinerant chemist

shops across the country. Other forms of corrupt practices in the health system include theft and embezzlement of money, medicines and other medical equipment and supplies by some of the frontline healthcare staff. The investigations carried out by Obinna Onwujekwe and colleagues, confirm that there are incidents of theft of drugs for resale, the pocketing of budgeted funds and user fees. They also remarked that in some cases, some healthcare staff can substitute original materials with inferior ones.⁴⁰⁴

3B. 2. 5. *Problem of Ethnicity and Language Barrier:*

Every individual human person is a complex entity, naturally characterized with personal idiosyncrasies, ideas, likes and dislikes. Likewise, in the multicultural societies, each ethnic group has its cultural peculiarities in relation to her ‘dos’ and ‘dons’. This shows that peoples of different backgrounds are likely to be so much attached to their specific cultural norms or backgrounds. Hence, conflict of norms can easily be envisaged when two or more cultural norms or people of different backgrounds, come together.⁴⁰⁵ It is a fact that all the different ethnic groups in Nigeria have different socio-cultural understandings, values, practices and norms in relation to health care. For example, the traditional medical practice relies so much on the cultural norms to make some positive impacts on the general health system metrics, especially in Nigeria.⁴⁰⁶ Another practical example of cultural conflict in the health care system is the case of the “purdah system” – i.e., wife seclusion. This is a very common traditional or cultural practice among the Hausas in the northern part of Nigeria. With this practice, women are restricted or can be denied of equal access to adequate health care.⁴⁰⁷ Of course, some Muslim husbands from the Hausa ethnic group would find it very difficult to allow their wives to be treated by any physicians from

other ethnic groups. Rather, they would prefer only the physicians from the North even with much less or no medical qualifications.

Also, it has been proved that some ethnic groups in Nigeria do not accept any form of blood transfusions. The reason is that they would not accept any other blood into their natural consanguinity or lineage affinity. As norm conflicts continue to create such ethnic disparities in healthcare, there is a tendency that it can make the application of biomedical ethics more difficult in such multi-ethnic society known as Nigeria. According to Sunday A. Adedini and colleagues, health disparities in Nigeria have more to do with differences in sociocultural and religious practices than with medical genetics.⁴⁰⁸ The issue of language barrier extends beyond patient and health professional interactions. Such patients are so convinced that they could receive better consultations and interpersonal cares without any language barrier from the physicians who are from the same ethnic regions than the ones from other areas.⁴⁰⁹ Consequently, all these can create a big gap in the doctor-patient relationships, thereby hindering the possibility for quality care and compliance to treatments.⁴¹⁰ These are reasons behind this high preponderance of rejecting immunizations in Nigeria due to fear, lack of trust, low confidence, confusion, religious, culture and ethnic or tribal affiliations.⁴¹¹

3B. 2. 6. *Poor Emergency Preparedness and Response:*

The concept of “emergency” as conceived by Ahmed A. Mahfouz et al., refers to sudden but unexpected incident that calls for urgent and appropriate reactions to handle its outcomes in order to avoid more of its catastrophic sequelae. A situation can be regarded as a health emergency if a particular unexpected incident poses a great risk to human life, health of the people and the entire physical environment in which they live.⁴¹² Thus, with adequate planning and training for emergency situations ahead of time, some emergencies can be avoided, while

other inevitable emergencies can be controlled or properly managed to minimize risks and potentially prevent more catastrophic adverse consequences.⁴¹³ To plan for any medical emergency like auto accidents and the likes, Laura M. Cascella considers making the initial provisions to stabilize medical situation of the accident victims before transferring them to the nearest professional emergency care providers as quickly as possible, are very fundamental.⁴¹⁴

Few years ago, Nigeria launched the introduction of paramedics into the nation's health system. Thus, the current status of Emergency Medical Service (EMS) in Nigeria, as indicated by Vivian Okeke and Ogbebo W., reflects one of the many positive efforts by both state governments and private organizations to upgrade the entire health system. Unfortunately, further investigations reveal that most of the EMS lacked Emergency Medical Trainings (EMTs), paramedics or any special prehospital training.⁴¹⁵ Even Babatunde Solagberu et al., see EMS in Nigeria as a political benchmark, rather than a fundamental health necessity. Hence, he is of the opinion that the country should upgrade its emergency apparatus and be set to address any emergency challenges in the future.⁴¹⁶

3B. 2. 7. Absence of Integrated System for disease prevention, surveillance and treatments:

With the recent scientific innovations in modern medicine, some non-communicable diseases can be tracked, screened, immunized and treated as well. At times, some health experts can refer to low incidence rate for disease like cancer in Africa, especially in Nigeria, because what is not screened for is not absolutely reported. This is the major reason for the extremely low screening rates for blood sugar, cholesterol, cancer, diabetes, hypertension and other chronic and communicable diseases, hence, the reported incidence and prevalence rate are considered to be still very low.⁴¹⁷ On the contrary, the first report released by the WHO on Global Status on non-communicable disease listed Nigeria and other developing countries as the worst hit with deaths

from non-communicable diseases.⁴¹⁸ These diseases with a rising burden in Nigeria include cardiovascular disease, cancer, diabetes, chronic respiratory diseases, sickle cell disease, asthma, coronary heart disease, obesity, stroke, hypertension, road traffic injuries and mental disorders. Also, in other reports of 2009 and 2011 on World Health Statistics, the mortality rates due to tuberculosis and malaria in Nigeria are 311 per 100,000 and 146 per 100,000 of population, respectively.⁴¹⁹ The absence of integrated system for disease prevention, surveillance and treatments shows that the nation's health system is weak due to ineffective and inefficient management.

3B. 2. 8. *Effects of Pollution on Public Health:*

In the area of public health, the effect of pollution poses serious health challenges in the Nigerian health system. As a nation located in the tropical rainforest, Nigeria is naturally endowed with very rich ecosystem that contains one of the highest concentrations of biodiversity or natural resources including petroleum. With the discovery of the mineral resources or petroleum in Nigeria, there was a huge sigh of relief on the nation's economy. Even till date, both oil and gas exports have accounted for more than 92% of export earnings and about 83% of federal government revenue. Unfortunately, the impact of the unprecedented oil spillage for the past five decades now has seriously affected the lives and health of people in the Niger Delta region of Nigeria. It is estimated that Nigeria has recorded more than 9,343 cases of oil spillage within 10 years.⁴²⁰ On the effects of oil pollution, Julia Baird observes that many of the people in the affected area have lost the basic human rights to good health, access to quality food, clean water, and an ability to work.⁴²¹ This has attracted a suit filed against Shell company by the people of Niger Delta. In one of the suits, a Dutch court ruled on the 30th of January 2013 that

Shell is liable for the pollution in the region, and consequently Shell agreed to pay \$84m US Dollars as compensation and cleansing of oil disaster in the affected localities.⁴²²

3B. 3. 0. Ethical Solutions and Recommendations to Promote Human Life in Nigeria.

The future and progress of a nation with relatively more unhealthy citizens is not absolutely guaranteed.⁴²³ It is an indubitable fact that the value of good health – which is qualified as a golden crown on a healthy man’s head – is of paramount importance to all human endeavors and developments in the society.⁴²⁴ In relation to the major challenges in the healthcare, it is quite unfortunate that despite all the previous efforts including wonderful policies formulated, Nigeria is still battling to evolve into a formidable health care system. Due to the above major challenges that confront the healthcare system, the nation is still very far from achieving “Health for All” her citizens, which is a fundamental priority in the Ottawa Charter for Health Promotion.⁴²⁵ Consequently, with the high prevalence of diseases like malaria, cholera, acute hepatitis E, stroke, hypertension, typhoid and all forms of cancer, the average life expectancy at birth in Nigeria still within 53 years. This is the lowest life expectancy when compared to some other countries from the same continent.⁴²⁶ In another separate research conducted by Mela Danjin and others, confirm the CIA report of 2018 on the life expectancy at birth in Nigeria which still falls within the acceptable range or margins of 53.8 years for the total population, male: 52.8 years, and female: 55 years.⁴²⁷

Table: Average Life Expectancy at birth (total) in Nigeria compared to other countries.⁴²⁸

Countries	1980	1985	1990	1995	2000	2005	2010	2015	2018

Cote d'Ivoire	50.7	52.6	52.6	49.5	46.7	47.7	50.1	51.9	
Ghana	52.3	54.1	56.7	57.5	56.9	58.7	60.6	63.0	
South Africa	56.9	59.9	62.1	61.4	55.8	51.5	54.4	57.4	
Rwanda	47.9	50.4	33.4	31.6	48.1	54.7	61.4	64.5	
Nigeria	45.5	46.3	46.1	46.1	46.6	48.6	51.3	53.0	53.8

Thus, the absence of proper planning whether short term, medium term or long term in any society is likely to spell a grim destiny on the masses. Faced with multiples challenges in the healthcare system, some sustainable strategies or recommendations to improve the health sector in Nigeria have been proffered. However, it is important to note that, any recommendations provided at this level are primarily intended for proper administrative coordination and competency in the health system. So, with regards to the application of biomedical ethics in some specific clinical practices and research activities will be considered in the subsequent chapters of the dissertation. The recommended solutions include:

3B. 3. 1. *On Human Resource Management:*

Both Stefane M. Kabene and colleagues come up to recommend that proper management of human resources is critical in providing a high quality healthcare services. This implies the need to refocus on the human resources management in healthcare by developing better new policies that will favor all the parties involved in caring for the patients. This is because, only with effective human resources management, free from corruption, can apply strategies that can guarantee greatly better outcomes in the treatment of patients.⁴²⁹ Also, with an

effective management, the system will be capable to address some of the issues related to equity, accessibility, affordability, quality, effectiveness and efficiency which are the overall policy objectives of a good healthcare system.⁴³⁰ Moreover, the financial incentives or motivations can solve the problem of dire shortage of health workers due to economic and social brain drainage that have left the nation to function with an estimated only 27 physicians per 100,000 people.⁴³¹

3B. 3. 2. *On Poor Financing of Healthcare:*

The issue of poor financing of healthcare system is a perennial problem that is yet to be resolved in places like Nigeria. It is a non-negotiable primary duty of the government to endeavor to provide ‘healthcare for all’. This is clearly stated in the Safe Motherhood Newsletter (March 1995), that it is the responsibility of the government of every nation to make available all forms healthcare services accessible with affordable prices. The only way to get rid of the problem of inadequate financing of health is to increase budgetary allocations to healthcare and provide healthcare insurance scheme affordable for all.⁴³² As earlier indicated, most of the health centers in Nigeria are saturated with out-of-stock drug syndromes. In fact, this has led to many patients falling prey to quacks or purchasing drugs from drugs peddlers that have endangered and is still endangering the health and lives of many people in Nigeria.⁴³³ In the same vein, WHO calls on each nation to make every effort to ensure adequate supply of quality drugs/vaccines to tackle the diseases like malaria, typhoid fever, meningitis, tuberculosis, poliomyelitis, yellow fever etc., which continue to claim millions of lives in Nigeria.⁴³⁴

3B. 3. 3. *Solution to Emergency Situations:*

In the situations of emergencies, Laura M. Cascella suggests a three-pronged approach – *prevention, preparation and action* – that are needed to handle such cases. Granted that some

medical emergencies are inevitable, while others can potentially be avoided or prevented with adequate planning ahead of time.⁴³⁵ She equally agrees that any preventive measures are important parts of emergency preparedness. So, since medical emergencies must surely occur at any possible occasion, proper preparations are paramount. Though, time factor, financial constraints and low prioritization can all play negative roles in thwarting preparedness efforts. Even at that, she notes that the emergency response plans should include comprehensive information on the specific roles and responsibilities of the responders, communication protocols, policies for staff training, use and maintenance of emergency supplies and equipment.⁴³⁶ Thus, at the wake of an emergency, it is expected that responders must be ready to quickly act by implementing their emergency response plans.⁴³⁷

Similarly, in every pandemic outbreak like coronavirus, Li Y and Xia L propose some strategies that include screening, containment (or suppression) and mitigation of its spread. With an advanced scientific device like thermometer, early screening can be performed, followed by containment of those infected by the virus in isolated places.⁴³⁸ However, once the disease is out of control, all efforts should gear toward the mitigation of the disease spread, by applying all the precautionary measures. Thus, a combination of both containment and mitigation measures may be undertaken at the same time.⁴³⁹ Possible suppression may be solicited for more extreme measures to be applied so as to reverse the pandemic by reducing the basic reproduction number to less than 1.⁴⁴⁰ This was exactly put into practice during the time of spread of Ebola virus disease (EVD) in Nigeria. Such quick response and decisive management of EVD in Nigeria that attracted global commendations need to be applied to other pandemic diseases in future.⁴⁴¹

3B. 3. 4. *On Problem of Ethnicity and Language:*

It is very imperative to address the problem of ethnicity and language barrier in

a pluralistic state like Nigeria, especially within the healthcare system. This is because, the perpetual strife or conflict due to ethnic diversities in Nigeria has been classified as a threat rather than a source of national pride or integration for progress.⁴⁴² Popular opinion is convinced that “cultural competency” stands as the best option or ultimate approach to reduce, if possible, eliminate this problem that can cause discriminations in the medical sphere. Even Smith W. R. et al., advocate for the training of clinicians on the cultural competence.⁴⁴³ This implies that, those still undergoing medical training should be professionally committed in eliminating all forms of inequalities in the health care.⁴⁴⁴ Also, this training is expected to retrogressively enhance self-awareness of one’s attitudes in relation to others from different backgrounds. So, a profound knowledge about cultural norms, faith beliefs and practices, can equally improve the quality of healthcare deliveries in such a pluralistic milieu.⁴⁴⁵ By affirming this position, Alexander G. Rumay adds that an effective cultural competence training, remains a powerful key or tool that can positively advance the health outcomes to the patient’s satisfaction, etc.⁴⁴⁶

To achieve this specific objective in places like Nigeria, it is necessary to refer the suggestion made by Melanie Tervalon and colleague. Hence, they advocate for an unquantifiable cultural humility devoid of ethnocentrism or negative tribal tendencies on the part of all the clinicians that will undergo this cultural competence training. Again, they equally suggest that such training needs to take place in different rural localities, but not necessarily within the academic campuses.⁴⁴⁷ Such training programs can be further improved by making it possible for the participants from particular ethnic backgrounds to be trained in another ethnic regions. This will make them feel, experience and know more about other cultural practices of the different ethnic groups in Nigeria. Being well grounded in the basic different ethnic modes of life, common ideas, behavioral attitudes, their ‘dos’ and ‘dons’, the Nigerian health care purveyors

will be able to apply such skills into the clinical practices. This, no doubt, is likely to improve cultural competency and patient – centeredness in the health care,⁴⁴⁸ eliminate ethnic disparities, ensure effective, equitable, and respectable quality care services that would meet the expected outcomes of the entire society.⁴⁴⁹ In this sense, people like Betancourt are convinced that the formulation of new ‘framework’ for cultural competence health system in Nigeria is possible. He goes on to say that the ‘organizational cultural competence intervention’ will give room for ethnic diversity in the administrative leadership and workforce. Again, he notes that the ‘structural cultural competence’ will make provisions for full access to quality health care for all, regardless of the ethnic lineage or socio-economic status.⁴⁵⁰

To eliminate the problems of ethnicity that affect the nation’s healthcare system, the role of the principle of justice should not be undermined to balance the unjust structures. In this light, both Tom L. Beauchamp and James F. Childress note that justice should address the problems of inequalities with regards to quality access to healthcare. This includes effective distribution of health services and lowering the costs for health care, by making it affordable to people of lower socio-economic status.⁴⁵¹ Hence, justice in the health sector implies making available provisions of health services and care for all, irrespective of cultural backgrounds, class, status, gender, age, etc.⁴⁵² This is because the notion of equality among persons is at the core of the fundamental personal dignity and human rights principle.⁴⁵³

In sum, the discussion so far, shows that Nigeria is a nation with heterogeneous cultures and ethnicities. As such, the issues of ethical choices or conflict of opinions are likely to come up while providing healthcare services for persons with diverse values living in a pluralistic and multicultural society like Nigeria. This is because, according to Judith C. Baker, bioethics is still largely entangled in asocial, acultural, and decontextualized philosophical, moral

and legal discourses. Again, she adds that this discipline is yet to investigate comprehensively the social and cultural realities that matter to patients from diverse backgrounds.⁴⁵⁴ This implies that bioethics should engage more fruitfully and meaningfully with the diverse cultures and moral worldviews in this era of globalization. At this point, Subrata Chattopadhyay and his colleague, understand such bioethical engagements as showing respect for cultural diversity which should not confound any moral or ethical judgments in health system. I vividly agree with them that, the respect for cultural diversity in bioethics is an ethical imperative that should not be compromised.⁴⁵⁵ With such good understanding of the existence of bioethics in diversified (world) cultures draws every attention on the application of its basic principles, with special reference to the respect for autonomy in clinical practice and in the field of research.

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Chapter Four

4.0. The Principle of Autonomy and Abortion Dilemma in Clinical Medicine

Introduction:

The practice of medicine is a universal phenomenon, and the relationship that exists between a doctor and a patient forms its fundamental component. To ensure good relationship with the patients, physicians rely on the application of different ethical models in the doctor-patient encounters to achieve the expected goals of medicine. According to Fallon E. Chpidza et al., element of trust is a strong bedrock in this kind of relationship. So, good ethical knowledge by both parties is considered as an essential factor that can determine good treatment outcomes of patients.⁴⁵⁶ For a very long period, the paternalistic or authoritarian model by which out of trust, patients were able to comply absolutely with the doctor's decisions, has remained unchallenged. Recently, as doctors work to understand medical problems through the lens of the unique patient's case, there is need to advocate for a more patient-centered approach, in which patients are viewed as autonomous and holistic entities. Suffice it to note that medical paternalism is the reason behind the clamor for a shift to an ideal doctor-patient relationship over time.⁴⁵⁷

Etymologically, the term *paternalism* is derived from the Latin *pater* for 'father', and its adjective *paternus* or *paternalis* that simply means 'fatherly'. People like John S. Mill consider paternalism to be appropriately used in the relationship between a father and his children. In this respect, it does not just apply only to people who have attained the age of maturity and with stable mental faculties, nor to others below the age of maturity. Rather, he concludes that paternalism towards others is sometimes thought of as treating them as if they were one's children.⁴⁵⁸ A further interpretation of the concept of paternalism by Seana Shiffrin

indicates a kind of action that may limit a person's or group's liberty or autonomy, even if the motives are meant to promote the best interest of the person. Thus, it expresses an attitude of superiority over others.⁴⁵⁹ Within the healthcare, paternalism refers to a set of medical attitudes and practices in which a physician may take unilateral decisions without full participation of the patient, or even considering his or her wishes, choices, values, preferences, etc. Most often, the physician may act based on the patient's best interest, but the action itself may lack the respect for patient autonomy.⁴⁶⁰ In the recent years, paternalistic medicine is increasingly considered as inappropriate, especially in the West as the General Medical Council indicating that it is ethically unsupportable. This is because only qualified medical personnel, with their expertise can properly understand symptoms and at the same time, take useful medical decisions, as the patient remained passive or irrelevant in the decision-making encounter. Such a paternalistic attitude is the reason for some people to agitate for a shift or movement away from such model of clinical relationship. At the wake of this shift from the paternalistic attitude, autonomy continues to receive a positive consideration as a 'universal' value, upon which every health system may be evaluated upon.⁴⁶¹

Thus, in the context of this dissertation, every autonomous choice, as in the case of abortion, should endeavor to consider, promote and protect the concept of intrinsic dignity of human life. This is because most women that advocate for abortion base their arguments on the 'woman's right' to their own body to the detriment of terminating the life of the fetus. Granted that abortion may be considered as an ethical and justifiable last option to save the mother's life, but the patient's autonomy is at some points limited.⁴⁶² As such, the decisions to abort if subjected to appropriate moral reasoning, clear communication, comprehensive assessment of the situation, respect for empathy and personal judgement, are likely to indicate that they operate

within the ambience of ethical limitations. So, since there is an urgency to balance the autonomy that exists in the physician-patient relationships through thoughtful dialogue for better therapeutic health outcomes, it is then necessary at this point to delve into the concept of autonomy in relation to abortion in the clinical medicine.

4A. 0. The concept of Autonomy in Physician – Patient Relationship

4A. 1. 0. Autonomy: General notion, Scope and Ethical Conflicts

4A. 1. 1. *A General Notion of Abortion:*

It is very interesting that some experts like Leigh Turner sees autonomy as an absolute principle that takes precedence over other values like beneficence. As an important ethical principle, autonomy is also considered as basic to human dignity. Though, the obligation to respect autonomy is not absolute as there are multiple challenges to its universal validity.⁴⁶³ For instance, since the cradle of civilization, religious beliefs and practices have been intertwined with the practice of medicine. Such religious connections with medicine are mostly viewed by scientists as mystical that seem to lack any scientific proofs. The dilemmas of baseless empirical verifications make it difficult for medical experts to always respect and accept the cultural *cum* religious beliefs of their patients. Acceptance of such beliefs in medical matters might have big detrimental influences on modern rational and empirical science. Reacting to the implications of religious beliefs on medicine, Dana I. Al Hussein notes that, this has caused intense or fanatical debates between people with different ethical, social and religious beliefs on the one hand, and medical personnel on the other hand.⁴⁶⁴ However, the connexion between religion and medicine is in an inseparable union. This is because, religion still lies at the heart of most cultures where medicine is practiced, daily. So, despite the scientific advances in modern medicine and the

forces of secularization, religion offers fertile ground for moral reasoning and ethical justifications of some medical decisions. To achieve this fundamental goal in the clinical settings, most patients and medical professionals embody the engagement of religion with modern medicine in both visible and unconscious ways.⁴⁶⁵

Etymologically, the concept of ‘autonomy’ is derived from the two Greek words *autos* that means “self” and *nomos* which stands for “law” or “rule”. It is to be recalled that the term “autonomy” was first used to describe Greek city states exerting their own laws. It then invokes the notion that the subject or a ‘citizen’ in question, in one way or another, is free to govern and decides for oneself. In a very clear terms, the idea of *personal autonomy* simply suggests that a person who “governs oneself”, as such, an autonomous agent is capable of deciding and acting according to one’s own convictions, values and desires, without any unwanted external influences. By so doing, an autonomous person lives according to the motives that can count as expressions of oneself, i.e., of *who one is (or wants to be)*. The notion of autonomy, as opined by John Christman and others, suggests the notion of *authenticity* or expression of authentic personality.⁴⁶⁶ In this light, Immanuel Kant (1724–1804) conceived autonomy in relation to contemporary ethics on three categorical themes. Firstly, he defined the term as one’s *right* to make their own decisions devoid of any interference from others. Secondly, he viewed autonomy as the *capacity* to decide through one’s own independence of mind and after much due reflections. Thirdly, he considered it as an *ideal* way of living an autonomous life. Therefore, the principle of autonomy is the moral right one may possess, or the capacity to make personal or cooperative rational decisions to ensure ideal way to live comfortably with others.⁴⁶⁷

According to Elizabeth Neil, the principle of autonomy is the acknowledgement of one’s right to stand firm on one’s personal views, with regards to making choices and at the same time,

take deliberate actions based on personal values and beliefs. The term also refers to the idea of ‘the right to be left alone’ which includes a right of autonomy to control certain kinds of information about oneself.⁴⁶⁸ The concept of ‘autonomy’ in its maximal form, as John Kultgen alludes, advocates for absolute rationality, self-control, knowledge of relevant facts, and other demanding conditions internal to the agent, as well as freedom and recourses to act.⁴⁶⁹ It also requires the ability to reason, make and carry out simple plans on the basis of one’s desires, free choice and decisions. On another note, both personal autonomy and human rights are highly connected and cannot exist without other. This reflects not only the equality of all individuals but also their autonomy, their right to have and pursue interests and goals different from those of the state and its rulers. So, basic human rights are the rights necessary for the development and exercise of personal autonomy.⁴⁷⁰

Moreover, the concept of human dignity is very essential in developing human rights. Basically, human rights are morally superior to society and state, and they are under the control of individuals who hold them and may exercise them against the state in some extreme cases. The right to life, as well as rights to protection against slavery, torture and other inhuman degrading treatments are very essential to the recognition and respect of a person. In this sense, the three main values are: *first*, that each human person is important; *second*, that each person is to be counted equally in terms of whatever criteria that make humans worth counting; and *third*, that each competent person is an agent, who is capable of conceiving and of trying to bring to fruition projects and values.⁴⁷¹

To be a free agent is to be autonomous, but autonomy may be viewed not as isolation but in terms of a mutual supportive solidarity in social environment of critical dialogue and reciprocity.⁴⁷² In a sense, autonomy is the right of every competent individual to make

momentous personal decisions based on his convictions about the value of life, on other issues like morality, marriage, procreation, death, etc.⁴⁷³ However, in all the theories of autonomy, Tom L. Beauchamp and James F. Childress note that three conditions – *liberty*, *agency* and *understanding*– are very essential. As the notion of ‘liberty’ in autonomy suggests a kind of independence from any controlling influences, then ‘agency’ in the same context refers to the capacity for intentional or deliberate actions.⁴⁷⁴ The role of ‘understanding’ is to indicate that one is fully aware of an act to be performed. Therefore, an agent becomes autonomous in one’s actions, if the agent acts in a substantial degree that respects these three conditions, *liberty*, *agency* and *understanding*.⁴⁷⁵

Besides, the notion of integrity is *a moral claim* which belongs to every human simply by *virtue of being human*. As such, it is very necessary for the justification of the principle of informed consent. For instance, a person’s integrity has to do with his or her *dignity* as a human person. So, any act of violation on one’s dignity, also violates one’s integrity, because each person’s integrity is closely linked to his or her *identity*.⁴⁷⁶ Similarly, the same applies in the kind of relationship that exists between the integrity and the autonomy of a person, since the principle of respect for integrity lies at the foundation of the principle of respect for autonomy. These principles – *integrity*, *respect for autonomy* and the principle of *informed consent* – form *a triad or triangle* in biomedical ethics. To respect any of them implies accepting all of them, and therefore, one cannot turn down any of them without turning down the rest as well. Though, some experts may consider the principle of respect for integrity as most fundamental, which serves as a justification of the two other principles.⁴⁷⁷

Logically, it is important to add that any deliberate act towards others that fails to indicate respect for autonomy or not in accord with the above three essential conditions,

automatically violates other person's integrity. The principle of autonomy should be understood both in negative and positive forms. In its negative form, it simply comprises a broad and abstract obligation by which all autonomous actions should not be subjected to controlling constraints by others.⁴⁷⁸ Again, in its positive form, it asserts the more affirmative demand that respect for autonomy obligates professionals to disclose information, to probe for and ensure understanding and voluntariness, and to foster adequate decision-making.⁴⁷⁹

Recently, the respect for a patient's personal autonomy seems to gain more prominence as one of the fundamental ethical principles in modern medicine. The value of the concept seeks the ability of a competent person to make his or her own decisions. This idea is highly appreciated and developed in more than five decades ago as the central premise of the concept of informed consent and shared decision-making.⁴⁸⁰ The evidence of the Nuremberg trials detailed the accounts of horrific exploitative medical 'inhuman experiments' which violated the subjects' personal dignity, integrity, and autonomy.⁴⁸¹ These incidences sparked clarion calls to protect human beings in all forms of medical practices and research. It is believed that the Nuremberg Code served as the premise for many current documents regarding voluntary participations in research ethics.⁴⁸² For some experts like Daniel Callahan, a well-known bioethicist, thinks that the principle of autonomy has been taken to certain extremes or levels. But he is also convinced that such should be restrained for nothing is of greater importance than to regain "the moral commons in medicine". There is an urgent need to balance the autonomy that exists in the doctor-patient relationships.⁴⁸³ This invokes the scope or limit of autonomy.

4A. 1. 2. *Scope and Ethical Conflicts of Autonomy:*

Arguably, the concept of autonomy is of the Western origin. Embedded with the spirit of individualism, as many people would assume, one can easily make personal decisions

regarding one's own health issues. So, there is no doubt that autonomy will continue to thrive and gain more prominence, especially in the Western world, where the respect for autonomy is widely accepted as an ethical imperative, especially in medical practice.⁴⁸⁴ This is the reason why there are various ideas of autonomy which have evolved from the different experts from different fields of study, each establishing their respective stances on the concept. Tracing the notion of the concept from Immanuel Kant to John Stuart Mill, shows that there are a lot of intricacies of respect for autonomy, which may differ among themselves. At times, understanding the scope or limits of autonomy becomes very complex, especially when it is further evaluated in the context of other different cultural, religious backgrounds, etc.⁴⁸⁵ Even in a multicultural state, the notion of autonomy may differ from one ethnic group to another. According to Falahati S., it is possible to find that autonomy is strongly based on the rights of the individual in one place, but in another location, it may be difficult to notice if it really exists at all. Despite such cultural differences on the importance and application of autonomy, he affirms that the major conflicting issue is mainly on the scope of autonomy.⁴⁸⁶

In effect, there are some situations where in the attempt to respect the concept of personal autonomy in some traditions or cultures, it may end up creating an atmosphere of conflicts of ideas in the decision-making. For instance, in places like Africa, where communalism is enshrined in most of the peoples' cultures and traditions, the notion of personal autonomy with regards to decision-making is likely to hit a wall in some cases. This is because, communalism as Polycarp Ikuenobe conceptualizes it, is a set of cultural practices that prioritize the role and function of the collective group over the individual.⁴⁸⁷ In a broad sense, communalism refers to people's life pattern that lays more emphasis on the common good of a community rather than on the personal or individual goods.

With such a communal spirit, the members of a given society are expected to possess a common spirit to work together, live and feel mutually together, and in solidarity, arbitrate one another.⁴⁸⁸ Each person is expected to possess communal values such as: mutual sharing, solidarity, mutual help, mutual trust, interdependence, cooperation, etc. These values clearly show that traditional African societies may abhor or dislike extreme individualism, at least, to a reasonable extent.⁴⁸⁹ In this regards, Ifeanyi Menkiti alludes that in most of the African traditions, it is mainly the community that defines a person as a person, not merely the static quality of rationality, will and memory.⁴⁹⁰ As such, most of the decisions, including health issues in a communal setting are made collectively, by the members of the family, group, etc.⁴⁹¹ Worthy of note is that, communalism is not against personal autonomy, but the issue is how to balance the exercise of extreme individual autonomy in the healthcare, especially in the communal African context.

To concretize this point, here is a possible case which highlights the example of such ethical conflicts in dealing with respect for personal autonomy. This is the case:⁴⁹²

A member of Jehovah's Witness (name withheld) was involved in a car accident. He was bleeding excessively, and unconsciously was rushed to an emergency unit in the nearest hospital. In such critical state, he needed an urgent blood transfusion, as without it the prognosis could be fatal.

Here are the analyses of the case:

Ethically, both the demand for and refusal of treatments are also closely bound to personal autonomy. In this case, though it is against the religious belief of Jehovah's Witnesses to undergo blood transfusions, but there are many factors to be considered as well. First, even if

the patient was competent and able to communicate to the doctor(s) of his wish that might reject blood transfusion, it is still left at the discretion of the doctors to determine if the patient had the capacity to make such autonomous choice at that critical moment. A reference to the Kantian position, would insist that a patient in such critical condition might lack the power of rationality to make justifiable choices.⁴⁹³ Second, the fact is that the patient is unconscious, this automatically disqualified him as a competent person for decision-making. Third, even as a Jehovah's Witness, Falahati S., says that it would be foolish to make assumptions that if he were awake, he would definitely refuse a blood transfusion. Fourth, if there were enough time, a member of his family could be consulted, or his past notes be studied as well, to discern and figure out what his wishes, interests or preferences could be. However, since time is of great essence in this case, then the doctor could proceed to make ethical decision based on the four basic ethical principles proposed by Tom L. Beauchamp and James F. Childress.⁴⁹⁴

Applying the four basic ethical principles in the above case, implies that the patient's autonomy is likely to be compromised, since it is only the doctor who could assume what the patient would want. Again, based on the principle of beneficence, the attending doctor would continue with the medical treatments based on the patient's best interest. So, to think of the principle of 'non-maleficence' is to make every effort to minimize all possible harm or risk that justifies "not to do harm". But the question would be, between 'doing no harm' not to give a blood transfusion and 'allowing' the patient to die, which one is more harmful? Of course, the principle of justice would insist that the patient should be given proper treatments regardless of race, color, faith-belief, gender, place, time, etc.⁴⁹⁵ At this juncture, Beauchamp and Childress declare that, when trying to balance out these principles, a degree of instinct is inevitable.

Granted that in this case, the patient's own intuition would possibly be the true decision maker, but the balancing act of the principle of autonomy will be effectively left redundant.⁴⁹⁶

Presently, the principle of autonomy is generally upheld in a very high esteem, because it makes a subject as the best expert on his or her own interests and decisions. Interestingly, it is primarily invoked either to formulate a certain constitutive moment of the subject in question or to function at least as an essential justificatory criterion. According to John Christman et al., it remains a value to be respected when it comes to assess positions of plausibility and validity.⁴⁹⁷ The fact is that a common challenge to patient autonomy arises once the patient's expressed preferences that may contradict what the physician considers as acting on the patient's best interest. For examples, if the patient refuses necessary treatments or expresses desires drastically different from the ones suggested by the physician, family members and friends, then conflict of autonomy may arise.⁴⁹⁸ As in serious ill cases, a clinician may turn to capacity evaluations to address an ethical issue, but the real underlying moral dilemma is likely to stem up from the conflict between a patient's autonomy and the physician's paternalism.⁴⁹⁹

However, both Beauchamp and Childress categorically affirm that there is a disparity between the principle of paternalism and autonomy. Paternalism, either *soft* or *hard*, is more of an intrusion of a person with another individuals, to counter their wishes, and often justified by a claim that the individual will be protected from potential harm.⁵⁰⁰ Indeed, autonomy is really the opposite of this, as it refers to the ability of being oneself to the exclusion of external forces.⁵⁰¹ Though, paternalism may directly aim at benefitting the patient, but Sarah B. Mackie still maintain that it is ethically erroneous if it violates the patient's autonomy, dignity and integrity as a person.⁵⁰² From the above case study, it clearly shows that autonomy may be extremely far-reaching, but at same time, has its limited scopes. Most interesting of it is that the same scenario

that makes autonomy far-reaching can equally limit it. From a legal, cultural, religious to humanitarian perspectives, there are a lot of factors which enable as well as limit autonomy.⁵⁰³ Hence, there is an urgent need to balance autonomy in the doctor-patient relationship. In all aspects, the concept of autonomy remains a value to be respected when it comes to assess positions of plausibility and validity.⁵⁰⁴

4A. 2. 0. Autonomy and Models of Physician – Patient Relationship

In the recent times, there seems to be a struggle over the patient's role in medical decision-makings. This has been observed by many as an atmosphere of conflict between autonomy and health, between the values of the patient and the values of the physician. Remarkably, as some people advocate for an ideal of greater patient control, Ruth Macklin conceives such an unhealthy atmosphere in the healthcare as aiming to limit or curtail physician's freedom to exercise his or her expertise.⁵⁰⁵ The danger is that this ideal may hardly acknowledge the potentially imbalanced nature of such interactions. According to Charles Fried, the imbalance presents a situation when one party is sick, searching for cure and security, and when judgments entail the interpretation of technical information.⁵⁰⁶ Still others are trying to delineate improved mutual relationships.⁵⁰⁷ This struggle continues to shape the expectations of physicians and patients as well as the ethical and legal standards for the physician's duties, informed consent, and medical malpractices. Faced with such unhealthy relationship in the doctor-patient encounters, one would be compelled to ask: What should be the 'ideal' model for physician-patient relationship?

As earlier noted, from the times of Hippocrates till the last quarter of the 20th century, physicians relied so much on the principle of beneficence, though by upholding and enthrone paternalism, to seek for the patient's best interests. Virtually, while seeking for the good of the

patient, physicians then seemed to act unilaterally in their respective decision-makings. A change of attitude and approach on this model of medical practice took place in the early 1970s. It is precisely when the doctor-patient relationship took a dynamic and dramatic change with a growing recognition of the importance of patient autonomy in decision-making. This reflects a new trend toward more interaction and dialogue between the patient and physician in mutual bilateral processes to discern any healthcare decisions. Such bilateral discernment of decisions or ideas is not only “medically indicated” but also, it is mostly aligned with patient values, interests, wishes, preferences, etc. In support of this shift to provide an ideal model of relationship between the physician and patient, many experts have made numerous contributions towards this direction. But for convenience, this dissertation will limit its focus on the models proposed by Robert Veatch in 1972, and Ezekiel Emmanuel and Linda Emmanuel in 1992.

As one of the strong advocates of patient autonomy and critics of the Hippocratic tradition, Robert Veatch in 1972 was the first to postulate four models of relationship in the physician-patient encounters, namely: *priestly*, *engineering*, *collegial* and *contractual models*.

4A. 2. 1. *Priestly Model*:

This model is also known as ‘Paternalistic’, and it dates back to the Hippocratic tradition. Thus, as indicated in the Hippocratic Oath of medicine, physicians are admonished and morally obliged to dedicate medical treatments to help the sick within the best of their ability and judgement, not to harm them. This suggests that the physician knows the best for the patient, and the latter is expected to be submissive to do the needful during the treatment process. This is the sole reason why the patient may relinquish his moral authority and puts full decision-making responsibility in the hands of the physician.⁵⁰⁸ Similarly, it beholds on medical professional as a moral obligation and primary duty, to protect the patient from all potential risks or harm. This

model operates exactly on the *medical model*, which treats patients as not necessarily as mere persons, but as illness itself. The main ethical principle which summarizes this priestly tradition hinges on the maximization of benefits and minimization of harm to the patient.⁵⁰⁹ As treatment may be continued irrespective of the patient's contributions and regardless of the outcomes, at this point, this model can be justified, especially in emergency situations.⁵¹⁰

4A. 2. 2. *Engineering Model:*

With this model, a healthcare professional is considered as a technical expert. It is the responsibility of the professional to endeavor to present all the necessary facts to the patients without making any value judgements. In other words, the physician abdicates his moral authority, reduces his role to that of a scientific expert who presents medical findings in a factual, value-free way. After which, the physician places the full responsibility of decision-making in the hands of the patient. It is the patient that makes the final decision. Though, Robert M. Veatch criticizes this model since the physician is only to present all the facts and let the patient make the choices, even if it is morally and ethically justifiable. Then, he charges physicians to participate actively at all the critical points where decisive choices are to be made, if not, the physician may end up fooling himself or herself, including the dignity of medical profession.⁵¹¹

4A. 2. 3. *Contractual Model:*

Very peculiar to this model is that there is a kind of contractual moral obligations and benefits for both parties. The patient is a client who is always at the receiving end, while the medical professional remains the treatment provider. The notion of contract in this context does not invoke any legalistic implications, but it is more symbolic with the traditional religious or

marriage ‘contract’ or ‘covenant’. So, the basic norms of freedom, dignity, truth- telling, promise-keeping, and justice are very essential to such a contractual relationship. Again, the keywords are ‘trust’ and ‘confidence’ even without full mutuality of interests. Therefore, once there is disagreement of opinions or conscience between the parties, then the contract is either broken or declared non-existent in the first place. It is expected that each party should be involved in each contract and should maintain a degree of control and individuality as well.⁵¹²

4A. 2. 4. *Collegial Model:*

In this model, M. Veatch tries to present both the patient and professional as colleagues whose primary objective is to pursue a common goal. This model provides a kind of equality of dignity and respect, which automatically leads to equality of value contributions. In conclusion, it is expected that they are to consider and treat each other as equals with utmost trust and confidence. As the physician is seen as the patient’s ‘pal’, both will be ready to provide vital pieces of information to ensure mutual agreement on specific treatment plans.⁵¹³

Exactly after about two decades Robert M. Veatch made his postulations on the four models of physician – patient relationship, Ezekiel Emanuel and Linda Emanuel came up with another four models of such relationship. These models are *paternalistic, informative, interpretive and deliberative models*. Very interesting, their first two models are very similar to Veatch’s models, i.e., paternalistic (as in priestly), and informative (as in engineering). Meanwhile, the other remaining two models – interpretive and deliberative – seem to be more collaborative in nature that spell out the roles of the physician in more clear terms than Veatch’s postulations.⁵¹⁴ These models as presented by the Ezekiel group include:

4A. 2. 5. *Paternalistic model:*

As earlier noted, this model is also known as priestly or parental model.⁵¹⁵ In the clinical encounter, the physician makes sure that patients are provided with the best medical options that will promote their health and well-being. At the extreme, this model limits patients' active roles but allows the physician to make unilateral decisions with regards to the treatment options. With shared objective criteria for determining what is best, the physician can as well discern what is in the patient's best interest. In return, it is expected that the patient appreciates the decisions made by the physician even if they may seem not to be in accord with the choices and values of the patient at the time.⁵¹⁶ No matter the conflict of ideas between the patient's autonomy and well-being, between choice and health, a paternalistic physician will be more concerned with the latter.

In addition, this model presents the physician as a parent, guardian to the patient, whose decisions are expected to be holistic and best for the patient. The conception of patient's autonomy in this model demands his or her assent, either at the time or later, to the physician's determinations of what is best.⁵¹⁷ Analyzing this paternalistic model further, Antal Szerletics rules that paternalism can be appreciated by its motive, which implies benevolence, or benevolent decision-making in another's best interests.⁵¹⁸ Therefore, any interventions that are intended to promote the good or welfare of the agent who is coerced,⁵¹⁹ Douglas N. Husak sees it to be justifiable, even when they interfere with personal autonomy.⁵²⁰

4A. 2. 5. 1. *Objection/criticism on Paternalism:*

The advocates of paternalism are convinced that it can be justified especially in emergency cases that require no time to obtain informed consent, which might irreversibly harm the patient.⁵²¹ One of the major criticisms against paternalism is that it is not certainly tenable to assume that the physician and patient may indicate similar values and views of what constitute a benefit. For this reason, as observed by Ian F. Tannock et al., a lot of physicians rarely advocate for the paternalistic model as an ideal for routine physician-patient interactions.⁵²²

4A. 2. 6. *Informative Model:*

This is the second of the models proposed by Ezekiel Emmanuel and Linda Emmanuel, but also known as the *scientific* or engineering in Robert M. Veatch's postulations.⁵²³ Very fundamental to this model is that it beholds on the attending physician to provide the patient with all relevant information before making choices. It involves full details on nature of disease, diagnosis and prognosis, including the potential risks and benefits, etc., before considering the proper interventions that might best realize the patient's wished and values.⁵²⁴ Again, this model assumes a fairly clear distinction between facts and values. The patient's values are sometimes well defined and known, but what the patient may lack are some facts about the illness. It is the physician's obligation to provide all the available facts needed, and the patient's values then will determine what treatments are to be given. As a competent technical expert or purveyor, the physician is morally obliged to provide truthful information, or the means for the patient to be responsible to make decisions. So, the conception of patient autonomy in this model would demand patient exercise of control over medical decision-making.⁵²⁵

4A. 2. 6. 1. *Objections/Criticism on Informative Model:*

Granted that informative model offers an opportunity for good interactions between

a physician and a patient, but it seems both descriptively and prescriptively inaccurate. Also, it seems to lack the essential qualities of the ideal physician-patient relationship. This is because with the informative model, a physician tends to care for the patient by fully respecting the patient's selected views or interventions. By so doing, a physician is not free to manifest proper caring approach and exercise of his or her professionalism towards the patient. In this light, Paul S. Appelbaum et al., add that an informative physician is proscribed from giving medical recommendations for fear of imposing his or her wishes on the patient which may compete with the patient's decision-making control.⁵²⁶ Based on that, this model lacks the necessary ingredients that may qualify for an ideal model for physician-patient encounter.

4A. 2. 7. *Interpretive Model:*

Another model is the interpretive model. With this model, the goal is to explain in clear terms the patient's values and wishes, and then to guide the patient in making the right choices. In effect, an interpretive physician will be disposed to furnish the patient with the vital information on his or her ill situation, including the risks and benefits of any possible interventions.⁵²⁷ Again, Ezekiel and colleague rightly point out that the physician is not meant to pass judgement on the patient's values, but as a guide, he is to assist the patient in applying those values in the medical situation.⁵²⁸ Moreover, this model presents a physician as a counselor, who plays advisory roles to the patient during the clinical interactions. So, the conception of patient autonomy in this model is more of patient self-understanding of the realities surrounding his or her sickness for proper applications of any selected medical therapies.⁵²⁹ In the same vein, Michael S. Sandel alludes that an interpretive physician ought to view the patient's life as a narrative whole, thereby be able to note the patient's values and their priority. Without dictating

for the patient, the physician should always promote a kind of joint or bilateral processes with the patient throughout the encounter.⁵³⁰

4A. 2. 7. 1. *Objections/criticism to the Interpretive Model:*

This model wins the admiration of many for recognizing that each human person has the ‘second-order’ desires and dynamic value structures, which can as well be placed at the center of the physician-patient interaction. Nevertheless, among some of the criticisms of this model is that technical specialization is likely to militate against physician’s effort to cultivate the skills necessary to the interpretive model. At the extremes, physicians may unwittingly impose their own values under the guise of articulating the patient's values. As a weak vulnerable candidate, and overwhelmed by the medical situation, a patient may be compelled to accept such impositions. Under such concrete scenarios, as judged by Ezekiel and his companion, a physician may tend to push the interpretive model to tread the pathway back to a paternalistic approach.⁵³¹ The concept of autonomy in this context may be viewed as self-understanding which may exclude every evaluative judgment of the patient's values or attempts to persuade the patient to adopt other values. Consequently, by excluding evaluative judgments, this team concludes that the interpretive model fails to characterize accurately an ideal model of physician-patient interactions.⁵³²

4A. 2. 8. *Deliberative Model:*

The last of the models proposed by Emmanuel et al., is the deliberative model. With this model, a caring physician offers to assist the patient to determine and choose the best health related values that can be realized in the clinical situation. In effect, the physician needs enough time to delineate important information on the patient's clinical situation, and then indicate the

types of values embodied in each option. Automatically, this model is likely to engage the physician and patient into extensive deliberations about what kind of health-related values the patient could and ultimately should pursue.⁵³³ Affirming the physician's role in the deliberative model, Charles Fries believes that a medical purveyor should act as a teacher or friend before the patient. This provides the means to engage the patient in a mutual dialogue on what course of action that would be proper.⁵³⁴ With this model, the conception of patient autonomy throws more light on moral self-development. This conception empowers the patient not simply to follow unexamined preferences or examined values, but through an elaborate deliberative dialogue.⁵³⁵

4A. 2. 8. 1. *Objections/criticisms on Deliberative Model:*

A lot of critics may not be comfortable with this model since they argue on whether it is proper for a physician to judge patients' values in order to promote health-related values. At this point, it is important to note that, a physician does not possess privileged knowledge of the priority of health-related values compared to patient's values. As medicine is practiced in a pluralistic society with incommensurable values, there is every tendency to experience such conflict of values between the physician's and patient's values.⁵³⁶ Also, some people would frown at this model as it seems to misconstrue the purpose of the physician-patient interaction. Of course, patients see their physicians to receive treatments, not to engage in moral deliberation or to revise their values. No doubt, as a professional in his domain, a physician can easily outwit a weak vulnerable patient in moral deliberations or debates on values, etc. Very similar to interpretive model, the deliberative model may easily metamorphose into unintended paternalism. Thus, this model is yet to provide the basic elements for an ideal physician-patient interaction.⁵³⁷

To conclude, Mehdi M. Shah makes the synthesis of critical analyses of the four

models of physician-patient relationship proposed by Emmanuel et al., thus: 1) – In the *paternalistic model*, the physician decides for the patient; 2) – With the *informative model*, the physician presents facts to the patient; 3) – Applying the *interpretive model*, the physician presents facts and helps the patient to find his or her preferences; 4) – Lastly, in the *deliberative model*, the physician presents facts, helps the patient to find his or her preferences, and then, tells the patient of his or her own (physician's) preferences.⁵³⁸ Despite having various models and different approaches, the doctor-patient relationship is still confronted with many challenges. Therefore, Mehdi Shah strongly affirms that ethics ought to play vital roles towards balancing this relationship to ensure positive outcomes in medical activities.⁵³⁹

4A. 3. 0. Towards Balancing the Patient-Physician Relationship

Medical interaction is the major medium of health care, where a medical practitioner engages in serious health discussions with a patient. For the past centuries, the physician's act of beneficence virtually went unchallenged as the first principle of medical ethics. Today, the relationship between doctors and their patients has received some attentions and continues to be one of the major subjects of ethical debates. Meanwhile, patient autonomy ranges from very high, where a patient may be allowed to make all decisions, to very low, where he or she has minimal or no active roles to play in the decision-making. As understood by Emmanuel et al., the *paternalistic* model in this relationship is not characterized with high valued formation, high autonomy, and high information disclosure like other models. For few decades ago, Tom L. Beauchamp and James F. Childress also observed that the patient autonomy has now become the dominant principle that tries to reshape the physician – patient relationship.⁵⁴⁰ They clearly hold that since the physician – patient relationship is a moral equation with rights and obligations, there is an urgent need to balance it, in order to promote the concept of 'beneficence', which is

the *keystone* for a proper care of the patients.⁵⁴¹ So, for Edmund Pellegrino, to effect this balance is a morally mandatory and exacting exercise, since it will reduce the risks of medical malpractices and the rate of unjust mortality, especially in the health care.⁵⁴²

In effect, Mohammad Y. Rathor and others declare that autonomy should not be considered as the absolute prerogative of the patient but rather a shared responsibility between the patient, family, surrogate and a physician or team of professionals.⁵⁴³ For them, promoting patient autonomy does not mean that the physician's expertise should be ignored or disregarded. Instead, physicians' participation and beneficence will always enhance a patient's ability to make an autonomous decision. Though, a competent patient is qualified to make medical decisions, but there should be mutually agreements upon common objectives, with due respect to the patient's cultural, psychological, and spiritual needs.⁵⁴⁴ This implies that the good relationship that ought to exist between a patient and a medical practitioner needs to be well defined to ensure that their autonomy is respected, respectively. While revisiting the shared decision-making models, Fries and colleagues suggest a model that can examine the interplay of patient autonomy and information exchange.⁵⁴⁵ Recognizing the likely influence of family and friends in decision-making, Bradley and colleagues developed a model where the key players in decision-making would serve as 'central variables'.⁵⁴⁶ This motivates Humphrey et al., to search for a new model that is will incorporate both the physician's interaction style and patient coping ability.⁵⁴⁷

The over-emphasis of patient autonomy in the healthcare seems to undermine the expertise of medical practitioners towards improving the health conditions of their patients. If this remains unchecked, it will likely create unnecessary tensions in the relationship between a patient and a healthcare purveyor. This is because as much as a physician wants to prevent a patient from suffering, he or she still has personal autonomy to be respected too. Reflecting on the ethics of

medicine, Mackenzie C. Roland notes that the principle of beneficence obliges physicians to act responsibly in their practices and in the best interests of their patients, which may involve overlooking autonomy, at times.⁵⁴⁸ But sometimes, the gap that exists in the patient-physician relationship has led to numerous problems, probably due to poor communications in the encounter. At this juncture, a school of thought led by Annie-Marie Greaney, suggests that a more inclusive form of autonomy, *relational autonomy*, should be advocated for, which can easily bridge the gap between the patient and the physician.⁵⁴⁹ These different concepts of autonomy can be troublesome as the acting physician is faced with deciding which model he/she will implement in a given clinical practice.⁵⁵⁰ Of course, a good therapeutic relationship, with reflective dialogue between the client and the physician may lead to better outcomes for the patient, as an active participant in decision-making.

It may be erroneous to single out a particular model as ‘ideal model’ since in different clinical contexts, different models may be appropriate. For instance, in any emergency cases where delays to obtain informed consent from patients might irreversibly harm the patient, then paternalistic model correctly fits well in such situations. Conversely, for patients who have clear but conflicting values, the interpretive model is probably justified. In other circumstances, where there is only a one-time physician-patient interaction without an ongoing relationship, the informative model may be justified. However, some ethicists support and justify the deliberative model as being very closer to an ‘ideal’ model in the physician-patient relationship with the following points. Firstly, this model seems closely to prove the ideal of autonomy, because its process of deliberation is very integral and essential for realizing patient’s values, wishes, preferences, etc.⁵⁵¹ Secondly, an ideal physician is not just one whose knowledge is vast only in literatures, art and popular cultures. Rather, he is a caring physician who integrates the relevant

information and values, able to convince a patient to accept selected recommendations that best promotes the patient's overall well-being.⁵⁵²

Thirdly, the deliberative model is considered not to be a disguised form of paternalism. No doubt, on some occasions due to human mistakes, a deliberative physician may unknowingly lapse into paternalism. Like a seemingly ideal teacher, a deliberative physician attempts to convince the patient of the worthiness of certain values, not to impose those values, paternalistically. He should not subject a patient to his or her will, but he tries to convince them of the necessary course of actions as desirable.⁵⁵³ Fourthly, physician's values are not necessarily relevant to the patient, but he may inform the latter of his or her personal choices. By so doing, a deliberative physician helps the patients to make their choices in critical ill cases.⁵⁵⁴ Fifthly, with this model it is expected that physicians should not only help fit therapies to the patients' elucidated values, but they should strive also to promote health-related values. Such good caring attitude can also make patients to be willing to adjust their values and actions to be more compatible with the health-promoting values. This still falls within the nature of seeking proper caring in medical recommendations.⁵⁵⁵

4A. 3. 1. *The Preferred Model for Physician – Patient Relationship:*

From the analysis so far, it seems that some notable experts like Ezekiel and others favor the deliberative model as the most appropriate to implement changes in medical care and education to encourage a more caring approach. This school of thought insists that more emphasis should be on mutual understanding rather than on mere provisions of factual information in keeping with the legal standards of informed consent and medical malpractices.⁵⁵⁶ Worthy of note is that, a deliberative model of physician- patient relationship is still in the process of development, and it requires a considerable amount of time.⁵⁵⁷ While still waiting for

an ‘ideal model’ in this relationship, the *deliberative model* remains the preferable model that can lead to a full balanced of autonomy in the physician-patient interactions. As the search for an ‘ideal model’ continues, John Stuart Mills insists that self-determination in relation to autonomy is valid provided it does not cause any harm or potential risk to others. Moreover, it is an important factor in autonomy not to always yield to individual’s autonomy if such could engender direct harm to others.⁵⁵⁸ Within the network of inter-relationships and inter-dependency among humans, Michael Fine et al., believe that each person has a moral duty to care for others. So, they unanimously affirm that ‘relational autonomy’ as opposed to individual autonomy, is highly acceptable and more justified.⁵⁵⁹ This implies that the respect for patient autonomy is indubitably important, but John Lantos et al., argue that the clinician integrity should not as well be compromised to always yield to all the patients’ requests.⁵⁶⁰

4B. 0. The Abortion Dilemma: Legal and Religious Perspectives

Introduction:

The concept of abortion is considered absolutely as a universal phenomenon. It is one of the most difficult, controversial, and painful subjects that some people may not be comfortable to debate upon, in public forum. In his typological study of abortion, George Devereux, affirms the universality of the concept when he notes that it is impossible to construct an imaginary human society in which no woman would ever feel the need to commit abortion.⁵⁶¹ Thus, abortion is not a new phenomenon, it is as old as human history. Besides the fact of its universality and history, abortion is also known to exhibit several other distinctive features. Among the distinctive feature of abortion is the *willingness* or *readiness* on women seeking for abortion. This ‘willingness’ is often supported by those who are ready to defy all laws and social conventions that prohibit the

practice, to procure abortion illegally. Another distinctive feature is the *status* of abortion which seems inextricably bound up with larger social, cultural, religious, moral and political factors. Simply put, abortion is associated with some elements of lasting stigma or negative influences on the status of women who commit it.⁵⁶²

Moreover, the notion of *legality* is one of the distinctive features of abortion. This does not necessarily imply that in all the places abortion is legalized that every woman has equal access to abortion services.⁵⁶³ It is important to add that the crucial factors to procure an abortion are the structure of healthcare system and the willingness of the medical personnel to provide abortion. At this point, it is very necessary to throw more light on this concept, because most of the arguments in support of abortion always begin with the respect of the patient autonomy. On this point, Warren M. Hern remarks that the principal controversy that revolves around this ethical concept is mainly on the dilemma of who decides on abortion related issues. Between a woman, physician and the state, Hern is still not yet convinced of who makes the final decisions to procure abortion. She also maintains that medical questions on the circumstances and the techniques for abortion are less controversial but are sometimes part of the larger debates.⁵⁶⁴ To proceed further, it would be advisable to delve first into the meaning, brief history, and basic factors surrounding the concept of abortion.

4B. 1. 0. Abortion: The meaning, Brief History and Basic Factors of the Concept

4B. 1. 1. *The meaning of Abortion:*

The concept of abortion is one of the highly controversial debatable topics across the globe based on religious, moral, ethical, medical, social and political grounds. As such, the concept can be associated with varied definitions or meaning from one source to another,

depending on the contexts. Given to this contentious nature of abortion, different notable scholars will continue to face multiple difficulties in defining and presenting arguments for or against abortion.⁵⁶⁵ At one time or the other, some influential non-state actors like the world largest ruling body, the United Nations and other institutions like the Roman Catholic Church, have also encountered a kind of vigorous face-off in their attempts to provide meaning, defense and justification of abortion. Hence, the terms used to define the concept will often reflect the primary sources and background views of these contributors.⁵⁶⁶

Etymologically, the term ‘abortion’ is traceable to the Latin word *abortionem* that simply stands for ‘abortion’ or ‘miscarriage’. In a similar pattern, the word *aborior* has its English equivalent as ‘to miscarry’. Within the medical parlance as presented by David A. Grimes and his friend, ‘abortion’ can simply refer to either a spontaneous (miscarriage) or induced abortion until the fetus is viable independent of the mother. Another medical term often used to refer to spontaneous abortion is ‘pregnancy loss.’ It is mainly accidental to cause the death of an embryo or fetus before it is capable to survive independently on its own. The focus here will be limited to induced abortion which is a deliberate ‘termination’ of pregnancy.⁵⁶⁷ Such an abortion could be ‘elective’ or voluntary to indicate an unrestricted right of a woman to abort at will, whether it is medically indicated to do so or not.⁵⁶⁸ The end motive of all the abortion services is the termination of unwanted pregnancy, causing the death of the most vulnerable specie of human beings before the attainment of the age of fetal viability outside the womb.⁵⁶⁹ The ethical controversies surrounding the concept are yet to be resolved. While some countries have legalized it, others are still advocating for its legalization, and some countries apply very strict measures in enacting and implementing abortion laws.⁵⁷⁰

As earlier noted, all the abortion services end up in the termination of pregnancy and or delivery before the attainment of the age of fetal viability. In the developed countries the gestational age for the attainment of fetal viability falls within 24 weeks, while 28 weeks for the developing countries. With modern technologies, some developing nations are progressively able to salvage fetuses of gestational age closer to that of developed areas.⁵⁷¹ In other words, it refers to the means of ending an unwanted pregnancy by deliberate means or expulsion of the embryo or fetus. This is one of the classical definitions of abortion, the expulsion of the fetus before it is viable with the use of objects. Objects like catheters are introduced into the uterus to disrupt the placenta and embryo (or fetus) so that a miscarriage could result to abortion.⁵⁷² This may include spontaneous abortion or miscarriage, but the emphasis is more on induced abortion, in which at least two persons (a doctor, the woman herself, or a layperson) can intentionally procure an abortion. The analysis given by Joseph K. Hurt and colleagues shows that abortion that occurs without any deliberate human means is understood as a miscarriage or spontaneous abortion. According to their report, it can occur approximately at the rate of 30% to 50% of pregnancies.⁵⁷³ Another medical term often used to refer to spontaneous abortion is ‘pregnancy loss’. It is mainly accidental to cause the death of an embryo or fetus before it is capable to survive independently on its own.

Still on the spontaneous abortion, Gail E. Robinson specifies that it can take place within the 20 weeks of gestation period, after which fetal death is no longer classed as ‘pregnancy loss’ but known as a stillbirth. The most common symptom of a miscarriage is excessive vaginal bleeding, with or without much of pains, associated with sadness, anxiety and guilt. However, once deliberate steps are taken to ensure that an unwanted pregnancy is terminated, it is no more a ‘miscarriage’, but it is known as an induced abortion, or less

frequently regarded as an induced miscarriage.⁵⁷⁴ Besides, there is serious contention with the classical definition of abortion that lays more emphasis on the concept of *viability*, i.e., the ability to live outside the womb. This is because in the distant past years, premature birth is historically associated with high rates of morbidity (like disability for babies born alive) and mortality at birth. Today, with all medical advances it is possible to save the lives of babies born after only thirty weeks of pregnancy when the usual pregnancy may last forty weeks. There are some babies born at twenty-six to twenty-seven weeks or even younger who have survived through massive medical interventions and supports. Unfortunately, it is not a news that some abortions can be performed at up to twenty-five to twenty-six weeks of gestation. Therefore, for people like Clifford Grobstein, this old definition which emphasizes more on the term ‘viability’ may not be helpful or tenable in determining whether an abortion should be performed or not, especially at such stage of pregnancy. Nonetheless, he rightly points out that the primary motive of induced abortion has not yet changed from terminating an unwanted pregnancy, causing the death of the most vulnerable specie of the human family.⁵⁷⁵

While reviewing the policies regulating abortion, the United Nations remarkably observe that abortion laws vary considerably between countries and have changed over time. The policies guiding the concept range from being freely available on request, to regulation or restrictions of various kinds, to outright prohibition in all circumstances. In effect, while some countries have legalized or advocate for the legalization of abortion, others are still applying very strict measures in enacting and implementing abortion laws.⁵⁷⁶ For instance, in countries like Nigeria, the laws on abortion make it one of the most restrictive countries in the world. These laws are expressed in the Nigerian Criminal Code (as applied in the southern part of Nigeria) within sections 228, 229, and 230. Particularly, the section 228 uses the term ‘miscarriage to

refer to abortion, and it clearly states that any person who assists a woman to procure a miscarriage is guilty of a felony and up to 14 years of imprisonment. Similarly, the section 229 also adds that any female that asks and obtains a miscarriage is guilty of a felony and up to imprisonment for 7 years. Lastly, the section 230 of the Code frowns at those who may provide necessary logistics intended for a woman's miscarriage, and such persons are liable for committing a felony with up to 3 years of imprisonment.⁵⁷⁷ Within the Nigerian Penal Code that operates in northern states, the abortion laws are contained in sections 232, 233, and 234. These sections of the Penal Code are very similar or parallel to the Criminal Code, besides permitting abortion with the purpose of saving the life of the mother. Any defaulter is punishable with imprisonment, fine, or both, regardless of whether the miscarriage is successful or not.⁵⁷⁸

With so much of restrictions on the concept of abortion, there is every tendency that many women seeking for an abortion may resort to unsafe abortion methods. Such primitive methods were used along with the introduction of foreign objects into the uterus (wooden sticks, knitting needles, catheters, etc.) to cause abortion. Although these methods can be effective, but at the same time, they may also result in the death of the woman if her uterus is ruptured, or if some quantity of amniotic fluid surrounding the fetus enters her blood stream.⁵⁷⁹ They are likely to cause tragic results on the health and life of the mother. Consequently, such are likely to lead to other abortion-related complications with an increase rate of morbidity and mortality. This is confirmed with the research carried out by the Guttmacher Institute, which indicates that an estimated 456,000 unsafe abortions are done in Nigeria every year.⁵⁸⁰ Also, in another study by the Society of Gynecologists and Obstetricians of Nigeria and Nigeria's Ministry of Health, the result shows that about 20,000 women engage in unsafe abortion, annually.⁵⁸¹

4B. 1. 2. *Brief history of Abortion:*

The practice of abortion is as old as the earliest time humanity began to witness a population increase. Initially, the practice of induced abortion was primarily conceived to be within the domain and care of some women like midwives or well-informed lay people. In his *Theatus*, Plato mentioned the expertise of midwives to induce abortion in the early stages of pregnancy.⁵⁸² Though, the policies regulating abortions can be referred to the ancient times, probably it started with the Romans.⁵⁸³ Within the 13th century, there was a kind of widespread regulations on abortion. Later in time, laws against abortion were scrapped off within the Roman empire. The reasons are: First, the Roman laws then did not consider a fetus as distinct from the mother's body. This implies that the mother has the right over her body to seek for abortion. Second, abortion was permitted to control family size; third, to maintain one's physical appearance. By the year 211 AD, abortion was outlawed for a period in time as violating the rights of parents, and it is punishable with temporary exile.⁵⁸⁴ Besides, the Hippocratic Oath which served as a guide to ancient physicians in the clinical matters seems not to prohibit abortion, absolutely, as experts like Helen King still maintains divergent opinions on the Hippocratic stance on the concept of abortion.⁵⁸⁵ Thus, it only forbids the use of pessaries to induce abortion, but it does not explicitly prohibit abortion in general. The primary reason for banning pessaries then, as investigated by John M. Riddle was because they were reported to cause vaginal ulcers.⁵⁸⁶

By the mid-20th century, there were agitations in many places around the world to liberalize and legalize abortion laws, especially when the life of the woman is at great risk, and in some cases on woman's request. Back then, the Soviet Under Vladimir Lenin legalized

abortions on request in 1920 and insisted that it must be performed only in the state recognized hospitals.⁵⁸⁷ At a time, the Communist states considered abortion as a temporary necessary evil, which might disappear in the future. By the year, 1936, Joseph Stalin placed prohibitions on abortions, which restricted women to medically recommended cases only, in order to increase population growth after the enormous loss of life due to incessant wars.⁵⁸⁸ Within the same timeline, many other countries like Poland, Turkey, Denmark, Sweden, Iceland, Mexico, etc., followed suit to legalize abortion, especially in certain cases pregnancy results from rape, or due to fetal complications which can pose serious threat to mother's health and life.⁵⁸⁹

It is an indubitable fact that in theory, laws or policies may be very easy to promulgate, but in practice, they are very difficult to implement. Granted that abortion has passed different epochs in human history with a lot of laws promulgated to ensure control over it, but it will not be out of place to reason how far these implementations have exerted much control on abortion. For instance, with a critical mind focusing on the robust and elegant nature of Nigerian abortion laws, Lawrence O. Omo-Aghoja and colleagues would question: "How many violators have been arraigned, prosecuted and indicted for performing illegal acts of abortion in the country?"⁵⁹⁰ Another interesting issue is that almost all, if not all, the colonial masters who imposed restrictive abortion laws in different parts of the world, have virtually liberalized their laws with a huge drop in abortion rates, morbidity and mortality from abortions. Today, many countries and peoples who are antiabortionists, still hold tenaciously to their views based on ethical, cultural, social, and religious affiliations.⁵⁹¹ The worse is that the risk of dying from unsafe abortion in Africa is 1 in 150 and 1 in 1,900 in Europe. In the United States, abortion was estimated to be about 14 times safer for women than childbirth. The Center for Disease Control estimated that in 2019 the US pregnancy-related mortality was 17.2 maternal deaths per 100,000

live births, while the US abortion mortality rate is 0.7 maternal deaths per 100,000 procedures.⁵⁹² While the unintended pregnancy rate was 86 pregnancies per 1000 women (67–114) in west Asia and north Africa, and 91 pregnancies per 1000 women (86–96) in sub-Saharan Africa.⁵⁹³

4B. 1. 3. *The Concept of Abortion in African/Nigerian Contexts:*

All the definitions put forward on ‘abortion’, according to Jonathan Glover, are not far from presenting it as a deliberate intent to terminate pregnancy or human life beginning from the time of conception till birth. He further explains that abortion is bound by the immoral attitude of non-conception that may lead to a decision to kill the unborn baby or fetus. This deliberate intent to commit abortion, excludes all premature delivery of a viable fetus as long as it can be kept alive, and all natural miscarriages ‘ime opupu’ (Igbo).⁵⁹⁴ The terms that portray the same meaning for abortion in some of the African/Nigerian cultures include: *ite ime* or *ishi ime* (Igbo), *işeyun* (Yoruba), *zubar da ciki* (Hausa), etc., which represent a deliberate act of terminating of pregnancy in anticipation of the death of the fetus. With particular reference to Igbo culture, just like in other African cultures, Charles U. Anuolam holds that abortion *per se* was very uncommon in the traditional Igbo society before the advent of Christianity or colonialism. Instead, it was ‘miscarriage’, either spontaneous or natural, that was very commonly discussed and experienced by them. This is the reason why some writers in the past were very silent on the topics like ‘induced’ abortion, unlike other themes such as suicide, murder, rituals, sexual crimes and so forth.⁵⁹⁵ Hence, a typical Igbo person or an African traditionalist believes that all forms of miscarriage are seen as terrible loss of human lives. This is the general belief of the people, since the ‘fetus’ is not only a product of conception, but it is also considered as well as a human being with temporary residence in the mother’s womb. So, this understanding of

human life at this early stage is one of the factors that militate against any easy attitude towards the practice of a deliberate abortion.⁵⁹⁶

It is not an overstatement to note that African cultures have special respect for the intrinsic dignity and value of human life. In these cultures, Anuolam U., adds that there is wholesome acceptance of and respect for life in all its totality, form or state. As a matter of fact, they love and cherish progeny or offspring; hence they like the following names as ‘Ajunwa’ (a child should not be refused existence), because ‘Ibeyinwa’ (there is nothing like a child), and therefore ‘Nwahiri’ (a child should live or stay).⁵⁹⁷ All the controversial debates, whether theological or philosophical, on whether life begins at conception or at the period of ensoulment have no place in the African tradition. My own opinion is not different from the traditional popular African/Igbo belief that life begins at the moment of conception.⁵⁹⁸ As earlier indicated, African notion of life is highly communal in nature. Based on that, the concepts like abortion, suicide and other crimes against human life and dignity in Igbo settings, are therefore not considered as private offenses or crimes. They are not simply regarded as “one’s own personal sins” alone. Rather, they are equally considered to bear some kinds of serious communal perspectives or implications.⁵⁹⁹ Besides, each person’s moral behavior is seriously regulated as stipulated in detail by the *Omenala* or tradition or customs of the people. According to Lazarus Esomonu, in Igbo worldview, it is the ‘Umunna’ (kinship) that makes a person apparently and intensely ‘naked’. Relying on ‘Omenala’, all moral demands are duly scrutinized by everybody so that a person who fails to live up to them cannot escape notice or punishments.⁶⁰⁰

Judging from the above backgrounds, to nurse any intentions or to procure abortion in the traditional African society, especially in Igbo region is considered as an abomination — ‘*aru*’ or ‘*imeruala*’. In this context, an abomination includes serious personal and moral crimes, such

as incest, a woman being pregnant within a year after husband dies, willful abortion, murder, homicide, suicide by hanging, etc.⁶⁰¹ The communal implication of a willful abortion, like other abominable crimes, is viewed as a grave offense against the earth spirit, the ancestors, and the entire community. It goes on further to include that such an immoral act is a desecration of the land, the abode of the ancestors, believed to be sacred, and thus requires expiatory rituals of atonement. As such, purificatory rituals or sacrifices are needed to cleanse the polluted land, appease the earth spirit, the ancestors, in order to save the people from the imminent wraths from the gods of the land. Above all, the rituals are also intended to reconcile the offender (if he or she is not killed with jungle justice) with the whole community.⁶⁰² To cover up one's abominable offense or refuse to sacrifice for atonement, Cardinal Francis A. Arinze quickly remarks that, it is just like leading a dangerous life, walking on a tight rope, or playing with the wrath of gods both on the culprit's or on his or her relations and descendants. Once the secret is later known to the public, the person (offender) is not only ostracized and cut off from social communications, but also denied worthy befitting burials at point of death.⁶⁰³ Of course, I can easily agree with Charles U. Anuolam that all these prohibitions on abortion serve as moral deterrence to the people from committing abortion.⁶⁰⁴

In Nigeria, like in other places across the globe, unintended intercourse is the primary cause of unwanted pregnancies. Most women who are victims of unwanted pregnancies would like to seek for abortion to terminate the pregnancy.⁶⁰⁵ Since abortion is illegal in Nigeria (unless medically recommended to save a mother's life), many abortions are carried out clandestinely, and often in an unsafe environment.⁶⁰⁶ Despite the stringent restrictions against induced abortion, it is still not only widespread in Nigeria but procured in different locations, ranging from traditional medical practitioners, herbalists, and private practicing clinicians to modern

pharmacists. According to the studies by Uche Amazigo et al., the consequences of these clandestine abortions are grave and can be life-threatening, often leading to maternal death. They bemoan that series of abortion accounts for 20%–40% of maternal deaths in Nigeria. For them, the leading contributory factor to unwanted pregnancy in Nigeria is mainly due to low contraceptive usage.⁶⁰⁷ Affirming this position, the group led by A. A. Fawole believes that the consequence of low contraceptive use among Nigerian women leads to an estimated 1.5 million unplanned pregnancies annually, with half of these resulting in elective abortions.⁶⁰⁸

(Cf. The Table):

	Total no. of patients	1 st Trimester abortion	2 nd Trimester abortion
Age (year)	No. of Percentage (%)	No. of Percentage (%)	No. of Percentage (%)
15 – 19	42 (55.3)	19 (25.0)	23 (30.26)
20 – 24	19 (25.0)	4 (5.26)	15 (19.74)
25 – 29	9 (11.84)	2 (2.63)	7 (9.21)
30 – 34	6 (7.9)	0 (0.00)	6 (7.90)
Total	76 (100)	25 (32.90)	51 (67.10)

In conclusion, I categorically state that Africans /Nigerians have a deep respect for the dignity and value of human life. This is the basis for recognition and acceptance of the inviolability of life and its sacredness. They have a natural humane attitude towards life. Therefore, life for them is the greatest value any one can possess. With the names like ‘Nduka’ (life is greatest value) and ‘Ndubuisi’ (life is primary or first) are clear demonstrations of the fact that abortion has no place as such in African / Nigerian worldview. For this reason, any

procurement of abortion will always provoke the consciousness, interests and interventions of the whole African / Nigerian society.⁶⁰⁹ Of course, any critical and moral person can easily join me to disregard the practice of induced abortion at will, based on Ronald Dworkin's stance that, it is a great insult to the intrinsic dignity and value of life.⁶¹⁰ Therefore, if the stringent abortion laws in Nigeria must remain, I would solicit for more collaborative (a notion of human solidarity) efforts should be directed at reducing the incidence of, or completely eliminating, unwanted pregnancy. This will entail the provision of comprehensive services and a determined mass literacy campaign. In this light, Joseph I. Ikechebelu et al., opine that the improvement of the existing national health services and the introduction of comprehensive post-abortion medical care will reduce the current high level of mortality and morbidity attributable to induced abortion.⁶¹¹

4B. 1. 4. *The Basic Factors of Abortion:*

Certainly, abortion occurs on daily basis at different locations across the globe, but there seems to be little emphasis on the factors that can push a woman to seek for abortion. Probably, this lack of information, as thought by Akinrinola Bankole et al., is not as such far from an overall scarcity of data on abortion. They equally note that both the legal, moral and ethical issues that are associated with the concept can pose a lot of difficulties to delve into some details about it. All these, no doubt, can affect the quality of the necessary information to be obtained on abortion.⁶¹² Also, in order to maintain confidentiality or privacy, adhere to perceived social norms and shield themselves from the stigma of abortion, most women who had committed abortions hardly engage into open discussions on their traumatic experiences. So, understanding why women seek abortion has been largely missing from fierce public and policy

debates.⁶¹³ With many reviews on several qualitative and quantitative reasons, few factors are articulated as the reasons to demand for abortion among women. Opinions may differ with regards to the factors that are likely to push women to abort. Despite methodological differences of some of the reviews, there is a consistent picture of women's reasons to advocate for abortion, and they are better illustrated into three categories thus:

i). *Women-focused Reasons*. One of the women-focused reasons, in the studies undertaken by Reed Boland and Laura Katzive, is when the pregnancy poses a great risk to a woman's health.⁶¹⁴ Other women-focused reasons include those issues related to the timing of pregnancy, the woman's physical or mental health, the family size, etc. This implies that a consideration of 'time' of the pregnancy can compel a woman to abort. For instance, if a lady is not in good state of physical or mental health status, or she had already more children to care for, she may vie for an abortion as result of an unwanted pregnancy. So, any pregnancy that results outside her time frame to conceive, is considered as an 'unwanted' pregnancy which she may not be disposed to keep. Based on her right as a woman, she is free to advocate for an abortion. In support of this women-focused reasons, Maggie Kirkman and group conclude that, regardless of age, marital status, and social class, when women are confronted with an unwanted pregnancy, they often seek to terminate it.⁶¹⁵

ii). *Material Reasons*: This refers to economic hardships and housing limitations on the part of the pregnant woman. Living under abject poverty has forced some women to take drastic decisions not to give birth to children again. The case is worse with jobless single ladies to be pregnant. For the fear of the unknown in their respective future lives with the unwanted

pregnancy, is enough reason to trigger single women's quest to seek for an abortion at all costs.⁶¹⁶

iii). *Other-focused Reasons*: This includes multiple external factors from the intimate partner, the health of the potential child, existing children, and others influences from the people around the pregnant mother. The pressures from them can plunge a woman into a distressful mood, which she may consider the procurement of abortion as the best option or means to come out from such unhealthy situations. In addition, Reed Boland and friend remark that even in some places where abortion is legalized, it is primarily intended only in specific critical cases such as rape, health complications with the fetus, or in the case of incest, etc.⁶¹⁷ According to Eugene M. Ikeanyi and his companion, there are other major reasons for a woman to demand for an abortion. They include the desire not to interrupt education or career, tender age of previous babies, relationship problems, age or health problems, and the fear of religious, social and cultural stigmas.⁶¹⁸

The above three categories may not be considered as exhaustive factors or reasons that propel women to commit abortion. There are other multiple factors which may directly or indirectly relate to the above reasons for procuring induced abortions. As a kind of synthesis that push woman to ask for abortion, a school of thought led by John O. Schorge, categorizes these factors as either *therapeutic* or *elective* reasons. From medical perspective, an abortion is termed 'therapeutic' if it is intended and procured based on health reasons to save the life of the pregnant woman, or to prevent potential harm to the woman's physical or mental health. In such critical situations, abortion may be permitted to terminate a pregnancy, especially if indications show that the child will have a significantly increased chance of mortality or morbidity. Also, it can be performed to reduce the number of fetuses to lessen health risks associated with multiple

pregnancies by a woman.⁶¹⁹ Similarly, an abortion is considered as an ‘elective’ or voluntary when it is committed at the request of the woman for non-medical reasons. Relying on their personal autonomy and right to make decisions about their own body, without much consideration on the dignity and value of life of the fetus, some women can schedule for an abortion at will, whether medically indicated or not.

Whatever may be the leading factors to seek for abortions, one can admit that safe abortion services are most often scarce, making it possible only for the affluent women who can afford the bills to visit doctors, privately. For poorer women who are so determined and willing to risk their health and life, the only option is to seek out for unsafe clandestine abortion services from the quack centers. Evidently, the report by the World Health Organization (WHO) shows that unsafe abortion is one of the public health problems in the developing countries, and by extension, in Nigeria.⁶²⁰ On this note, the WHO considers unsafe abortion as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills, or in a system that fails to meet up with certain requirements, or both. In the same report, about 97% of unsafe abortions occur mostly in the developing countries.⁶²¹ A cursory look into Nigerian stance vis-à-vis abortion as a case study, one will affirm that there seem to be much of restrictions on abortion in its Criminal and Penal Codes.⁶²² With such restrictions, many women would prefer unsafe means to terminate unwanted pregnancy. It is not absolutely guaranteed that abortion procured with safe procedures by trained professionals, may not lead to disastrous outcomes. In the developed and under-developed nations, not every woman is capable to access safe abortion services for unwanted pregnancies.

Reacting on the incidence of induced abortions in Nigeria, Stanley K. Henshaw and others remark that, these restrictions do not as such reduce the incidence of unsafe abortions, but

rather they drive it to the background and increase morbidity and mortality.⁶²³ Another report presented by the World Health organization (WHO) estimates that in every eight minutes a woman from one of the developing Nations will die of complications of an unsafe abortion. It is also known that women who live in countries where abortion has been legalized still patronize unskilled persons for termination of unplanned pregnancies due to religious, social and cultural affiliations.⁶²⁴ Today, while some countries like Britain have liberalized its abortion laws, Nigeria still holds tenaciously to the old laws despite years of her independence. Contrary to its intended purpose, Friday Okonofua asserts that restrictive abortion laws have not prevented abortions in Nigeria. He goes on to add that these laws have succeeded in criminalizing the practice of abortion, and this has driven it to underground, making it unsafe for women.⁶²⁵ Sometimes, when these women suffer complications due to unsafe measures to abortion, they are less likely to seek for treatments from skilled medical providers, because they believe that such treatments are expensive and may expose them.⁶²⁶ Both social, cultural and religious factors in Nigeria also prevent many women who suffer complications of unsafe abortion from seeking timely medical cares. They are also afraid of the social or religious stigmas. Such personal and social fears further reduce women's access to effective and high-quality post-abortion care following unsafe abortion in Nigeria.⁶²⁷ The same case applies to other poor women around the globe, especially where their respective governments have little or no proper plans to ensure good access to healthcare for their citizens. Consequently, this may result into unnecessary delays for appropriate treatments or high rate of morbidity or mortality due to unsafe abortions.⁶²⁸

4B. 2. 0. Ethical Controversies and Indications for the Legalization of Abortion

As the ethical controversies on abortion continue to cause serious rage among scholars, there is also a broad continuum of legal categories for abortion. For some people, abortion may be permitted at the request of a competent adult female with or without much of requirements for justification. But for others, it can be permissible but with restrictive laws that prohibit only unlawful abortions. It is only in a few independent nations that abortion is outrightly prohibited on all grounds.⁶²⁹ Reflecting on the abortion laws and policies across the globe, Marge Berer notices that most of them have been debated upon, reviewed and changed, thereby indicating the specific objectives they intend to achieve.⁶³⁰ Besides, the issues related to abortion are very sensitive and delicate, because a vulnerable defenseless life of the fetus is always at stake. In the locations where abortion laws are relatively liberal, many women may still struggle to have good access to abortion services. Cognizant to the strict regulations of some institutions, privacy at the clinics, the cost of procedures, and the availability of health workers willing to procure abortion services, all these may still create access barriers to abortion.⁶³¹ The WHO bemoaned on the lack of health workers providing good abortion services as a major barrier for women's access to safe abortion.⁶³² Some healthcare providers may not be so eager to engage into abortion services due to fear of facing all sorts of stigma, discrimination, shame, etc., associated with it.⁶³³

With regards to its legalization, the laws pertaining to abortion are very diverse. At the same time, both the religious, moral, ethical, and cultural factors play major influences on abortion laws around the world. For instance, the right to life, the right to liberty, the right to security of person and the right to reproductive health are major issues of human rights that sometimes constitute the basis for the existence or absence of abortion laws. Thus, to legalize

abortion, certain requirements must often be met before a woman may obtain a safe and legal abortion. On this point, Theodore J. Joyce and colleagues note that one of the requirements usually depend on the age of the fetus, often using a trimester-based system to regulate the window of legality. In the case of a minor female requesting for an abortion, it requires to seek the parent's consent for the abortion to continue.⁶³⁴ At some jurisdictions, the woman is required to seek for the consent of the fetus' father, before aborting the fetus. It is also required that a woman be well informed of the potential risks involved in the abortion procedures, and it then calls for medical authorities to certify that the abortion is either medically or socially necessary. Though, in situations of emergency, many restrictions are likely to be waived off. But in places like China, mandatory abortions are required as part of the population control strategy.⁶³⁵ However, popular opinion shows that legal abortions can be allowed in a variety of circumstances like in the cases of rape or incest that result into pregnancy. Again, if the fetus' development is impaired, or the woman's physical or mental well-being is endangered, or socioeconomic considerations make childbirth a hardship, then abortion may be permissible.⁶³⁶

Amidst the ethical controversies surrounding the abortion dilemma, the following indications are proposed by the World Health Organization (WHO) in its Geneva convention of 1971. The Organization urges the member states to consider these proposals for ethically and legally justifications of abortion in their respective codes regulating abortion in their independent states. The indications are, namely:

a). Abortion on demand: This is one of the statutes, especially in liberal states like Hungary, Russia and in some states in America (Alaska, Hawaii, and New York), that can allow a woman to proceed to terminate a pregnancy, simply based on her request. So, a competent adult female

does not need to show much of evidence or other indications before seeking to abort a fetus. Though, she must present the application in person to a legally competent board for proper scrutiny.⁶³⁷ If the application is approved or not, but if the woman remains exigent to her request, the board has no option than to authorize the abortion. The consideration for such authorization is given only during the first 12 weeks of pregnancy (first trimester), and the operation must be performed in an official health institution.⁶³⁸ Abortion on demand is clearly noted in the New York Abortion Art. This Art justifies every abortion provided it is performed upon a female with her consent by a duly licensed physician acting thus: (a) – if it is meant to save the life of the mother; or (b) - the gestation period of the pregnancy is still within 24 weeks.⁶³⁹

b). Medical indications: Virtually, medical indications are found even in the most stringent or restrictive legislative texts on abortion. Basically, once the life of the mother is at great risk as result of the pregnancy, then to abort the fetus would seem like the best necessary option to save the life of the mother. This medical understanding of preserving the mother's life also includes both her physical and mental health. Besides, the notion of 'health' in this context refers to the entire well-being (physical, mental, emotional aspects, etc.,) of the mother. The reason to save a vulnerable life of the pregnant mother, is still the only major indication for therapeutic abortion that is recognized in most countries of the world. For example, in France, the Code of Medical Ethics specifies that if the reason to abort is due to medical indication, then it is not to be viewed as therapeutic abortion. Rather, the authorization may be considered as a 'surgical operation', or the application of a therapeutic means that is likely to interruption or terminate the pregnancy.⁶⁴⁰

c). Ethical indications: Most countries that advocate for the legalization of abortion also base their arguments on ethical indications. Such indications stresses on the pregnancy that may result

from criminal incidences of rape, incest, or sexual intercourse with a minor or a person suffering from a mental disorders or deficiency. Based on that, abortion may be permissible, at least, it serves to preserve the integrity, dignity or honor of the pregnant victims and their families, as in the case of Jordan and Lebanon. Similarly, the Penal Code of Colombia provides for a reduction in the penalty, or granting a free pardon, for any illegal abortions that involve such related ethical indications listed above.⁶⁴¹

d). Eugenic indications: Today, many countries consider the eugenic indications as very necessary cogent reasons that can be used to justify the termination of pregnancy. Specifically, the objective is not merely to prevent the transmission of hereditary diseases to future generations. But it is fundamentally intended to prevent the news babies from suffering further physical or mental disorders, as result of complications in the womb. As such, some nations like Turkey, has produced a sample list of eugenic cases in which there is a risk of a serious defect affecting the fetus or succeeding generations.⁶⁴² In the same vein, Sweden adopted eugenic indications in 1963 as a result of the accidents due to thalidomide, insists that a pregnancy may be terminated when there is a risk, especially when such injury during pregnancy is likely to cause a serious disease or deformity on the baby.⁶⁴³

e). Social indications: Some European countries throw more weight on social indications as sufficient reasons to abort. This indication considers a situation whereby a woman has good number of children (four children with an average interval of less than 15 months between each delivery) under her care, she can abort any unwanted pregnancy. Again, if the unwanted pregnancy results within the six months after the last delivery, she is legally justified to go for an abortion. At some point, a pregnant woman, either alone or together with her husband, has to

provide the legal responsibility for four or more children living in the household, before the abortion is approved within 10 weeks to three months of pregnancy, depending on the country.⁶⁴⁴ Other social indications for abortion include; the death or disability of the husband, disruption of the home, predominant economic hardship on the woman for the maintenance of the family or the child, and other difficult circumstances on a woman due to pregnancy.⁶⁴⁵

f). Age as an indication for abortion: The fact that the pregnant woman is below a certain age (which may be considered as a social and humanitarian indication) or, in contrast, is above a specified age (which may be regarded as a medico-social, medical or even eugenic indication), is in some countries a sufficient cogent reason to ask for legal abortion. Thus, abortion is authorized, provided it is performed before the prescribed gestational time limit. For instance, if the woman is less than 16 years or more than 40 years in Eastern Germany then, or less than 17 years or more than 40 in Finland, and less than 16 or more than 45 in Czechoslovakia, abortion is legally permitted.⁶⁴⁶

4B. 3. 0. Abortion: Religious Perspectives and Ethical Reviews

Introduction:

Religion and its leaders are pivotal to influence the shaping attitudes towards sexual and reproductive health (SRH), norms and behaviors at all levels of human existence.⁶⁴⁷ There have been many instances when religion is seriously involved in the controversial intense debates resulting from people with divergent views. Obviously, in a sensitive controversial ethical issue like abortion, where human life, dignity, values and rights are at stake, Rebecca T. Peters asserts that religious doctrine and beliefs may come in direct conflict to influence the numerous laws, policies or recommendations regarding the practice of abortion.⁶⁴⁸ Though, some countries have

succeeded to legalize abortion, but the concept still draws a plethora of controversies. It causes a division among experts who stand either for ‘pro-life’ or ‘pro-choice’ groups. On the one hand, the ‘pro-life’ supporters are ready to defend the fetus’s right to live at all costs, no matter what. For them, abortion is direct deliberate murder or infanticide. While on the other hand, based on the woman’s *autonomy*, the ‘pro-choice’ defenders will be eager to support a woman’s choice in determining whether she wants to have the baby or not.⁶⁴⁹ Therefore, with reference to the Nigerian healthcare system, the discussions on abortion will be on the perspectives of its three main religions – African traditional Religion, Islam and Christianity.

4B. 3. 1. *Abortion in African Traditional Religion:*

Historically, African Traditional Religion (ATR) is the oldest known religion practiced across the African continent. Before the advent of western religions and cultures, the ATR had already existed as part of the peoples’ ways of life. People like Kofi A. Opoku agrees that Africans are generally and greatly influenced by their Traditional Religion. This is because, it has a pervasive role, and the whole of their life is wrapped up in religion. He conceives religion as a kind of summary of the totality of African Cultures. As a way of life, he then concludes that a person does not need any special instruction in African religion, one simply picks it up as one grows up and begins to participate in the communal rituals and ceremonies.⁶⁵⁰

However, to discuss the notion of abortion in African context, implies connecting it with the people’s views on the concepts of life, as earlier discussed. A deliberate abortion is an abomination, and it is outrightly prohibited in the African Traditional Religion.⁶⁵¹ The reason why abortion is absolutely and outrightly abhorred in the African Traditional Religion (ATR) is because within the African worldview, both religion, morality, social life, culture and ethics, are not only closely intertwined but are inseparable.⁶⁵² As earlier noted, such an abhorrence to abortion can

push women to clandestine self-managed abortion procedures that are periodically engineered mainly by the quacks.⁶⁵³ With such a mentality on the concept, Christopher C. Ngwu et al., allude that virtually in most of the traditional African communities, induced abortion is not only conceived as a taboo, but it is tantamount to a deliberate termination of human life at the early fetus stage.⁶⁵⁴ The fact remains that in Africa, as Ephraim A. Chukwu rightly notes, that once pregnancy results from mature, genuine and legitimate candidates, it is highly extolled and praised by the immediate relatives and friends. At the same time, such joy and happiness can easily be translated into the realm of unexpected reactions if it is discovered that there is an attempt to terminate the pregnancy.⁶⁵⁵ As earlier indicated, though abortion is practiced in secrets, but it has no place in the African traditional religion.

4B. 3. 2. *Islamic Perspective on Abortion:*

Without delving into the detailed history of Islamic religion in Nigeria, it is very necessary to indicate that Islam is predominantly practiced in the North, and part of the West including the central part of Nigeria. Besides, in the Islamic theology, procreation is generally accepted as a divinely ordained obligation, especially when it does not indicate any potential risks or harm to one of the spouses. On the certain issues related to induced or intentional abortion, the Holy Quran does not address them directly and explicitly. Instead, they are mainly left at the discretion to the laws of individual countries for further interpretations and applications.⁶⁵⁶ So, abortion is presented and understood as a premature expulsion of a fetus. Basically, the restrictive views on abortion as commonly held by Islamic jurists are in accord with the general Qur'anic interdiction of deliberately and unlawfully taking of human life.⁶⁵⁷

The Qur'anic descriptions with regards to evolution of the human embryo make some experts to differentiate between an initial biologic entity and the real fully developed embryo as a

human being. In other words, it simply suggests the ensoulment of a fetus some moments after conception. On this note, the Islamic position on abortion, accepted by all Muslim jurists, is that, after the fetus had been in the womb for 120 days (i.e., after the ensoulment of the fetus), abortion may be no longer permissible. Although, both the legal and individual opinions may still differ over the permissibility of abortion before this point.⁶⁵⁸ Indeed, many Islamic thinkers would continue to push for exceptions to this rule for certain reasons, depending on the circumstances. One of the Islamic thinkers is Azizah Y. al-Habri, an American academician, who affirms that the majority of his fellow Muslim scholars still favor abortion, even though they may seem to differ on the fetal developmental stages beyond which it becomes prohibited.⁶⁵⁹ In his critical analysis, Sherman Jackson advises that, though abortion is not permissible within the first trimester, but for the minority of jurists such should not be strictly held as a punishable offense that can merit criminal or civil sanctions.⁶⁶⁰

Due to the nuances that surround the concept of abortion laws among Muslims, the Islamic traditions attempt to clarify the concept, and then provide further justifications for it. The justifications that favor abortion include:

- i). In the case of a pregnancy that poses great risk to the life of the mother, abortion may be permissible to save a woman's physical or mental health, fetal impairment, etc.⁶⁶¹
- ii). Also, most of the Islamic teachings justify abortion in the cases of rape or incest. Though, within the Islamic ethics of life as reasoned by Vardit Rispler-Chaim, every child of rape should be considered as a legitimate child, and so, it would be immoral to kill such a person. So, abortion may be permissible if the fetus is less than four months old or before the ensoulment.⁶⁶²
- iii). On the contrary, Islam may not be entirely comfortable with the new reproductive genetics. But in the case of serious fetal deformity, some Sunni Muslim scholars would advocate for

abortion since the care or upkeep of the newborn might be extraordinarily difficult for the parents.⁶⁶³

In conclusion, there are disagreements on the moment of conception and the onset of ensoulment, and whether ‘viability’ pertains only to newborns capable of living outside the womb.⁶⁶⁴ Among the four Sunni Islamic schools of thought –*Hanafi*, *Shafi’i*, *Hanbali* and *Maliki* – each of them has its own differing reservations on when abortions are permissible in Islam. Worthy of mention is that only the ‘Malikites’ who do not permit abortion at any stages of gestation. On the issue of the life of the woman, most Muslims agree that her life takes precedence over the life of the fetus. This is because the woman is considered as the ‘original source of life’, while the fetus is only a ‘potential’ life. Based on this position, Muslim jurists agree that abortion is permissible and justified, based on the principle that the ‘greater evil’ (which is the woman’s death) should be warded off by the ‘lesser evil’ (death of the baby by abortion). Above all, in such cases, Islam sees physician(s) as better judge(s) than the scholars or patients.⁶⁶⁵

4B. 3. 3. *Christian Perspectives on Abortion:*

The presence of Christianity in Nigeria was as the result of the difficult adventures undertaken by early white missionaries.⁶⁶⁶ There is scholarly disagreement on how early Christians felt about abortion, as there is no explicit prohibition of abortion in either the ‘Old Testament’ or ‘New Testament’ books of the Christian Holy Bible. Though, it is clearly indicated in the Ten Commandments thus: “Thou shall not kill!”.⁶⁶⁷ Even at that, some scholars like Kristin Luker notices that early Christians took diverged nuanced stances on abortion, at different times and places.⁶⁶⁸ However, according to Robert Nisbet, Christianity considers the concept of abortion as a grave sin as sexual immorality.⁶⁶⁹ The rise of Christianity brought

brought more public regulations of sexual life, including increased condemnation of abortion. Early Christian thoughts were divided as to whether abortion of an early “unformed fetus” should be viewed as a direct murder. The Catholic church, for instance, tacitly permitted earlier abortions, but it failed to play an active role in antiabortion campaigns until in the 19th century.⁶⁷⁰

Historically, the Christian opposition to abortion has been constant throughout fluctuations in scientific and theological opinions as to when a human life comes into being.⁶⁷¹ As such, Christianity argues that the human person is not a purely ‘spiritual’ but a bodily being as well; hence, the soul is the body’s ‘life principle’, albeit directly formed by God.⁶⁷² Logically, it follows that each person is a composite being – body and soul – who possesses equal human rights, including the right not to have one’s life unjustly targeted by others.⁶⁷³ Increasingly, with the growing scientific knowledge, Christianity sees abortion as not only seriously morally wrong at any stage of pregnancy, but also (as in the earliest Christian tradition) as a form of unjust homicide against humanity and its creator - God. Certainly, every unborn child deserves respect as a person from conception. As such, the alienable human rights do not depend on the circumstances of their conception.⁶⁷⁴ Basically, all Christian denominations may have nuanced positions, thoughts and teachings about abortion, but they unanimously oppose deliberate abortion as immoral.⁶⁷⁵ Most often, one of the women’s reasons to demand for an abortion is not necessarily to terminate the life of the fetus as an end or as a means, but such can result as a negative unintended side effect. Such arguments suggest the notion of the principle of double effects.⁶⁷⁶

The *Principle of Double Effect* (PDE) is also known as *Doctrine of Double Effect* (DDE), or *Double-Effect Reasoning* (DER). To ensure consistency in this dissertation, this

principle may be abbreviated as ‘PDE’. According to this principle, as reasoned by Thomas Aquinas, refers to a set of ethical criteria by which Christian philosophers, and some others, base their arguments to evaluate the permissibility of a legitimate act. For example, abortion may be permitted to save the mother’s life which may also end up causing a negative side effect (death of the fetus or unborn baby), which one would otherwise be morally obliged to avoid. This principle was applied by Thomas Aquinas, ‘the angelic doctor’, in his work titled *Summa Theologica* to argue extensively for the justification of treatments in the homicidal self-defense.⁶⁷⁷ In effect, Christianity relies so much on this principle for the justification of some sensitive moral *cum* ethical issues like abortion. This principle consists of four basic criteria that must be satisfied before an act could be ascertained to be morally permissible and justified. They criteria are:

- i). The *nature-of-the-act condition*: This suggests that the *act* itself, apart from any foreseen evil, must be either morally good, legitimate, or indifferent.
- ii). The *means-end condition*: With this condition, a bad effect must not be a means by which one achieves a good effect. Of course, good ends do not justify evil means.⁶⁷⁸
- iii). The *right-intention condition*: This implies that every motive must be intended to achieve only a good effect, hence, a bad effect may be as a result of an unintended side effect. So, the procedures should respect all reasonable measures to avoid or mitigate potential bad effects.
- iv). The *proportionality condition*: Lastly, this condition must ensure that there is a proportionately grave reason for permitting the evil effect.⁶⁷⁹

From the Christian perspectives, abortion in its nature is a moral evil, an action against human life, dignity and rights. But with the application of the principle of double effect, it can at the same time, be permissible and ethically justified in certain serious cases.

4B. 3. 4. *The Ethical Reviews on Abortion:*

A series of ethical reviews on the moral, legal, and religious status of induced abortion shows that the debates are still ongoing. For the justification of abortion, the ‘Pro-choice’ group would insist on the right of women to make an *autonomous* choice to decide whether to terminate a pregnancy or not. On the contrary, the ‘Pro-lifers’ would argue that there are inalienable rights of the embryo or fetus from gestation to birth. These two opposing camps are also considered as the groups for ‘abortion rights’ and ‘anti-abortion’.⁶⁸⁰ Interestingly, these two opposing sides on abortion debate tend to agree that every human fetus is biologically and genetically human (that is, of the human species). Though, they tend to differ in their views on whether a human fetus may be considered as a *person*, with basic human rights. For the anti-abortion supporters, abortion is morally wrong on the basis that a fetus is an innocent human being, or a potential life that will yet develop to become complete human person.⁶⁸¹ They strongly ascribe that a fetus is a person from the moment of conception. The supporters of abortion rights are not comfortable with this position. Hence, they would base their arguments by drawing a distinction between *human being* and *human person*. For them, a fetus is simply an *innocent* and *biologically human*, and so, it is not yet a *person* with a *right to life*.⁶⁸²

With regards to whether a fetus is a ‘person’ with right to life, some experts like Mary A. Warren proposes a list of criteria for personhood. According to her, a person should be capable to feel pains (i.e., sensation or consciousness), reason, self-motivation, communicate and

self-awareness. Though, she notes that each human being needs not exhibit all these criteria to qualify as a person with a right to life. She then adds a clause that if a human being exhibits *none* of them, then it is certainly not a person. In a seemingly contradictory assertion, Warren concludes that as the fetus satisfies only one criterion ‘consciousness’; hence, the fetus is not yet a person, and therefore, abortion is morally permissible.⁶⁸³ Following her trend of logic, David G. Jones alludes that a fetus lacks a right to life because it lacks brain waves or higher brain function, self-consciousness, rationality, and autonomy.⁶⁸⁴ This argument is seriously truncated by some anti-abortion supporters who argue that, if there is uncertainty as to whether the fetus has a right to life, then having an abortion is equivalent to consciously taking the risk of killing another. According to this argument, if it is not known for certain that a fetus has a right to life, then it is reckless and morally wrong to treat a fetus as if it lacks a right to life. Therefore, I would support the argument posited by Stephen D. Schwarz that, if it is proved that the fetus has a right to life, this would place abortion in the same moral category as a deliberate manslaughter, otherwise it can be termed as a form of criminal negligence.⁶⁸⁵

An alternative approach is to base personhood or the right to life on a being’s *natural* or *inherent* capacities. On this approach, a being is said to essentially possess the right to life if it has a *natural capacity* to develop into full human features. This fetus’ right to life, according to Nobert Schwarz, is inalienable from the moment of conception, since the baby has this natural capacity to full maturity.⁶⁸⁶ Similarly, David Boonin also argues that arguments from uncertainty fail because the mere fact that one might be mistaken in finding certain arguments persuasive, a claim that fetus lacks a right to life, does not mean that one should act contrary to those arguments or assume them to be mistaken. Other notable scholars like Thomas Aquinas applied the concept of *individuation* to condemn abortion. So, abortion may not be permissible from the

point at which individual human identity is realized. Of course, the ethical reviews on abortion are still on-going, but as far I am concerned, I am in accord with David Boonin who avers that abortion may be permitted based on certain serious cases, as noted above. Therefore, I stand against allowing the practice of abortion at will, because the dignity and value of human life are at stake, if not, there will be possibilities of rolling on a ‘slippery slope’.⁶⁸⁷

Granted that, at some critical moments, abortion can be permissible, justified, liberalized or legalized, but I still hold that none of these logics that may justify the practice of abortion will ever make it to be a good moral act. However, if this critique on abortion will pave way for its permissibility or liberalization in places like Nigeria, especially on extreme cases when the life of the mother is at a great risk, then the concept of personal dignity and principle of human solidarity have major roles to play. Therefore, I would refer to John Paul II (Pope and Saint) who sees the notion of ‘dignity’ of human persons as a clarion invitation to apply all necessary precautions in dealing with human life at all stages. If not, such illegal, unethical and justifiable practices of abortion may be rolling on a slippery slope beyond the human expectation or limit.⁶⁸⁸

Again, I am convinced that with the principle of ‘human solidarity’, all the principal actors in the healthcare ought to put all hands-on-deck to make provisions for safe abortions at affordable rates with qualified professionals. Just as Hans-Martin Sass is convinced that in order to truly practice bioethics, one ought to be in solidarity with all forms of life.⁶⁸⁹ This could be the best means to reduce or eliminate clandestine abortion with the quacks that can cause morbidity and untimely mortality among women across the entire globe. Above all, abortion as conceived by Don B. Marquis, is nothing but a deprivation of one’s life for future generation.⁶⁹⁰ Though,

the ethical issues related to abortion are yet to be resolved, but if the present generation fails to respect, protect the dignity and value of each human life at all possible best, I wonder what the generations after would say about us. Hence, abortion remains an ethical dilemma!

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Chapter Five

5.0. **Dignity and Solidarity in Medicine**

Introduction: An overview of Dignity and Solidarity

Medicine is not practiced in isolation. Rather, it is practiced within the coordinated networks of human solidarity, inter-dependency and inter-relationships. Thus, in every clinical encounter, it involves at least a minimum of two persons, a doctor and a patient. The same thing applies to the field of scientific research with human beings, which involves at least a researcher and a human participant. In whichever case, either in clinical practice or in scientific research, bioethics would always insist on the respect for human *dignity* which should not be undermined nor taken for granted. According to the Catholic Magisterium, the two principles – *human dignity* and *solidarity* – are among the four basic principles (including the principles of common good and subsidiarity) which can serve as guide towards the reformation of every healthcare system.⁶⁹¹ As earlier noted, the concept of ‘human dignity’ is considered by the United States Conference of Catholic Bishops as the prime and most inviolable principle of each person as a being created by God. This forms the foundation of the paramount respect of the sacredness of human life beginning from conception till the end-of-life.⁶⁹² In other words, it invokes an absolute moral obligation, commitment to respect and safeguard human life, at all stages of human life and existence. So, this notion of the sanctity of life precludes any medical or scientific activities that may deliberately initiate taking the life of another person like in the cases of abortion, euthanasia, physician-assisted suicide, etc.⁶⁹³

In the same line of thought, the Catholic Bishops Conference of Nigeria (CBCN) reflects on theme ‘Faith and Dignity of the Human Person’ in one of her Plenary Assemblies. The participating Bishops unequivocally note that the defense of ‘human dignity’ is a true

obligatory moral act of commitment based on one's faith orientation. Reacting to the present situation in Nigeria, this College of Bishops vehemently frowns at and condemns every inhuman act committed against human dignity, especially in the health sector. Such acts for them are exactly affronts against humanity and God, Himself.⁶⁹⁴ They include murder, genocide, abortion, euthanasia, suicide, mutilation, physical and mental tortures, subhuman living conditions, arbitrary imprisonment, inhuman slavery, terrorism, human trafficking including illegal organ commercialization, etc.⁶⁹⁵ All these related acts against human dignity, as remarked by the Nigerian Bishops, will continue to poison human civilizations, and then debase its syndicates much more than their victims.⁶⁹⁶

Probably, this notion of human dignity may be the sole reason why Archbishop Ignatius Kaigama of Abuja openly reacts against President Joe Biden's stance on abortion. Speaking as a guest at the *Crux Interview* on abortion, the Metropolitan Archbishop states that: "It is so intriguing that one of Biden's first official acts is to promote the destruction of human lives domestically and in other nations."⁶⁹⁷ According to him, the Biden's order that supports abortion does not stand to sound ethical, critical and moral reasons; hence, it violates the dignity of human person. Rather, he alludes that President Biden ought to use his position of authority to prioritize the safety of the most vulnerable candidates, the unborn children.⁶⁹⁸ Applying logical induction on the position of the Catholic Bishops of Nigeria on the issues of dignity, it is evident that Africans generally respect not only 'personal' but also 'collective' dignity of each person. This notion of collective dignity, as Micha Werner opines, will always defend certain elements of 'human solidarity' or communal ways to safeguard life. His view is often linked to a group identity forged through shared elements such as language or culture, which form part of the private or personal dignity of each person in a society.⁶⁹⁹

Within the public domain, especially in the healthcare system, these four principles – *human dignity, solidarity, common good and subsidiarity* – as noted by the two different Conferences of Catholic Bishops (America and Nigeria), clearly invoke persuasive moral obligations toward providing and improving quality medical care for the sick and injured. Thus, such moral imperatives to respond to the needs of others in dire need are universally binding on consciences, and they can as well be legitimately fulfilled in a variety of means and contexts.⁷⁰⁰ However, to delve into the concept of ‘solidarity’ may pose a kind of difficulty to give an uncontroversial definition of the term. This is because in places like the United States, individualistic and self-interested healthcare norms are upheld, whereas in other locations, a sense of respect for the communal and personal support is more greatly upheld in relation to healthcare services. Such a situation is enough to present a possibility for multiple ambiguities and wrong applications of the term, solidarity.⁷⁰¹ Therefore, the concept of solidarity always highlights the intrinsic social nature of each human person, the equality of all both in dignity and rights, and the common paths of individuals and peoples towards an ever more committed course. Hence, solidarity should be seen in its value as a moral virtue that determines the order of each human institution, especially in healthcare system.⁷⁰²

5. 1. *The Principle of Solidarity: An African/Nigerian Perspective:*

Having discussed the concept of dignity in chapter two (2A. 1. 5.), it is time to pay attention on the principle of solidarity in the African *cum* Nigerian perspective. If not, it would seem like a big omission of an academic endeavor since the critique is more on the Nigeria health system. Etymologically, the term ‘solidarity’ is derived from the Latin word *solidum* with its French equivalent *solidarité* which refers to being “solid, whole sum or whole, firm, undivided, entire,” etc. Figuratively, it can also portray meanings like soundness, trustworthy, genuineness,

etc. Reflecting on this concept, Innocent C. Egwutuorah realizes that due to insufficiency and interdependency among peoples, they can easily accept to submit voluntarily to a system. As such, they are equally bound to live in unison and in mutual human solidarity.⁷⁰³ This suggests a strong notion of mutual complementarity as a positive measure to address any ethical challenges the vicissitudes of life may pose to human persons. For him then, another term that invokes the notion of solidarity in the African or Nigerian perspective is ‘communalism’. So, Africans, especially the Igbo people in Nigeria, see this social collaboration as a natural legacy, or a treasure worthy to be recognized and always kept.⁷⁰⁴ In another critical analysis, Innocent I. Asouzu uses the compound term ‘ibu-anyi-danda’ to explain the concept of solidarity or communalism in the African settings. This term ‘Ibu-anyi-danda’ is analogous which means that no load or ‘ibu’ is insurmountable (i.e., ‘anyi’) for ‘danda’ (a specie of ant). Applying it to human mutual existence and bioethics, it implies that peoples can surmount every difficult task when they are mutually dependent on each other in the complementation of their efforts.⁷⁰⁵ Furthermore, Oliver A. Onwubiko explains that ‘solidarity’ or ‘communalism’ as expressed with the concept of “ibu-anyi-danda” can be better understood in the context of the intra-community relationships based on interpersonal relationships realized in human society.⁷⁰⁶

This idea of mutual complementarity in solidarity among persons or institutions underscores a sense of *njikọka* (togetherness is greatest), or *igwe bu ike* (strength in togetherness).⁷⁰⁷ The analyses so far, prove that human beings have natural and fundamental inclination to solidarity, togetherness and community due to mutual co-existence, co-dependability, co-responsibility among persons.⁷⁰⁸ It then suffices to add that without human solidarity, human life would be full of isolated individual struggles that may end up into self-abandonment. This is the reason why Africans, like the rest of humanity, would appeal for

mutual complementarity and human solidarity, especially in times of great need or crisis.⁷⁰⁹ In effect, I am in an agreement with Heinz Kimmerle who insists that to be human is to recognize one's own humanity in order to respect the humanity of others in mutual relationships with them. Succinctly, Lekan Balogun remarks that human solidarity in this context implies to true commitment, unity of purpose, mutual affection and collaborative efforts to achieve common purposes.⁷¹⁰ Again, solidarity or African communalism supports and encourages unity in diversity. It then highlights that no person is considered superior to the other. Just like in bioethical decisions, Paulinus C. Ejeh recalls that each person is involved in the communal decision-making in view of attaining the highest form of communal experience of “onye aghana nwanne ya” (of being your brother's keeper) which explains the ‘solidarity’ in this context.⁷¹¹

As earlier noted on his conception of a person, John Mbiti succinctly states thus: “I am because we are”⁷¹², and likewise, for Desmond Tutu “a person is a person through other persons”.⁷¹³ Unfortunately, experience has proven beyond doubt that humanity is seriously challenged with multiple differences, discriminations, injustices, individualism, etc. Consequently, all these negativities in human interactions continue to blur the vision for some people to recognize the similarities, intrinsic dignity and solidarity that can easily unite them more rather than dividing them.⁷¹⁴ Amidst all these challenges, Ikenna U. Okafor calls for a strengthened solidarity by using the popular Igbo ethico-phenomenological expression: “O nuru ube nwanne agbala oso”, which simply means ‘being attentive and ready to assist those who are in critical situations or suffer serious pains in life’. This traditional Igbo moral dictum invokes the moral obligations and serious commitments to always act in fraternal solidarity to care for those in need, promote and safeguard human life.⁷¹⁵

The term ‘solidarity’ is a re-emerging concept in contemporary philosophy within

various sub-fields of law, ethics and political philosophy. Within the realm of bioethics, this principle is primarily identified as a three-tiered practice enacted at the *inter-personal*, *communal*, and *contractual* or *legal*. The first tier or level which is concerned with the *inter-personal* relationships where solidarity suggests a kind of willingness or readiness to assist others with whom a person recognizes as fellow humans from the same divine origin.⁷¹⁶ Again, the second level indicates a *communal* spirit or *collective* commitment to carry the task to assist others who are linked by means of a shared situation or cause. Lastly, at the third level, these commitments are officially institutionalized in *contractual* or *legal* norms. A good example of this third ‘tier of solidarity’ is possible in a welfare state, where shared values or collective ideal to care for the most vulnerable or disadvantaged ones are backed up and solidified in legal rules, specifying and possibly enforcing rights and obligations of citizens.⁷¹⁷

In addition, the modern practice of bioethics is significantly influenced by Immanuel Kant’s concept of the Categorical Imperative. While analyzing the Kantian Categorical Imperative, Fritz Jahr came up to demonstrate the obligatory, yet innately human practice of the Bioethical Imperative. In relation to the principle of solidarity, Fritz Jahr sees in Bioethical Imperative to be the guiding principle for all human actions towards other living things. This suggests mutual respect to others as ends-in-themselves; hence, they deserve to be treated with caution and quality care. Equally, he insists that in order to truly practice bioethics, one must act in solidarity with all forms of life, including plants and other animal species. If one only decides to be in solidarity with humans, then one should behave virtuously always.⁷¹⁸

Therefore, in this context of ‘dignity and solidarity’ in medicine, Pantaleon Iroegbu et al., argue that the bioethical value for life is ultimately based on its sanctity, dignity and quality. In effect, life as a precious divine gift from God needs to be protected, nurtured, and made to

flourish for the good of both society and the possessor of life itself.⁷¹⁹ Therefore, a good understanding of the concept of personal dignity and human solidarity at this point will play vital roles as the dissertation focuses its critique on medical genetics and research with human beings. This is because, with the recent unprecedented waves of success in science and technology, all activities in solidarity of persons related to medical genetics and research with human candidates ought to respect the dignity of each person.

5A. 0. Medical Genetics and Research with Human Beings

5A. 1. 0. Genetic Testing and New Eugenics: Meaning, Scope, Purpose and Contexts

5A. 1. 1. *The Meaning of the Concepts:*

According to the early proposed theories of heredity, there was a common belief that offspring was a concoction of fluids derived from one or both parents of a given specie. This implies that any inherited characteristics were more or less, determined by the properties of these fluids. With this conception in mind, Charles Darwin, agreed that inherited characteristics were literally dissolved like sugar in water.⁷²⁰ On the contrary, modern genetics begins to realize that ‘gene’ is not simply a fluid, but a ‘particle’, which has the capacity to retain its integrity or qualities for a long period of time. Before the word ‘gene’ was used by Wilhelm Johannsen in 1909, the modern concept of the term is traceable back to Gregor Mendel in the 1860s. During his scientific experimentations, Mendel found out that a hybrid between two phenotypically distinct varieties resembled one of the two parents – the *dominant* parent.⁷²¹ As medical genetics is directed towards improving the quality of genes for certain individuals and families, then eugenics is fundamentally concerned to produce better quality or healthier human populations with increased life expectancy of the entire world.⁷²²

Etymologically, the term ‘genetics’ is derived from the Greek word ‘γενής’ which means a ‘gene’, literally refers to ‘come into being or growing’. Medical genetics, as conceived by Dorothy Wertz et al., refers to the medical sector which is primarily concerned to assist persons with certain genetic disorders and their families with informed choices. Such is possible through genetic diagnosis, therapy and enhancements.⁷²³ So, genetics services, like other medical services, could be effective if conducted in respect to ethical guidelines or standards.⁷²⁴ Similarly, the word ‘eugenics’ originates from the same Greek root with its prefix ‘εὖ- ‘good’ and ‘γενής’ which can literally be translated as ‘good birth’, ‘healthy reproduction’ or ‘to grow well’. For people like Alberto Pektorowski, et al., eugenics is a set of beliefs and scientific procedures that are objectively intended to improve the genetic qualities of the entire human race. By attempting to improve quality superior human beings, eugenics falls short of excluding or eliminating those genetic disorders that are likely to produce inferior humans.⁷²⁵

The whole idea of venturing into the modern project for improved qualities of the human population through selective breeding was originally developed by Francis Galton.⁷²⁶ According to Peter J. Bowler, Francis Galton was highly influenced by the theory of Darwinism, especially its theory of natural selection as proposed by Charles Darwin.⁷²⁷ However, the theory of Darwinism tries to offer empirical explanations on evolution with the development of plant and animal species, which can as well be applied to human beings. From this background of biographical studies, Galton concluded that desirable human qualities are mainly the products of observable hereditary traits that need to be improved to ensure desirable future babies.⁷²⁸ By the year 1883, just about one year after the death of Charles Darwin, Galton came up to name the outcome of his research: *eugenics*. Hence, with the emergence of genetics, eugenics became associated with genetic determinism. The general conception of such genetic determinism

suggests that human character is entirely or in the majority caused by genes, not necessarily unaffected by educational upbringing, living conditions or environment. This notion is reported to mark the beginning of controversies that surround eugenics, coupled with the fact that evolution theory is no longer needed for eugenic policies based on genetic determinism.⁷²⁹

According to Francis Galton, the term “eugenics” is a scientific enterprise that deals mainly with much influence to improve the inborn qualities or the cultivation of healthier human race to an unprecedented utmost advantage.⁷³⁰ For him, the word ‘eugenics’ with its Greek equivalents, *eugenes* or *eugeneia*, which simply refers to ‘good in stock’ or ‘hereditarily endowed with noble qualities’ can as well be applicable to human beings, brutes, and plants. Thus, the term expresses his hard enduring scientific studies of improving human stock, which is by no means confined only to the questions of judicious mating. Rather, it takes the cognizance of all other influences that may give room for more suitable superior races, at the expense of prevailing speedily over the less suitable or inferior qualities of human beings. With this definition by Galton, eugenics stands for the study of all agencies under human control that are channeled towards improving or impairing the racial quality of future human generations.⁷³¹ This definition sparked off several controversial arguments with people like Edwin Black who argue that eugenics is a ‘pseudoscience’. Black believes that what is defined as genetic improvement of desired traits are culturally chosen choice, rather than a matter that can be determined through empirical objective scientific inquiry. The most disputed aspect of eugenics has been the definition of ‘improvement’ of the human genetic pool, such as what is a beneficial characteristic and what is a defect. So, he then concludes that this aspect of eugenics activity is tainted with racism and pseudoscience.⁷³² Nevertheless, Galton explicitly notes that the word *eugenics* sufficiently expresses his idea of improved human quality.⁷³³

This was exactly the same notion that motivated the early advocates of eugenics in the 19th century to channel all efforts toward improving the quality of the entire human race. Unfortunately, the contemporary application of *eugenics* is closely associated with a new method of scientific racism that can promote a kind of white supremacy. Such eugenic attitudes became so evident in the atrocious inhuman experiments or holocaust by the Nazi Germany that sent millions of people to untimely grave during the World War II. During the Nuremberg trial between 1945 and 1946, many of the defendants attempted to justify their human-rights violations by claiming that there was just a little difference between the Nazi eugenics and U.S. eugenics programs.⁷³⁴ Few decades after the ugly eugenic activities of the World War II, much emphasis was on the respect for human dignity and rights. As such, with the emergence of eugenics movements in places like Britain, Randall Hansen and colleague note that many countries followed suit to abandon certain eugenics policies, while some Western countries like United States, Canada and Sweden continued with forced sterilizations.⁷³⁵

As a positive means to espouse the eugenic ideas, modern bioethicists unanimously advocate for a ‘new eugenics’ that is simply characterized with the enhancement of human (individual) traits across the globe. As a result, many countries support any eugenic policies that are intended to enhance or improve the quality of genetic human populations or stock. According to Hansen et al., such programs involve both *positive* measures – as encouraging individuals deemed particularly ‘capable’ to reproduce, and *negative* measures - as marriage prohibitions and forced sterilization of those deemed unfit for reproduction. Those deemed ‘unfit to reproduce’ are mainly the groups with mental disorders, physically challenged or impaired persons, people with low intelligence quotient, criminals, etc.⁷³⁶

5A. 1. 2. *The Scope, Purpose and Contexts of New Eugenics:*

The urgency to apply positive eugenics which advocates for higher rates of sexual reproduction with desired traits is what Frederick Osborn claims to have resulted into practicing the opposite, i.e., *negative eugenics*. This type of eugenics is so much interested in the reduced rates of sexual reproductions, or application of sterilization on peoples with less desired or undesired traits.⁷³⁷ This kind of negative eugenics was so influential on the Nazi policy of identifying German citizens deemed mentally or physically unfit. Consequently, those deemed unfit were systematically killed with poisonous gas, referred to as the ‘Aktion TA’, which later paved the way for the Holocaust during the World War II.⁷³⁸ Such negative attitudes to human reproduction received serious condemnations from different institutions like the Catholic Church, as the chief opponent of state-enforced sterilizations. In the 1930 papal encyclical titled *Casti Connubii*, Pope Pius XI vehemently condemned sterilization laws or policies. The Holy Father clearly indicated in strong terms that no civil authorities or public magistrates have any direct power over the bodies of their subjects. He then argued that, in a situation whereby there is no crime committed by any person, it would seem unjustifiable and useless to impose any grave punishment on the innocent citizens. Thus, no one has the right to impose direct harm like sterilization, or tamper with the integrity of the human body, either for the reasons of eugenics or any related others.⁷³⁹ In this respect, Andrew Clapham sees sterilization processes as negative eugenics, which includes mutilation, torture, and other bodily punishments, as violations of the rights and dignity of human person.⁷⁴⁰

Cognizant to certain inhuman activities of negative eugenics, many people are still perplexed and confused on the scope of the new eugenics. At the defense of new eugenics,

Jonathan Anomaly understands that the modern eugenics, otherwise known as ‘new eugenics’ or ‘liberal eugenics’ a termed coined by bioethicist, Nicholas Agar, should be much more interested mainly on the enhancement of quality human genetic characteristics and capacities.⁷⁴¹ For him then, this scientific medical enterprise can easily be achieved with the advanced reproductive technology and human genetic engineering. Though, he adds that the selection of desired genes ought to be determined by the parents, not by the state.⁷⁴² This Jonathan’s scope of new eugenics affirms the old Galtonian eugenic ideology that was solely intended to promote the genetic qualities of a given human family at the expense of excluding few groups of people with lesser desired genes or traits.⁷⁴³ With this latest emphasis on the informed parental consent and choices, rather than on coercive governmental control, Giulio Cavaliere distinguishes the scope of the new eugenics from old eugenics.⁷⁴⁴ At this point, many bioethicists are more comfortable with the scope of the new eugenics that is more positive and non-coercive in all its activities. For the bioethicists like Guenther Witzany, positive eugenic programs should be ethically considered, advocated for, and practiced for quality gene enhancements. This is because the application of any negative eugenics is likely to encourage compulsory sterilization, racial eugenic policies that may lead to unwanted genocide of a group of people. Hence, while supporting a kind of liberal eugenics, he also concludes that the scope of the new eugenics fundamentally belongs to a positive new eugenic category.⁷⁴⁵

5A. 1. 3. *Criticisms Against Eugenics:*

The emergence of eugenics in modern medicine is considered as a thoughtful good idea in the right paths to boost the quality of future human species. It is indeed a huge breakthrough in medicine that would bring a big sigh of relief by improving on the genetic constitutions of the

entire future generations of human begins. Such a medical breakthrough is anticipated to be capable of disease resistance, with more longevity or life expectancy, etc. Though, to the greatest surprise of many people, this positive eugenic conception is not always ethically practiced with full respect to human life, dignity, values and rights. In this respect, Edwin Black has no option than to criticize some of the extreme eugenic policies and activities. According to him, some of the eugenics policies, positive or negative as they may seem to be, are most often susceptible to a kind of ethical abuse on human life, dignity and rights. This is because they involve in certain kinds of genetic selections of *inclusiveness* of certain genes and *exclusiveness* or elimination of others, depending on the particular interests to satisfy at any given moments.⁷⁴⁶ Again, some people criticize *negative eugenics* as its motives indicate violations of dignity and fundamental basic human rights as evidenced in the United Nations Tehran Proclamation of 1968 that includes the human right to reproduction.⁷⁴⁷

A notable figure in the person of David Galton, outrightly condemned some of the eugenics policies and practices that are likely to cause loss of genetic diversity, giving room for inbreeding depression as result of loss of genetic variation.⁷⁴⁸ Another major criticism heaped on the contemporary eugenics policies is based on the intention to permanently and artificially, disrupt millions of years of evolution. Such an effort to create genetic lines ‘clean off disorders’, as remarked by Isabelle Withrock, may have far-reaching ancillary downstream effects in the genetic ecology. She maintains that this may cause negative effects on immunity and on species’ resilience to diseases.⁷⁴⁹ Other criticism on eugenics according to Marius Turda, is because most of its advocates seem to greatly over-estimate the influence of biology.⁷⁵⁰ As such, Daniel J. Kelves notes that some people are very skeptical of certain eugenic activities in the belief that sterilization of ‘defectives’ would lead to the disappearance of undesirable genetic traits in the

nearest future.⁷⁵¹ Despite all the criticism against genetic and eugenic activities, Dov Fox expects every independent liberal nation to encourage and support safe, effective and functionally integrated genetic practices that act on analogous all-purpose traits of resistance to diseases and general cognitive functioning. He then concludes that with positive liberal spirit of new eugenics, any form of compulsory eugenics by the state may be considered as a *reductio ad absurdum* (i.e., logical reduction to absurdity or impossibility) that may contradict a liberal theory.⁷⁵²

5A. 2. 0. The Meaning and Purpose of Scientific Research with Human Beings

In the words of Carlos L. Lastrucci, there is no shortcut to objective truth. Hence, he articulates the best means to seek for any universal scientific knowledge should go through the gate ways of scientific methodologies. For him, science remains an objective, logical and systematic method of analysis of phenomenon devised to permit such accumulations of reliable knowledge. Thus, science is a systematized form of analysis that can provide such needed knowledge for the good of future human species.⁷⁵³ So, the essence of scientific research with human beings is not only just to satisfy certain scientific curiosities, but fundamentally to ensure quality medical treatments of different kinds of illness that may threaten human life and health. The term “research” suggests a series of rigorous activity undertaken by a group of determined experts to discover, develop, promote, and as well, to contribute to generalizable knowledge. Such generalizable knowledge consists of theories, principles, relationships, or the accumulation of empirical data that are based on the scientific methods of observation and inference. In other words, ‘research’ in this context can be understood as an art of scientific investigations.⁷⁵⁴ Within the biomedicine, research of this kind can be considered either as biomedical or behavioral studies that are objectively related to human health. Systematically, most of the

scientific investigations can be either *interventional* (as in “clinical trial”) or *observational* (without “test article” as in non-medical or social science). Medically, genuine systematic scientific research may involve both the collection and analysis of data to respond to specific medical issues. For instance, in a clinical trial, both drugs, vaccines, medical devices, etc., are mainly used and evaluated.⁷⁵⁵

On the basic principles of clinical research, Thato Urmila opines that all treatments ought to be within the controlled trial, to ensure maximum effectiveness and efficacy of future care of patients.⁷⁵⁶ With regards to unintended medical malpractices in the scientific research with humans, the Indian Council of Medical Research hints that, relying on human solidarity, all aspects of such scientific research activities are ethically and morally obliged not to compromise with human dignity and well-being. It implies the application of strict regime of evaluation at all levels of proposals to ensure sound scientific outputs and avoidance unethical pitfalls.⁷⁵⁷ The United States’ Code of Federal Regulations notes that it is systematically intended for collecting and analyzing data to improve the care of currently unknown beneficiaries in the future.⁷⁵⁸ In addition, Pamela Sankar believes that a human participant plays a vital role in biomedical scientific research as a specimen in the collection of necessary data. This is quite different, as Sankar notes, from ordinary clinical research by which therapeutic interventions are suggested or carried out solely to benefit the current patient, which may not be a future-oriented task.⁷⁵⁹

Furthermore, Robert M. Veatch provides some salient ethical values that are not only implicated but should be considered in the scientific research with human beings. These ethical values or principles are, viz: *beneficence* (doing good), *non-maleficence* (preventing or mitigating harm), *fidelity* and *trust* within the fiduciary investigator/participant relationship,

personal dignity (respect of one's inalienable rights), and *autonomy* that invokes both informed consent, a competent voluntary decision-making and the *privacy* of personal information.⁷⁶⁰ These ethical concerns with regards to scientific research with human participants are given extensive considerations and regulatory structures by Albert R. Jonsen in his book titled *The Birth of Bioethics*. Today, Jonsen is reckoned as one of the reliable sources (or founding fathers) of bioethics that culminate in the present American system of governmental command and control regulations on scientific research with humans.⁷⁶¹

Suffice it to indicate that constant ethical reviews are highly recommended in the modern biomedical scientific research. As the first person to use the concept of 'informed consent', William Beaumont emphasized on the need to respect a methodological approach as opposed to a random approach in his research on human digestion.⁷⁶² Explicitly, the Nuremberg Code places much emphasis on voluntary consent from the participants for any ethical scientific research to address a series of egregious transgressions against human dignity and rights.⁷⁶³ Few years later, the Declaration of Helsinki in 1964 provides international ethical guidelines for the experts conducting biomedical scientific research with human participants. According to Bosnjak Snezana, the Declaration of Helsinki is widely regarded as the cornerstone document on human research ethics.⁷⁶⁴ However, I am convinced that the fundamental purpose of conducting scientific research with human beings is not only to provide immediate benefits to individual patients, but also, it aims at expanding the boundaries of scientific knowledge for better results in future medical practices on human population.

5A. 2. 1. *The incidences of unethical scientific research with human beings:*

Since the time medicine has been involved in scientific advancements, human

beings across the globe and at different historical epochs, have been subjected to uncountable series of unethical scientific experimentations. Despite the existence of bioethical guidelines, codes and policies that regulate scientific research with human beings, it is still appalling that there are still lots of abuses on human dignity and rights that are related to scientific research with human participants. For instance, in the review of Tuskegee Syphilis research (between 1930 and 1973) with mainly poor African-Americans, James H. Jones reveals that the vulnerable sick participants were denied follow-up treatments despite the availability of penicillin in the 1950s as an effective treatment of the disease by then.⁷⁶⁵ According to Allan M. Brandt, racism is the major reason the subjects were denied of medical intervention as stated on the study's predication on nontreatment.⁷⁶⁶ Worse still, Jones H., notes that the Tuskegee Syphilis study was never *ab initio* submitted to, nor approved by an ethics committee before the commencement of the trial.⁷⁶⁷

5A. 2. 2. *The Pfizer "Trovan" Trial in Nigeria:*

The *Trovan* case in Nigeria is one of the ugly incidents of unethical scientific research with human beings. In this case, the Pfizer firm located in Kano, in the northern part of Nigeria, manufactured a 'Trovan' medicine in 1996, and then decided to carry out some studies to determine its effectiveness in the treatment of an epidemic known as *meningococcal meningitis*. Investigating into this ethical issue, George J. Annas discovers that Pfizer did not obtain neither authorization from the Nigerian government nor informed consent from the parents,⁷⁶⁸ before giving the unproven drug to nearly 100 children and infants. A law court sitting in the United States that took up on the adjudication of this matter indicted Pfizer Company for carrying out an illegal and unethical trial of an unregistered drug, that caused liver complications and death of

some children.⁷⁶⁹ Consequently, the Pfizer firm would walk slowly on tight ropes to seek for an out of court settlement with a huge sum of \$75 million that was subject to a confidentiality clause.⁷⁷⁰ Although, many children died and heavy fine paid in the process, but Tamar Lewis equally adds that this incident alone has succeeded in drawing global attention to highlight the importance of ethics review of scientific research in many other developing countries.⁷⁷¹ The above incident of Trovan trial for meningitis in Kano has instigated a lot of fear among the people to refuse to participate in other future scientific research.⁷⁷²

5A. 2. 3. *Some of unethical Scientific Research in Africa:*

Other similar incidents show that developing regions like Africa always falls victim of ethical violations in scientific research with human beings. As a fertile ground for scientific inquiries, Benjamin M. Meier recalls the AZT trials conducted on HIV-positive African subjects by the American physicians in collaboration with the students from the University of Zimbabwe, were not performed with proper informed consent.⁷⁷³ The medical trials involved testing of over 17,000 women for a medication in view of preventing mother-to-child transmission of HIV/AIDS. It was also discovered that the subjects did not fully understand the testing methods, effectiveness, potential risks involved, and the nature of a placebo in testing procedures.⁷⁷⁴ Unfortunately, Benjamin M. Meier reports that all the expectant mothers who received a placebo that had no effect, finally transmitted HIV/AIDS to an estimated 1000 babies at birth.⁷⁷⁵ It is also on record that there was an aversion research project headed by Aubrey Levin (from 1971 to 1989) with the South African Defense Force. With a secret intention of sexual reassignment program, the lesbian and gay military personnel were forced to undergo 'sex-change' operations to purge out homosexuality in the army. From his investigation of this research, Robert M. Kaplan was shocked to observe that there were a kind of psychological coercions, chemical castrations, electric shocks

and other unethical medical experiments performed only in the military hospitals. The aftermath of this secret program includes high rate of morbidity due to complications and mortality of the patients that were left halfway finished of the procedures.⁷⁷⁶

As earlier noted, the German government had supported the use of racial hygiene to create an Aryan ‘master race’, and to exterminate those who did not fit into their criteria. One prominent personality whose name continues to attract condemnation from the general public is Eugen Fischer. In the early 20th century, Harriet A. Washington discovered that Fischer had been involved in the sterilization activities on the ‘Herero’ women in the city of Walvis, in the present Namibia.⁷⁷⁷ This experimentation was focused on mixed-race offspring as an attempt to provide justification to ban mixed-race marriages. When he finally joined the Nazi party, Fischer did similar sterilization experiments in the Jewish concentration camps.⁷⁷⁸ Both Fischer and other German physicians, usually the advocates of racial hygiene were accused by the public and the entire medical society of unethical medical practices. Hence, they were held accountable for a multitude of war crimes against humanity.⁷⁷⁹

Consequently, such unethical scientific experimentations that have occurred for ages have instigated much fear and lack of trust on physicians and medicine, especially in Africa and Nigeria in particular. For instance, due to fear and mistrust as remarked by Harriet A. Washington, most peoples in countries like Nigeria are afraid to participate in scientific research or be vaccinated due to lack of trust on the experts.⁷⁸⁰ Amidst such challenges with regards to scientific research with human candidates, I would recommend an urgent need to sensitize the masses of the details of any scientific investigation before each research, and the application of bioethical guidelines is highly recommended as well.

5A. 3. 0. Scientific Medical Research: The Relevant Bioethical Principles

Based on the notion of respect to personal dignity, bioethical principles are applied in research to ensure the protections and well-being of participants, and at large, to guarantee maximum benefits to the human society. The recent scientific innovations in medicine have propelled the field of bioethics to keep on updating and revisiting the ethical guidelines, policies and rules to apply, especially in scientific research with human participants. This implies that an independent ethics committee should be set aside in every scientific investigation to better track, review and document all the stages of the procedures. To ensure safe scientific research procedures, there are lot of well-known international research ethical guidelines including the Nuremberg Code, Declaration of Helsinki, Belmont Report and others that offer comprehensive concepts, ideas and ethical guidelines to investigators.⁷⁸¹

Compliance with good research ethics and scientific research practice is a top priority to promote and uphold the safety of human life, health, rights and dignity. This is in accord with the Nuremberg Code that emphasizes on the participants' rights to ask relevant questions at all stages of scientific research, and which permits them to withdraw from the study without prejudice at any time.⁷⁸² All scientific research procedures must ensure accuracy, integrity, consistency, and privacy or confidentiality of all data.⁷⁸³ Also, the Declaration of Helsinki which is considered as the best international standard for ethical guidelines, reinstates the fundamental objectives of scientific research with human persons. Based on that, this Declaration provides multiple ethical categories to respect, such as risk management, participants' protection, informed consent, public registration and publication, scientific principles and research protocols, quality control, etc. This implies that, every research procedure ought to be monitored and analyzed for its effectiveness, efficiency, accessibility and quality.⁷⁸⁴ Hence, the Helsinki Declaration clarifies the role of a

physician and a researcher, and then provides the needed ethical solutions to the dilemma associated with scientific research involving human subjects.⁷⁸⁵

In the same trend, the *Belmont Report* (1974–1978) drafted by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research,⁷⁸⁶ presented three fundamental ethical principles for the protection of human participants in the scientific research studies, namely, *respect for persons, beneficence (invokes nonmaleficence) and justice*.⁷⁸⁷ So, in the event of any conflicts of interest during the trial, the Belmont Report notes that it is advisable to seek for an independent third party to monitor the progress and data accuracy of research procedures.⁷⁸⁸ According to Ruth R. Faden and Tom L. Beauchamp, the research participants should accurately be informed of the goals, procedures, risks, benefits and alternatives to the scientific research, before granting a complete uncoerced consent in the trials. This is to ensure maximization of benefits and minimization of potential risks on the participants and society at large.⁷⁸⁹ Thus, every research must be performed in the respect to bioethical principles, with proper equipment, in the protected facility, and by qualified experts.⁷⁹⁰

Both Jermaine R. McMillan et al., equally emphasize on the proper roles of those in authority and institutional Research Ethics Committees (RECs), especially in Nigeria, for the protection of human research participants.⁷⁹¹ In conclusion, Kevin K. L. Wong et al., argue that the significant contributions of scientific research are based on the quality and impact on the general welfare of the society. To ensure that research benefits both the individual persons and society, they maintain that the principal investigators must endeavor to seek first the approval from a regulatory agency, bioethics committee or an institutional review board. It beholds on these independent regulatory groups to review all documents including the informed consent

form, research protocols, details of all investigations, declaration of conflict of interests, advertising materials, etc., before the commencement of a scientific research.⁷⁹²

5B. 0. **Beneficence and Compassion: The moral imperatives in clinical medicine**

Introduction:

Medicine is a science, an act and a practice that involves more than one person. The existence and practice of medicine has been within the contexts of interconnected human (solidarity) relationships and dependency. Its embodiment in the physician-patient relationships is fundamentally a moral activity that arises from the imperatives to care for patients by alleviating pain, suffering, etc. By discharging these tasks, physicians continue to impact positive reliefs to human life, health, and society at large.⁷⁹³ Besides, the ethics of medicine has traditionally obliged physicians to provide the best therapies that benefit each individual patient. Evaluating the mutual relationship that exists between a physician and a patient, Fielding H. Harrison does not rule out completely the possibility of bioethical issues arising from the encounter. It is very interesting to remark that the relationship that exists between a patient and a physician is based on mutual consent or trust, or at the extreme, such may give room for medical paternalism. Probably, due to traditional medical paternalism, he adds that the factual basis for the recognition of some ethical issues in clinical malpractices was late in coming in the history of medicine.⁷⁹⁴ In this modern time, such ethical issues related to medical malpractices are highly pressing for several reasons.

The fact is that all the personnel that provide medical cares to patients are from different backgrounds around the world. This is enough to anticipate a kind of conflict of ideas, especially in the decision-makings. Suffice it to note that, practicing in a moral community, medical professionals are more united by a common public oath or commitment to act primarily for the benefits or best interests of those they are dedicated to care for. Amidst the potential ethical

conflicts in medical practices, some bioethicist like Edmund D. Pellegrino et al., suggest that the focus of the physician's ethics should not be only on what benefits the individual patients, but on societal benefits as well.⁷⁹⁵ However, physicians are ethically obliged to place patients' best interests above their own self-interests, by applying their professional knowledge or skills to seek for the patients' well-being.⁷⁹⁶ Therefore, with this notion of seeking what benefits the patients and the society at large, this segment of the dissertation is dedicated to make a critique on the roles of the concepts of "Beneficence" and "Compassion" as moral imperatives in clinical medicine.

5B. 1. 0. The Principle of Beneficence: A Basis for Patient safety and Quality care

The principle of beneficence is an integral part of biomedical ethics including other fundamental ethical tenets like autonomy, non-maleficence, justice, fidelity, privacy, and confidentiality. As earlier remarked, when this principle is viewed in relation to autonomy, it may pose some difficulties to balance the beneficent intent of a caregiver and the rights of a patient to make best choices in the treatment plans. Reflecting on the possible pitfalls of beneficence in seeking for the good of patients, Stephen N. Macciocchi opines that, potential risks must be weighed against the benefits of care.⁷⁹⁷ Since physicians are compelled to abide by their professional oath, Ana M. Rancich et al., state that they should embrace the ethics of beneficence proactively by seeking the utmost good and then try to avoid what may harm the patients. By performing such a worthy value to be sought in all aspects of the clinical encounter, a net of benefits can be achieved over harm.⁷⁹⁸

According to Tom L. Beauchamp and his colleague, beneficence is defined as a basic moral obligation to seek for the legitimate best interests of another person. Based on this definition, beneficence can be considered as a morally obligatory act of charity, mercy, and kindness with a strong connotation of doing good to others. Of course, at the mention of the term

beneficence, automatically, it invokes the principle of non-maleficence or “*primum non nocere*” that simply stands for “first, do no harm”.⁷⁹⁹ Though, acting on the presumed patient’s best interests may not necessarily be a beneficent act. For instance, some medical interventions that are intended to benefit the patients, at the same time may pose potential risks or harm to the same patients. Therefore, Raanan Gillon suggests that it is better to weigh the magnitude of the benefit versus the magnitude of potential risks.⁸⁰⁰

On the primacy of beneficence in the healthcare, Edmund D. Pellegrino and David C. Thomasma affirm that it is the overriding principle in medicine, upon which all other principles are subsidiaries to it. They justify this claim by arguing that the primary objective of medicine is to serve the health and well-being of each patient in the mutual relationship between a patient and a physician. Thus, it is expected of a physician to advance and honor the patient’s autonomy provided it is in accord with the ethics of medicine that prioritize to serve the patient’s good, interests, values, preferences, etc. The same applies to the principle of nonmaleficence, which does not exclude the possibility of harming a patient, still efforts should be harnessed to seek for advancing the overall good of the patient.⁸⁰¹ So, in such a circumstance when harm may be inevitable, Beauchamp and his closed ally, James F. Childress, cogently argue that it is only beneficence that can stand out in the promotion of human life, health, or patient’s values.⁸⁰² As I perceive in beneficence as one of the fundamental ethical principles, Virginia L. Hood also affirms that it is the most prominent principle that guarantees the treatment of patients, especially in emergency situations when time to save a life is of great essence. In such a dire situation, she admonishes caregivers not to relent in providing quality care to ensure the patient’s safety, within the best of their professional, ethical and moral obligatory scope of practice.⁸⁰³

Evidently, the principle of beneficence as a basis for patient's safety, plays a vital role in ensuring adequate care with a net of benefits on the patients. This principle, for Martin Hoffman, places a kind of an obligation, a duty to care and a commitment to extend beneficent cares to the patients, professional colleagues and to the society.⁸⁰⁴ The analysis on this concept by Philip C. Herbert shows that any care provider who fails to understand nor internalize this duty is likely to act malevolently. By so doing, the clinician is likely to violate the fiduciary principle of honoring and protecting the vulnerable candidates in need of medical care.⁸⁰⁵ Within the health care milieu, as far as I am concerned, it will be very difficult for me to object that the principle of beneficence embraces some elements of humanism. According to Steven J. Baumrucker, each person has immutable rights to life, good health and liberty. As such, these rights ought to be respected, nurtured, and facilitated. So, in relation to a suffering patient in need of compassionate care, with the spirit of humanism, I would easily agree with Baumrucker et al., that full respect ought to be accorded to his or her individuality or uniqueness as a human person.⁸⁰⁶ On this point, Beauchamp et al., would expect medical practitioners to act towards promoting and safeguarding the patient's life, health and overall well-being, by avoiding any potential risks or harm.⁸⁰⁷

Still on this principle, William G. Enright accepts the fact that beneficence cannot but always strives for the best care while embracing the principle of "*primus non nocere* – first, do no harm". A wider interpretation to this assertion by Enright G., one can as well extrapolate into a generous, supererogatory category. This is simply an obvious inter-relationship with the ethics of non-maleficence, that always emphasizes on the active avoidance of any act that would cause harm on others.⁸⁰⁸ In conclusion, therefore, it may be so difficult to argue or deny the fact that

the principle of beneficence is the summary of medical practices and goals, otherwise as a basis for patient safety and quality care.

5B. 2. 0. The Role of Compassion and Solidarity in Care Ethics

5B. 2. 1. *The meaning of Compassion:*

In medical parlance, the concepts like *compassion* and *solidarity* of care, are always in tandem with the patients' pains and sufferings. Both pains and other unpleasant symptoms that may cause or aggravate the patients' suffering can be eliminated by treating the pains or curing the disease itself. This objective as proposed by Panter B. Eggerman et al., can be easily achieved with the spirit of compassion and solidarity among physicians.⁸⁰⁹ Since the concept of solidarity has been discussed earlier (5. 1.), the concentration will be more on the term 'compassion'. Etymologically, the word *compassion* which refers to *suffering together with others*, is of Latin lexicon. The prefix 'com' is equivalent to the archaic version of the Latin preposition *cum* that stands in English usage as "with". The suffix '*passion*' is derived from the Latin *passus*, that can be understood as "to suffer". By joining these two words together 'com' and 'passion', they form a single whole known as "compassion", which can stand both in origin, form and meaning in its English usage as 'suffering with one who suffers', as in the case of a patient. This implies a kind of proactive approach that includes two constructs of compassion – *empathy* and *sympathy*.⁸¹⁰ From this perspective, Warren T. Reich understands compassion as a virtue that moves one with a sympathetic consciousness in sharing the distress or suffering of another person. This moral virtue moves an individual interiorly, but exteriorly to act by rendering some sorts of assistance in alleviating the pains and sufferings of others.⁸¹¹

Furthermore, Leonard Blum provides in a broad sense, a synergistic definition of compassion that tries to offer explanation on the neurotic processes that may take place simultaneously inside a compassionate person. In his critical analysis, Blum presents compassion as a complex emotional attitude toward other human persons in difficult conditions. This suggests a kind of an imaginative assumption of being in the same situation of a suffering patient, an active regard for his well-being, which may attract emotional responses of a certain degree of intensity. So, in a nutshell, his definition of compassion implies: (1) a sympathetic awareness of other's discomfort or distress; (2) a sense of being in the same condition of the sufferer (empathy); and (3) a motivating moral obligation to render assistance.⁸¹² Affirming this definition, Sherlyn Jimenez conceives compassion as referring to 'being sensitive' – an emotional aspect to suffering or feeling – with another person who suffers. This sensitive aspect of compassion, I am so sure that, it could be the propelling force that can launch one, especially the care givers in places like Nigeria, to go out of one's inner self to render assistances toward the physical, mental, or emotional pains of others. As such, an individual's compassion is often given a property of 'depth', 'vigor', or 'passion'. Hence, leveraging on the views of Eric J. Cassell, compassion for me is nothing but a strong feeling for another, a precursor to empathy, which in practical parlance connects one into active desire and steps to alleviate the sufferings and pains of others.⁸¹³

More wider interpretations are given on the concept of compassion by people like Paul Gilbert. In this respect, he asserts that compassion does not only move one to feel and act on the pains of others, but also it suggests prevention of further pains. Then, he explains that an act of compassion is mainly defined by its helpfulness, and its qualities include love, care, patience, wisdom, kindness, perseverance, warmth and resolve. It may be regarded, though not inevitably,

as the key component in what manifests in the social context as altruism. However, the expressions and expected positive responses associated with compassion may be hierarchical, paternalistic and controlling.⁸¹⁴ At this point, Nanda K. Reddy et al., are able to differentiate between sympathy and compassion. While the former may respond to suffering from sorrow and concern, the latter is keen to respond with warmth and care to a patient.⁸¹⁵ With this elaboration, I understand the term ‘compassion’ as simply a variation of distress, love or sadness, not a distinct emotion,⁸¹⁶ but can be differentiated from them,⁸¹⁷ as people can only emulate and feel the emotions of others.⁸¹⁸

In other words, the take home I can offer on the concept of compassion can be summarized as a *sense of concern* that arises in a person before the other suffering person in dire need of assistance. It is accompanied by a wishful thought or an ‘authentic desire’ to see the relief or end of that situation, with a motivation to act positively to offer practical assistances to those who suffer in pains.⁸¹⁹ The more one knows about the intricacies of human conditions and experiences, the more vivid the route to identification with suffering becomes clearer to him or her.⁸²⁰ Therefore, the cognitive process involved is translating compassion into a compassionate act. In my own words, it simply means that when true compassion touches the heart, it should dispose one to offer any possible assistance to the needy. Just as a singular person’s response to those in need should be accompanied by a motivation to offer practical assistance to the sick.⁸²¹

5B. 2. 2. *Biomedicine: Few instances of Compassion and Solidarity in action:*

Cognizant of the meaning of solidarity as presented above, it is time to review few instances where it is applied in some compassionate concrete cases to ensure that the dignity and value of life are not lost due to human indifference or negligence. Objectively, all medical

enterprises are geared toward proffering solutions to patient's pains and sufferings caused by illness, trauma and bodily degenerations. To achieve this holistic goal, especially in clinical medicine, Michael Balint uses the joint terms "compassionate solidarity" to summarize an alternate model of the physician's response to patients and their suffering. For him then, to act in compassionate solidarity will encourage empathic listening (cognitive and emotional empathies) and positive responses (compassionate empathy), which can as well facilitate objective assessment of the patient's subjective state. So, he admonishes all caregivers, Nigeria inclusive, to meet on regularly basis to analyze their difficulties in their encounters with patients and their corresponding personal reactions to patients.⁸²² In the field of medical research, the case of River Blindness is a typical example of compassionate solidarity in action. The parasitic disease known as 'Onchocerciasis' was a leading cause of river blindness in the rural of West and Central Africa.⁸²³ A medical study shows that the parasitic worms are spread by black flies that breed in fast-flowing rivers. For some decades or even centuries ago, there was no safe and effective drug to treat onchocerciasis till in the early 1980s. With the spirit of compassionate solidarity, Bill Campbell, at Merck & Company laboratories in New Jersey, began scientific research which resulted into the production of a drug known as 'ivermectin' proved to be a potent antiparasitic agent to treat river blindness.⁸²⁴ This story of onchocerciasis illustrates what David Hunter and colleague describe as 'a global tapestry of influences' to dismantle the systemic effects of social suffering and pains.⁸²⁵

Similarly, guided by the same notion of dignity of human person and compassionate solidarity, a team of global health network led by World Health Organization, collaborated to fight and ensure successful eradication of infectious diseases like polio (poliomyelitis), smallpox, bovine rinderpest, Lassa fever, Ebola disease, etc.⁸²⁶ The recent report by Naomi Scherbel-Ball

shows that Nigeria is one of the countries in the world that are declared polio free, today.⁸²⁷

Though, much collaborative efforts are still needed toward the eradication of some diseases like malaria, HIV/AIDS, covid-19, that continue to menace human lives and health, especially in the tropical region of the world. Thus, Scott Barret advocates for more compassionate solidarity in medicine to ensure absolute elimination of such diseases to the point that there will be no more possibility for further transmissions.⁸²⁸ In conclusion, Daniel C. Boston remarks that global health network represents massive solidarity efforts capable to respond positively to human sickness, pains and suffering. At its core, he points out that global health is grounded or enshrined in radical values that are deeply informed by the principles of bioethics which can situate suffering in a context of solidarity, compassion and the pursuit of justice. Therefore, I still maintain that due to the dignity and value of human life (person), biomedical principles of solidarity and compassion will continue to highlight the moral imperatives to engage and commit to relieve pains and suffering associated with all kinds of diseases.⁸²⁹

5B. 3. 0. The Professional Moral Obligations and Duty for ‘Patient’s best interest’

Any discussion on what can be regarded as morally obligatory and aspirational for physicians will automatically resonates the idea of *human dignity* situated in the context of medical professionalism. The word ‘profession’ is derived from the Latin word *professio* which means a public declaration with the force of a promise. So, according to David Isaacs, a professional is member of a group who abides by a public oath to act in certain moral ways, and at the same time, he or she is liable for punishment or be excluded from the group, once he or she transgresses or violates the oath.⁸³⁰ For him then, this clearly indicates the essential difference between a profession and a business. In the former, the relationship is built on trust, and a professional has fiduciary duties to those whom he or she serves, unlike in the latter.⁸³¹ In this

light, medical professionalism can easily be understood in reference to the three fundamental principles articulated in the US Charter, namely: *primacy of patient welfare*, *patient autonomy* and *social justice*.⁸³² Equally, Isaacs enumerates the basic four pillars of medical professionalism which include – *accountability*, *altruism*, *excellence* and *humanism* – that are very necessary in the model of physician-patient relationships. Furthermore, he elaborates that, *accountability* obliges physicians to always take responsibility not only for their patients, but also be accountable to the society and to their profession. The notion of *altruism* refers to the physician's moral obligation to attend to the best interests of patients rather than to his or her self-interest. While the concept of *excellence* suggests a kind of commitment to life-long learning, the word *humanism* stands for the respect to 'human dignity' in this context, as Hippocrates had emphasized on treating others as persons with intrinsic dignity and value of life.⁸³³

Moreover, the Hippocratic understanding of medical practice is not different from being a practice of an art as well as a science. It is neither a trade nor a mere business enterprise, but it is a 'calling' (vocation) which involves the use of one's head and heart in all the activities towards caring for the sick. In other words, medical practice, as Francis Peabody rightly supports, is simply a profession to be freely chosen and entered into by those who are ready and willing to practice it.⁸³⁴ Based on that, David Isaacs then states that empathy that invokes warmth approaches, sympathy and good understanding of the patient's ill situation, might be as important as any other therapeutic interventions in medicine.⁸³⁵ In effect, Isaacs clearly expresses that medical professionalism demands a moral *duty* or commitment to service within the profession and in the community. The commitment to serve will always remind physicians to function with honor and integrity. They should be more committed to their profession and be ready to engage in truthful and straightforward interactions with the patients. By no means, this

does not detract a show of respect to patients and to others, including their fellow colleagues at all levels of training and practices. By acquiring these values, physicians stand a better chance to act professionally and can as well make difficult ethical decisions.⁸³⁶

As a profession, medicine is characterized with a specialized body of knowledge that its members have the added skills and responsibilities to teach and expand, by applying its proper ethics. Physicians are expected, as reasoned by Lois Snyder et al., either individually or collectively, to fulfill the duties of their profession, mainly based on the respect to patient's *dignity* and patient's *centeredness*. Therefore, the ethical foundation of the profession is supposed to remain in sharp focus, irrespective of any possible influences on medicine, individuals, and the patient–physician relationship.⁸³⁷ At this juncture, I am consigned to note that the patient-physician relationship is most likely asymmetrical due to inequalities on the personnel involved in such therapeutic encounters. According to James Giordano, these imbalances may not be wholly unilateral, and they will continue to define the responsibilities and the obligations of the patient and physician. For instance, as the physician possesses considerable expertise knowledge of the objective facts of diseases, treatments, and prognostic possibilities, may not be compared to the esoteric knowledge of a vulnerable patient.⁸³⁸ Thus, the intersection of the physician's expertise and the patient's needs relies so much on the patient's autonomy.⁸³⁹

Again, Michael Meyer notes that it is such medical relationship that objectively focuses on the patient's centeredness that gives room for the establishment of some ethical rules and obligations.⁸⁴⁰ Just as the professional obligations are mandated by the rules (i.e. - the *deontic frameworks*) that establish the structure of medical practice, so too are the obligations of the patient.⁸⁴¹ Broadly speaking, Howard Brody explains that the patients' relative duties are not only limited to physicians, but to other health care professionals, and to the society, as well. For

him, these moral duties are grounded as responsibility to oneself as a moral person who should:

1) – endeavor to justify one’s actions, and then, 2) – show respect and regard to others who are equally worthy of moral considerations.⁸⁴²

5B. 3. 1. *The Physician’s Moral Obligations to the patient:*

In the recent times, greater attention is drawn towards some ethical issues, as evidenced by the roles the bioethics committees play in different healthcare institutions. For example, there is much greater attention given to patients’ rights, and the physician’s obligation to respect patients’ wishes, which Tom L. Beauchamp recognizes as the main points of discussion on the issues like informed consent and advance directives.⁸⁴³ To give a valid informed consent, the patient must *understand* what is being offered, its rationale, benefits, risks, and likelihood of achieving the therapeutic goals. Further, validity of consent requires that there will be no elements of *coercion* from any person, or an active authorization for certain procedures. These elements support the principle of respect for personal autonomy as described by Beauchamp and Childress.⁸⁴⁴ A brief historical review shows that, the medical ethical guidelines on the duties or obligations of physicians to the patients is traceable to the ancient Hippocratic Oath. Though, the conception that medical practice is a fiduciary profession was formally introduced by Thomas Percival and his colleague, John Gregory. In this fiduciary relationship between a patient and a physician, both are expected to hold a position of trust and welfare for another, but more especially a position of responsibility to protect the interest of the second party, the patient.⁸⁴⁵

To ensure more positive outcomes in the clinical encounters, the duo, Gregory and Percival provide very important basic tools of ethics as a guide to the medical professionals. These tools, presented in form of virtues, include:

- a). *Self-effacement*: Under the self-effacement, the authors encourage all caregivers to free themselves from all forms of inconveniences or differences they might experience from their patients. So, they should desist from being influenced by issues related to patients' unruly behaviors, race, faith-belief, socioeconomic status, culture, ethnicity, nationality, etc. As such, they should be more committed to care for the patients as fellow human beings with utmost respect and dignity, at the expense of the lucrative aspect of their profession.⁸⁴⁶
- b). *Self-sacrifice*: This notion of self-sacrifice obliges physicians to be ready to take some risks when caring for patients, as in the case of caring for patients with communicable diseases, or during pandemic disease. This virtue also demands more commitment to focus on the expectation or positive results, rather than on the exception when caring for a patient's best interest. The physicians must respect the dignity and uniqueness of each person, and they should not relent in providing quality care to the patients.⁸⁴⁷
- c). *Compassion*: As earlier noted, this virtue demands physicians and others, with the spirit of compassionate solidarity, to engage in more collaborative efforts in relieving pains, suffering, and be able to manage the stress of the patients. I can deduce that this is one of the ways to strengthen the fiducial relationships that may exist between a physician and a patient.⁸⁴⁸
- d). *Integrity*: With the notion of integrity, the authors re-echo the integral roles of professional discipline and scientific rigor which may play in selecting and deciding the proper clinical treatments for the patients. This means that all treatments to be administered to the patients must be scientifically and medically approved by an official consensus, capable to withstand the test of peer ethical reviews.⁸⁴⁹

However, these four medical virtues as remarked by Marc A. Rodwin, are highly recommended, especially at the developmental stage of medical ethics, when physician's personal responsibility predominated medical practice. The personal responsibility of a physician is still a major point of debate in the contemporary medical ethics literatures.⁸⁵⁰ On this point, some ethicists like Edmund D. Pellegrino argue that medicine is more or less, a collective practice of *human solidarity* with other professionals or experts in the same field. Though, I will not fail to indicate that elements of unique practices by each individual physician cannot be ruled out absolutely. In effect, Livovich alludes that any moral guidelines or obligations should be intended to promote the professional group's roles toward the patients.⁸⁵¹ Based on that, Pellegrino has no option than to articulate the following moral guidelines for the professional group in medical practices, thus:⁸⁵²

- 1). First, physicians by virtue of their profession should not be considered as mere managed care functionaries. So, with the level of acquired knowledge and skills, they are believed to be capable to assist patients in need of adequate medical care.⁸⁵³
- 2). As professionals, physicians must remain worthy stewards in providing quality care to patients, in respect and application of the ethical principles or standards like – autonomy, beneficence, non-maleficence, justice, fidelity, privacy and confidentiality – including other policies, rules or regulations set aside by the managed care organizations.⁸⁵⁴
- 3). Again, Pellegrino expects physicians to always insist on the professional integrity to ensure strengthened mutual physician-patient relationships, irrespective of any external influences like social whim or government authoritative fiat.

- 4). Also, he advises physicians to oppose the temptation of using lucrative or other incentives to lure or modify their attitudes at the expense of causing great harm or risks to the patients.⁸⁵⁵
- 5). In reference to the principle of beneficence, Pellegrino urges physicians to always strive for the primacy of the patient's best interest, in preventing and treating all sorts of illness.
- 6). Lastly, he equally suggests and encourages physicians not to relent to engage themselves into further training or studies for more therapeutic efficacies.⁸⁵⁶

As the patient–physician encounter entails special obligations for the physician to serve the patient's best interests, they are to maintain both the aspects of privacy and confidentiality and be able to handle the vulnerability associated with the illness. This is to ensure that as they publicly profess, they are reminded and encouraged to use their skills for the benefit of patients, not for other reasons, including their own benefits. With good commitment to their profession, they are expected to uphold this declaration to put patients' welfare first.⁸⁵⁷ In sum, the policy of the American Medical Association notes that physicians are morally obligated to work toward understanding of the patient's health conditions, concerns, interests, values, goals, and expectations. With much admiration and support to this policy, I then reaffirm that effective communication is very critical to strengthen patient–physician relationship. So, a physician has a duty to promote patient understanding and should be aware of the potential barriers both language and poor health literacy might cause to the patient during the medical consultations.

5B. 3. 2. *The Patients' Right and Moral Obligations in healthcare:*

The rights of patient in relation to quality healthcare are a subset of human rights that evoke the minimum standards people are expected to be treated by others. Ethically, it suggests the customary standards by which people ought to treat their fellow human beings. As such,

rights and ethics can be considered as the two sides of a coin, hence, a ‘patient’s right’ is enshrined in one or more ethical principles from which ‘right’ is derived. Thus, it reflects that each person possesses inalienable right to adequate medical care, and the ability to enjoy the highest attainable standard of physical and mental health status. To speak of the patient’s right in this context automatically includes the respect for the patient’s personal autonomy, which is one of the novel fundamental ethical principles in modern medicine.⁸⁵⁸ Granted that, the principle of autonomy has been defined, criticized and applied by different schools of thought in various contexts, but its meaning has not yet been altered from referring to the ability of a person to make his or her own autonomous decisions. This is very central to notion of informed consent. Based on that, Tom L. Beauchamp et al., would frown at the detailed accounts of horrifyingly exploitative “Nazi experiments” which violated the subjects’ dignity, physical integrity and personal autonomy.⁸⁵⁹ Such related incidences triggered the urgent clamoring calls to protect human beings in subsequent medical practices and scientific research with human participants.⁸⁶⁰

Meanwhile, my reason is yet to fail me to think that the principle of autonomy is not just considered as one of the key ethical principles in the health care system. According to Ames Dhai et al., this principle in essence reflects a manifestation of one’s legal and mental capacity to understand and make an uncoerced informed decision.⁸⁶¹ Thus, it obliges moral responsibility on the caregivers to always show respect to the patients due to the intrinsic dignity and value attached to their lives as human persons. By implication, it is not expected of a caregiver, more especially in Nigeria, to act in a manner that may violate a patient’s self-worth. So, the important component of autonomy is to allow patients to make deliberate informed decisions.⁸⁶² Both Kristen Rowe and his colleague, Keymanthri Moodley, argue that autonomy is of paramount ethical and legal priority, an invitation for informed consent. These two values are closely tied

together, hardly exist inseparably in the physician – patient encounters. I would clarify here that the autonomy of the former (physician) is nothing but a privilege not a right. It is a privilege conferred on him by the society, but it beholds on the patients to cast the ultimate decision about their health and well-being.⁸⁶³ For Gain van Norman, the competence for a patient to make valid medical decisions is ethically adjudged if the patient meets these four criteria: 1). Ability to communicate a choice; 2). Being in state of good mental capacity to understand the relevant information; 3). Able to appreciate the medical consequences of each decision; and 4). If the patient possesses the rational capacity to reason about treatment decisions.⁸⁶⁴

These criteria generally can be assessed in the preoperative conversations with the patients, though may not require any further expert consultations. If there is conflicting evidence on the patient's competence or capability to give an informed consent, Van Norman proposes that other formal re-evaluations may be applied.⁸⁶⁵ At various times, the respect to personal autonomy may vary in applications, especially in emergency cases or in dealing with the minors. There is a likelihood that such critical situations may pose some ethical challenges, especially in emergency cases when time may be of great essence to save human life and the patient's consciousness may be very limited. Under such conditions, some ethicists like Ivo S. Muskens are of the opinion that the patient's informed consent may be compromised, while the attending physician evaluates each unique case to make the most professional and ethically sound decision.⁸⁶⁶ So, it is only by relying on the principle of beneficence, as noted by Ronald C. Mackenzie, that motivate a compassionate physician to act responsibly to save life in the best interests of their patients.⁸⁶⁷ Based on that, I welcome the opinion of a school of thought that lays more emphasis on the recognition of a broad range of possibilities in the balance of participation between patients and clinicians in medical decision-making, especially in critical settings.⁸⁶⁸

Evidently, the respect for personal autonomy which guarantees informed consent, is a key principle with regards to decision-makings in the healthcare systems, especially in the Western world. On the contrary, I can refer to other non-Western cultures, especially in African (Nigerian) cultures, who are likely to depart almost completely from over reliance on personal autonomy-based ethics of informed consent. As I had earlier reviewed, such cultures can easily resort to a more “collectivist” decision-making model. In this collective model, both families and groups may champion the course for decision-makings, based on the obligations of “onuru ube nwanne agbana oso” (being one’s brother’s keeper / active human solidarity) to care for one another, preservation of mutual harmony and values of group interdependence.⁸⁶⁹

While a patient has a right to refuse medical therapies, a physician is ethically obliged not to offer a treatment out of nonmaleficence. It is interesting to add that the ‘Nigerian Patient’s Bill of Rights’ was recently signed by Yemi Osibanjo (Vice President of Nigeria). This Patient’s Bill of Rights (PBoR) states that every patient has the following rights:⁸⁷⁰

1. Right to relevant information,
2. Right to timely access to medical records,
3. Right to transparent billing,
4. Right to privacy,
5. Right to clean healthcare environment,
6. Right to be treated with respect,
7. Right to receive urgent care,
8. Right to reasonable visitation,
9. Right to decline care,

10. Right to decline or accept to participate in medical research,
11. Right to quality care.
12. Right to complain and express dissatisfaction regarding services received

In the book titled, *The Virtues in Medical Practice*, Pellegrino et al., notes that the application of bioethical principles is basically to achieve the short-term goals of medicine like cure, containment, amelioration, or prevention of illness, pain, and disability. The long-term goal of medicine is to promote the overall good health of the human society.⁸⁷¹ So, the ethical principle of nonmaleficence “do not harm”, automatically obliges the patient not to spread infectious disease to others. In other words, a patient needs to collaborate with the physician(s) keeping in mind the obligation to act to attain the objective ends of care—cure, care, and promotion of good health. Specifically, with this obligation, a patient is expected to provide the real needed data, comply with agreed-upon medical plans, and be ready to disclose conflicting advice or doubts. Therefore, a patient needs to bear in mind that the attending physician is also a fellow human person, with equal dignity and rights. As such, a patient should respect the physicians’ professional autonomy and moral values. This mutual relationship is bolstered by shared virtues of trust, honesty, benevolence, humility, and courage.⁸⁷²

Conclusion:

So far, a synthesis of this chapter shows that, medicine in its entirety is an honorable and dignified profession. Hence, it calls for the application of biomedical ethics to ensure a good consideration of the intrinsic value of life, personal dignity and the role of compassion in the healthcare. All these bioethical considerations will propel a good network of human solidarity in caring for the vulnerable individuals, precisely the patients. According to St. John Paul II, human

life is not just an ultimate but a penultimate reality. As a divine gift, life still maintains its sacredness and dignity, worthy to be safeguarded at all costs, with a deep sense of compassion and responsible efforts from the solidarity of persons.⁸⁷³

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6. 0. Ethical Tensions between Personal Dignity and Human Solidarity

Introduction:

The idea of inherent dignity of human person is as old as the creation of human life.⁸⁷⁴ This concept has formed a central theme for ethical reflections, attracting acrimonious public ethical debates and criticisms among experts from different fields of study. On this point, Michael Quante alludes that the concept of ‘dignity’ is one of the concepts that can arouse controversial ethical thoughts and debates on the real inequalities that exist among human beings.⁸⁷⁵ Within the realm of bioethics, Antonio Autiero notes that this concept is a foundational principle that imposes moral obligations on medical professionals in all activities related to clinical practices and scientific research with human beings.⁸⁷⁶ Also, he adds that ‘dignity’ does not just simply define a person, rather it remains as a foundational value that gives meaning to other ethical concepts like autonomy, freedom, responsibility, solidarity, etc.⁸⁷⁷ Unfortunately, despite all the numerous clarifications and respect to the term, dignity, I still perceive some elements of thorny and dramatic problem of violence that could be termed as ‘man against man’ or ‘human beings against their fellow human beings’. This is to say that there are some moments in life, when personal dignity has been neglected, and at worse, trampled upon underfoot, and thus, seriously violated.⁸⁷⁸

Since humanity is exposed to all kinds of violations where some people are determined to subjugate others, it is always the most vulnerable ones in the society that are likely to fall as the victims of various circumstances of such dignity violations. Suffice it to recall that in the categorical imperative formulated by Immanuel Kant, human beings are admonished to use the ‘humanity’ or ‘humanness’ and the power of rationality in them to act positively towards

others. This is possible only when people are ready and willing to consider others as their fellow humans, not just as mere pure means, but as ends-in-themselves.⁸⁷⁹ To buttress this point, the United Nations reacting on the incessant violence against the weak vulnerable persons, opines that the concept of dignity must be used to address some (bio)ethical issues in human relationships.⁸⁸⁰ For instance, in the process of trying to do good to others as in the case for organ harvesting and transplantation, Gordon Brown affirms that the refusal to recognize ‘equal dignity and rights’ of all human beings can lead to inevitable slippery slope to barbarity.⁸⁸¹

The issue of some people acting against fellow human beings will continue to create ethical tensions between ‘personal dignity’ and ‘human solidarity’, especially in the field of biomedicine. Therefore, at this segment of this dissertation, it will be very nice to review certain inhuman excesses in the healthcare system that can create unnecessary ethical tensions between personal dignity and human solidarity. Thus, while this bioethical critique discusses on the vital roles ‘human solidarity’ plays in the progress of medicine (e.g., in organ transplantation and improvement of public health), it will also delve into some illegal activities in organ procurement and unethical public health issues in Nigeria. Such bioethical reviews are capable to reveal they negative roles ‘human solidarity’ (negative cooperation) can play in biomedicine to the extent of violating the dignity of human person. Such can provoke more questions on solidarity in biomedicine *vis-à-vis* personal dignity. Lastly, possible ethical solutions will be proffered to address these ethical issues.

6A. 0. Organ Commercialization and Ethical issues of Public Health

6A.1. 0. *Organ Transplantation and Trade: An affront to Human Life, Dignity and Rights*

Evidently, modern medicine so far, has recently recorded unprecedented progress. As result of human solidarity in biomedicine, such huge advancements have made positive impacts

on the increase of life expectancy. Today, humanity can boast of higher longevity of elderly ones across the entire globe than before. In appreciation to the medical advancements in the modern world, Alexis A. Aronowitz et al., remark that the trajectories in new medicine are multi-dimensional. For instance, the scientific evolutions in medical sphere have facilitated the transplantation of organs, thereby making this an almost routine medical procedure at different corners of human existence, today. Although, it is quite unfortunate that, the demands for organs exceed the market supply, and the shortage remains acute till date.⁸⁸² Indeed, I am so much convinced that organ transplantation is one of the most challenging and complex areas of modern medical practices. This is because, organ transplantation involves some delicacies in the removal of human parts or organs from one part of the body and then be replaced into another or to a different recipient.⁸⁸³

An organ, as defined by Nega Assefa et al., is a part of human body or integrated collection of two or more kinds of tissue that work together to perform specific function in the body. In effect, each organ is naturally structured with multiple cells and tissues to carry out one or more specific vital functions in a living creature. Such human organs include heart, liver, lungs, kidney, stomach, cells, tissues, etc.⁸⁸⁴ Hence, both the skin, flesh, bone, appendages, bone marrow, body fluid, blood or a gamete, etc., may not be considered as organs per se.⁸⁸⁵ however, the removal of organ, body parts or tissues from a donor to a recipient is primarily intended to replace a frail or missing organ. It involves some complicated surgical procedures. In this light, St. John Paul II (Pope) is of the opinion that once organ procurement and transplant respect ethically acceptable procedures, in view to offering a glimpse of hope in promoting the health and life of the vulnerable hopeless sick people, it is a beautiful worthy act that expresses the culture of human interdependency.⁸⁸⁶ This Papal position on organ transplantation wins more

support from people like David Price, who notes that organ transplantation expresses a unique way of affirming and sharing one's humanity with others.⁸⁸⁷

A medical breakthrough to a successful organ transplant was first carried out with a human kidney transplant between two identical twins, by Dr. Joseph Murray, on December 23, 1954, in the city of Boston (USA).⁸⁸⁸ It might interest you to know that in Nigeria, the first successful organ (kidney) transplant took place at St. Nicholas Hospital, Lagos in 2001, by a team of medical experts.⁸⁸⁹ It is medically proven that once organs are successfully transplanted, they are likely to offer life-prolonging and life-saving surgical treatments.⁸⁹⁰ Besides, Price equally sees in organ transplant, a sensitive aspect which may involve some kinds of invasive procedures in the organ procurement. He then concludes that attempts of bodily invasion with regards to organ procurement or harvesting of human parts that fail to respect or meet up with the ethical standards are bound to raise serious ethical issues or tensions.⁸⁹¹

6A.1.1. *The Sources for Organ Procurement:*

As earlier indicated by Aronowitz A., et al., the current scarcity of organs is still very acute, this continues to pose risks to life of the patients on the awaiting-lists for organ transplant.⁸⁹² Nevertheless, there are two main sources for organ procurements – *living* and *deceased* donors.⁸⁹³ In effect, it is expected that all transactions must respect due process for one to consent to make donation of one's body parts, to be removed and transplanted to another person, legally. Ethically and medically, it is recommended that only healthy transplantable human organs or parts ought to be sacrificed for donation, and to be transplanted into another person.⁸⁹⁴ It is of great significance to precise that, if the organs from a living donor are to be used for transplantation, only an organ or part of it can be removed. This is to allow the

remaining part of the same organ to regenerate and continue its vital functions to ensure the viability of the living donor.⁸⁹⁵ In the book titled “Organ Transplants and Ethics”, the author, David Lamb, notes that organs from the living persons are the most common, desirable and recommended as the safest type of organs for donations. Such organs can reduce the chances of organ rejections, free from too much of health complications afterwards and can as well boosts more success rates.⁸⁹⁶

Similarly, to harvest organs from the cadaveric persons entails the application of certain professionalism, ethical and legal regulations. For instance, once a ‘brain death’ and ‘circulatory death’ are pronounced in a person, a post-mortem donation can take place, provided there were advanced provisions of consent by the donor for such donations before death occurs.⁸⁹⁷ For the sake of clarity, the procurement of organs from deceased donors may be possible in respect to two different consent systems: *explicit consent* (opting-in) and *presumed consent* (opting-out). So, with regards to the ‘opt-in system’, only those who in their lifetime had given *explicit* consent can be donors, but it still requires the relatives or surrogate of the deceased to make a free conscious choice to donate organs. Meanwhile, the ‘opt-out system’ of organ donations will rely more on the *presumed* consent, unless the deceased person had earlier before death occurs expressed or indicated otherwise.⁸⁹⁸

6A.1. 2. *Religious Viewpoints on Organ Donation and Transplantation:*

Religious opinions are strongly needed on the issues that concern human life, dignity, health, values, etc. Faced with the challenges of modern science and technology, it remains indubitable that different religious viewpoints on ethical issues will continue to have major impacts in biomedical ethics.⁸⁹⁹ Thus, Michael Oliver et al., would encourage healthcare practitioners to endeavor to be acquainted with the different theological and cultural views

related to organ transplantations and donations, as each human society continues to evolve into multi-pluralism.⁹⁰⁰ Leveraging on this suggestion made by Oliver, I now consider it very important to digress into discussing the positions of the three main religions practiced in Nigeria – *African Traditional Religion, Islam and Christianity* – on the organ transplant and donation.

6A. 1. 2. 1. *African Traditional Religion on Organ Transplant and Donation:*

It should be recalled that the African Traditional Religion (ATR) is inseparable from the African values, customs, cultures, traditions, etc., from the peoples' way of life. Hence, the position of the ATR on organ transplant and donation must reflect the peoples' worldview, which includes their beliefs, practices, or ways of conceiving life itself. In the research conducted by a group led by Ifeoma Ulasi, it shows that (living or deceased) organ donations may be accepted by most ethnic and cultural groups in Africa, and Nigeria inclusive, but not without some difficulties.⁹⁰¹ This is because, the ATR has a strong belief on the existence of tripartite natures in each human person – *body, soul and mind*. Defending the tripartite natures of man, Kunle J. Ayinde alludes that this belief makes it very difficult for a traditional African to accept, even at point of death, that the body or part of it can be considered useless, and so, can be separated from the soul.⁹⁰² As such, Ulasi et al., then conclude that the conception about death and organ donation are seriously impacted by the African cultural, religious, and social beliefs and practices.⁹⁰³

Moreover, the existence of communal harmony in the African culture attests to the fact that there is a strong bond between the living with the next-of-kin, ancestors, and those who have passed. This tries to justify the fact that a dead person is therefore venerated by most of African cultures, just like in Nigeria too. It is with this understanding that the African Traditional

Religion may not freely give an assent to organ donations of any kind, because the procurement process may be viewed as a denigration of the dead.⁹⁰⁴ As a result, it then tries to reaffirm that such an attitude of some Africans towards organ donation will be hampered due to strong affiliations to religious and cultural beliefs. Consequently, this will likely give rise to the dearth or scarcity of organs availability for transplantation in this part of the world.⁹⁰⁵ Again, the completeness of the body to ensure proper burials plays big role in the acceptability of the spirit of a deceased person in the life beyond. Therefore, for the fact that there is still too much of hesitation for organ removals, either from living or deceased persons, implies that certain issues like the practice of cremation are still unthinkable to core African traditionalists.⁹⁰⁶

6A. 1. 2. 2. *Islamic Religion on Organ Transplantation and Donation:*

In the studies undertaken by Arshad Khan shows that majority of the Islamic religious leaders are very keen to accept organ donations with the primary purpose to save human life, provided it is devoid of any form of potential risks to the life of the donor.⁹⁰⁷ According to the Islamic teaching, no person has full ownership of his or her body, instead, each human entity is a product of divine authorship, as a being created in the image and likeness of God. With regards to organ donation ethics, some Islamic schools of thought are of the same opinion that all bodily parts must be intact on the last day. This implies that, according to Adnan Sharif, organ removal is likely to affect one's testimony before God on the Judgement Day.⁹⁰⁸ With so much divergent opinions among the members of Islamic sect, there is an overall negativity towards organ donation. Such a negative attitude is the reason behind low rates of organ donations, even in the various situations the donation is deemed permissible and ethically justified.⁹⁰⁹

However, if there is any Islamic support for organ donation is mainly based on the Prophet Muhammad's teachings, which states that: "Whoever helps another will be granted help from Allah in the Hereafter". In my discussions with some groups of Muslim, I just realize that this official statement from the Prophet has been extensively interpreted and analyzed to be in support of organ donation.⁹¹⁰ Despite all the divergence of opinions among some Muslims, the Muslim World League (MWL) openly granted a positive nod to organ transplantation and donations before the Organization of Islamic Conference in 1985. This Conference clearly notes that organ donation is permitted once death is established via cardiopulmonary failures.⁹¹¹ In the same pattern, the United Kingdom Muslim Law Council in 1996 affirms that organ donation does not contradict but it coincides with the Islamic beliefs.⁹¹²

6A. 1. 2. 3. *Christianity on Organ Donations and Transplantation:*

Certain ethical issues like organ transplant and donations may not have direct references in most of the Christian sacred texts or scriptures. It is only by interpreting different texts, as Mike Oliver observes that, some religious experts will be able to substantially back them up with the scriptural citations, thereby making to freely air their views on organ donations.⁹¹³ For example, organ donation may be interpreted and understood with the biblical statements like: "There is no greater love than this: to lay down one's life for others".⁹¹⁴ Nevertheless, Christianity believes that organ donation is simply an altruistic act, but it should be left for each person to decide freely before donating part of one's body. Leveraging on this Christian stance, the Church of England is convinced that organ donation in good faith is a pure act of Christian duty of donation.⁹¹⁵ Similarly, Pope Pius XII stated that any competent person is free to donate his or her body, provided it is destined to ultimate ends that are useful, morally

irreproachable noble and desirable to aid the suffering patients. In this light, I can as well be convinced and agree with the Holy Father that once the procedures for organ transactions are ethical and legal, such a noble sacrifice should not attract any form of condemnations. Rather, it should be encouraged and positively justified.⁹¹⁶

According to the Catechism of the Catholic Church, organ transplants and donations are in conformity with the moral law, provided the potential risks to the donors are proportionate or do not outweigh the potential benefits to the recipients.⁹¹⁷ Thus, organ donations are acceptable and encouraged provided they respect all ethically justifiable standards, in view to promote the health and life of the ‘hopeless’ sick brethren.⁹¹⁸ Virtually, all Christian sects accept this position except the members of Jehovah’s Witness. The views of the Jehovah’s Witness may seem more complicated with organ transplant and donations since they do not accept external blood transfusion from others. My personal encounter with this group of believers shows that, they are very adamant to their position. As such, anything outside their above condition remains unacceptable, unjustified for them, and surely, it must all depend on each person’s volition to give a consent for organ donations or not.⁹¹⁹

6A.1. 3. *Ethical Concerns on Organ Transplant and Commercialization:*

Ethically, it is very difficult to ascribe that ‘organ donation’ is a pure gift motivated by compassion, altruism or feelings of friendship that may produce sweat savor of interdependence in human life. This is because all the activities of organ procurements and transplants involve some traces of elements of commercialization. Then, Marcel Mauss writes that, the term ‘commerce’ in the organ donation connotes some ambivalence of giving i.e., a gift that seems to be freely given yet it reflects an obligatory order, or a ‘giving’ that may be disinterested yet it

still implies participants' (both the donor, recipients and medical team) lucrative interests, etc.⁹²⁰ However, any attempts to save life through organ donations, either from the *inter vivos* or *cadaveric*, will continue to promote the network of human solidarity in reality.⁹²¹ Considering the processes involved, organ donation promotes an organizational network that brings and reunites individuals together for organ exchange with the assistance medical team of experts.⁹²²

No doubt, it is still highly appreciated that organ donations and transplantation are one of the most remarkable medical inventions in this modern era.⁹²³ Due to scarcity of organs, some of the means for organ procurements are illegal and unethical. The report released by the United Nations shows a lot of indices of illegal removal and trafficking of organs or tissues from both the living and deceased persons.⁹²⁴ Caught in the web of network or syndicate of illegal organ harvesting are the intersection between the world of organized crime, rich personnel, impoverished organ donors, sick recipients, unscrupulous medical staff, etc.⁹²⁵ It is really a global bioethical problem with a well-coordinated network of multi-transnational dimensions. Without any respect to the sanctity and dignity of life, in the context of developing countries, the synergy for organ procurement might be so coercive. The practice of coercion in the organ business is clearly defined as exploitative of the vulnerable poor population, which is likely to end up into violating the basic human rights and dignity.⁹²⁶ In addition, Leslie Whetstine et al., remark that even within developed countries there is concern that enthusiasm for increasing the supply of organs may trample on the respect for dignity and right to life.⁹²⁷

Unfortunately, in the journal of ethnography for illegal organ trafficking, Nancy Scheper-Hughes includes Nigeria in the 'black' list of the organ-donor and organ-recipient nations.⁹²⁸ In the contemporary Nigeria, the kidnapping activities for organ harvesting are on the

daily increase, not only on the foreigners but also on the citizens. For Christopher U. Ugwuoke, kidnapping comprises capturing and detaining an individual against his or her will, usually in an extension of other criminal motives.⁹²⁹ Such illegal activities reflect acts of human solidarity against personal dignity, and if it remains unchecked, it will continue to create serious ethical tensions between the two.

6A.1. 4. *Legislative and Ethical Framework: Resolutions for Organ Transactions:*

Granted that organ transplant and donations in modern medicine offer hope of continuous living to those with serious health complications or failed organs. Although, the activities associated with the procurement of organs in view of transplantations are not absolutely free from some irregularities, ethical violations, abuses, etc., to the dignity of life. To curb off such illegal *cum* unethical malaise in organ transactions, demands for the formulation of stringent laws. Already, many countries have enacted laws like the United Kingdom Human Tissue Act of 2004 to regulate human parts donations, storage and transplant.⁹³⁰ Following suit on this regulatory system, Nigeria equally has succeeded to pass and sign a Bill into law by the former President, Goodluck Jonathan, on the 9th of December 2014.⁹³¹ Among the various provisions stipulated in this Bill, its primary focus is geared toward regulating all the transactions for organ procurement and transplantation. Specifically, as this Bill prohibits all forms of organ donation by the minors, it also provides a framework for the living and post-mortem donations. Categorically, it condemns every aspect of illegal and unethical sales of human parts, including blood related products, and such are punishable on conviction by a fine and/or jail term.⁹³² As the organ transplant and acquisitions continue to pose major global bioethical problems, the World Health Organization (WHO) in its 63rd Assembly makes the resolution of eleven basic principles

to ensure an orderly and ethical organ transactions. These acceptable guiding ethical framework or principles are enumerated thus:

i). The first guiding principle provides the two ethical conditions that may permit the harvesting of human organs, cells or tissues from a cadaveric donor. These conditions include all the necessary efforts to obtain an informed consent as required by the law, and a proof that there is no sufficient reason to show that the donor has changed this decision before death occurs.⁹³³

ii). It also states that the attending physician(s) who declare(s) the death of a potential donor, should not take part in the organ removal of the same deceased person, nor be involved in the subsequent transplantation procedures and other therapeutic cares of the intended recipient.⁹³⁴

iii). Again, it stipulates that donation from deceased persons should be developed to its maximum therapeutic potential, but the donations by the competent *inter vivo* donors must be in accord with each country's respective domestic regulations.⁹³⁵

iv). In addition, this principle indicates that, no cells, tissues or organs should be removed from the living minors for the purpose of transplantation other than narrow exceptions allowed under the national law.⁹³⁶

v). This ethical framework specifies that no organs, cells or tissues should be given away absolutely free without any kind of financial compensations or incentives given to the donor for any justifiable expenses incurred in the process. It also prohibits any other form of illegal transactions of organs for lucrative selfish ends, or for other reasons; hence, such illegality must be outrightly abhorred and banned.⁹³⁷

vi). Similarly, this principle lays more emphasis on the need to sensitize and appeal to the masses

to promote in making altruistic donations of body parts. Therefore, any other form of advertisements intended for financial gains, should also be prohibited as well.⁹³⁸

vii). In relation to the illegal organ procurement, the guiding principle emphatically prohibits any organs obtained through exploitations or coercion of the donors that are mainly linked to some financial benefits. At the same time, it also condemns the issue of cover up, especially by the parties involved in the transaction deals.⁹³⁹

viii). Furthermore, this regulatory principle prohibits all the institutions and personnel involved in the procurement and transplant of organs from receiving any exorbitant payment that may exceed the justifiable fees for the services rendered.⁹⁴⁰

ix). Interestingly, this ethical guideline maintains that the procedures for the procurement and allocation of organs must respect the requirements of clinical criteria and ethical norms, not basically on personal status, the financial capacity, etc. Thus, the allocation rules, as defined by legitimate committees, should be equitable, externally justified and transparent.⁹⁴¹

x). Precisely, the framework insists on the high-quality system, safe, efficacious and professional means as very essential and imperative to ensure better results for organ transplant surgeries.⁹⁴²

xi). Finally, it lays much emphasis on the transparency and open scrutiny of all the activities related to organ donation and transplants. This tries to note that there is no need to neglect the personal anonymity and privacy of the participants in the organ transactions.⁹⁴³

According to Amitabh Dutta, these regulatory principles formulated by the WHO find their expressions in the four ethical principles developed by Beauchamp and Childress thus:⁹⁴⁴

a). Principle of autonomy (informed consent)

b). Principle of beneficence (maximum benefits, minimum risks, or in the risk: benefit ratio)

- c). Principle of non-maleficence (do no harm, risk: benefit ratio)
- d). Principle of justice (comparative/distributive, equity, fairness).

In conclusion, despite all the ordinances, policies, laws, rules, etc., set up for or against organ sales, the illicit and unethical practices in organ business, still persist.⁹⁴⁵ As a result, the Declaration of Istanbul condemns such illegal and unethical organ deals, because they are mainly based on violations to equity, justice, human right and dignity.⁹⁴⁶

A perfect transaction model to regulate organ deals is proposed by Charles A. Erin and John Harris. In such a scheme, the ‘would-be sellers’ of organs should not deal with the ‘would-be buyers or recipients’, directly. So, the best means of transactions will be within the officially recognized agencies with controlled fixed standard payments set by the law, and then followed with equitable distribution to those in need of organs.⁹⁴⁷ This model, according to Luke Semrau, has been endorsed by most of the advocates of organ markets.⁹⁴⁸

6A. 2. 0. Public health crisis and health security: Nigeria as a case study

Introduction:

A paradigmatic medical shift *from cure to prevention* has prompted this section of dissertation not to lose sight on discussing the public health issues, taking Nigeria as a case study. With a deep sense to promote human life, health and with special consideration to human dignity, most people like me are convinced that prevention of diseases that may threaten human life is the best option than waiting until they manifest before providing cure for them. It is really very interesting to point out that this medical shift has for years been considered as one of the major topics that occupy the center stage in some political and ethical debates, until it culminates in the enactment of the German Prevention Law in July 2015.⁹⁴⁹ The main objective of this Preventive Healthcare Act that came into full force on the 25th of July 2015, is not just for the promotion of the population health, but it focuses more on the disease preventions before their

manifestations.⁹⁵⁰ As such, it demands a network of human solidarity efforts or joint strategy to achieve these long awaited mutual prevention and health promotion goals. Thus, in Europe there is always a tendency of national health policies to approach Public Health issues through capacity building.⁹⁵¹ According to Felix Unger, to be in the state of good health is one of the most significant ingredients of human life, dignity and existence. This is because “health is wealth”, and it remains one of the greatest assets of human existence that can lead to one’s happiness and fulfillment in life.⁹⁵²

Besides, the term ‘health’ as defined by the World Health Organization refers to a state of being absolutely in good physical, mental and social well-being. Though, it does not necessarily imply living in the absence of illness or bodily disorders associated with pains and sufferings. In other words, from my own point of view, good health suggests a state of not being so much traumatized or perturbed as such, in any aspects of human life. Likewise, Innocent O. Eme et al., rightly indicate that good health is devoid of any human situations that would inflict serious pains and sufferings due to bodily injuries or sickness.⁹⁵³ With his personal analysis, he explicitly adds that the term ‘health’ exclusively refers only to the living persons. This shows that, neither death nor a dead person has something to do with health, whether bad or good. The above definitions invoke a kind of moral obligation to always strive for a conducive viable climate that would ensure the total well-being of each person. Only in such a conducive setting that one will be able to attain one’s highest human aspirations, maturity or developments, realizations, happiness, fulfillment, etc.⁹⁵⁴ Thus, any attempt, either by collaborative effort under the umbrella of *human solidarity* in this context, that tries to reduce the human life below the barest minimum of existence, are likely to pose big threats to life, health, dignity and rights. It is

against this background that motivates my critique at this stage to consider the issues related to “Public health crisis and health security” with special reference to Nigeria as a case study.

6A. 2. 1. *The Meaning and Brief History of Public Health:*

The notion of Public Health (PH), according to Theodore M. Brown et al., is closely related to global health that refers to the health of human populations in the worldwide context.⁹⁵⁵ As a scientific discipline, Jeffrey P. Koplan and group consider PH as an area of study, research, and practices that places a priority on improving and providing equitable “health for all” the peoples across the globe.⁹⁵⁶ Very specific in their clarifications, both Angus Dawson and Marcel Verweij further identify two primary meanings of the term “public” in public health, each of which they break down into three senses. They argue that the word “public” can stand for ‘population-wide’ which refers to (1) the epidemiologically measured health of a population or group; (2) the distribution of health in a population; or (3) the underlying social and environmental conditions impacting everyone’s health. Again, they view the concept ‘public’ to simply mean as a synergy of ‘collectivism’, ‘solidarity of persons’ or ‘communalism in the African context’. This refers to a concerted effort of human solidarity to address the pressing societal health challenges in view of improving the overall public health of the entire human race.⁹⁵⁷ Furthermore, the term *public* can represent a few groups or small handful of people which may be as large as a village or an entire city. However, in situations of health crisis as in the cases of pandemic, the word ‘public’ may not be limited just to a few groups of people or nations, but it may encompass multi-nations or several continents.

The World Health Organization (WHO) acknowledges that it is within the domain of Public Health as a special discipline, that the determinants of the entire societal health and the

potential threats or challenges that confront human life and existence, can be addressed.⁹⁵⁸ In a nutshell, Charles-Edward A. Winslow provides a concise definition of public health as the science and art of disease prevention, in view of improving the quality and longevity of human life. This can be easily achieved through organized efforts and informed choices of a society, groups, organizations (private or public), communities and individuals.⁹⁵⁹ So, the public health initiatives would encourage high level of hygiene, sanitary activities, breastfeeding, vaccinations and controls over sexually transmitted diseases. Such huge tasks require multidisciplinary teams (human solidarity) of public health workers, experts and other related professionals.⁹⁶⁰ The studies carried out by Tom Crook shows that the modern public health initiatives which started in the early 19th century was attributed to Britain.⁹⁶¹ As one of the most civilized nations on earth, Britain focused her initiatives more on sanitation, precisely on the improvement of sewage systems in the cities of Liverpool, London, etc. The same initiatives were channeled towards disease control with the vaccination programs and quarantine. Lastly, there were concerted efforts in the evolution of infrastructures, especially in the field of science, e.g., statistics, microbiology, epidemiology, sciences of engineering, etc., as necessary means to plan on time for any possible public health emergency.⁹⁶² Today, there are numerous activities of public health across the globe, including in the developing nations like Nigeria, both at the community, state and federal levels as well.⁹⁶³

6A. 2. 2. *Public health crisis and health security: Nigeria as a case study:*

The bioethical issues that are related to public health crisis and health security in Nigeria, which are likely to pose big threats to human life, dignity and health, can be briefly presented thus:

i). *The issue of disease infections*: The world is seriously challenged today with the numerous threats of emerging and re-emerging diseases. Considering the climatic conditions, increase in the population density, socio-economic realities coupled with the transborder migrations, Ebuka Onyeji remarks that Nigeria is highly exposed as a ‘hotbed’ for infectious diseases. According to him, there are clear indications that people in the tropical regions like Nigeria have the tendency to witness incessant outbreak of diseases like cholera, Lassa fever, typhoid fever, yellow fever, Ebola, chicken pox, small-pox, covid-19 pandemic, malaria, severe acute respiratory syndrome, etc.⁹⁶⁴ As life expectancy is likely to be on the increase in the civilized areas, the poor vulnerable societies are most likely affected by such chronic and infectious diseases.⁹⁶⁵ With the spirit of human solidarity, I am very optimistic that some of these diseases are curable and preventable. Hence, both life, dignity and health are at stake.

ii). *The effects of fake drugs*: Outside the epidemiological issues, the effects of fake drugs or hard substances like ‘*mpkuru mmiri*’ (Igbo) pose a big health crisis and insecurity in Nigeria. Remarkably, Bryan A. Liang et al., point out that the effects of counterfeit drugs take the advantage in making⁹⁶⁶ a lot of profits from the consumers, for purchasing fake products that have little or no medical value. Consequently, all these fake products are capable to cause unresolved health complications that can lead to untimely death in the nearest future.⁹⁶⁷ The WHO equally reacts that the adverse effects of fake drugs have the capacity to increase the risks of morbidity and mortality by prolonging illnesses, heightening the risk of treatment failures, etc.⁹⁶⁸ worse still, it is really very difficult to quantify the impact of falsified medicines on patients’ health, because of fragmented and incomplete reporting of incidents.⁹⁶⁹

iii). *Poverty*: Another major ethical challenge that threatens the safety of human health and life is the issue of poverty. To this effect, the Universal Declaration of Human Rights of the 1948

declares thus: “Everyone has the right to a standard of living adequate for health and well-being of himself, his family, including the elimination of hunger”. So, subjecting human beings to a substandard of living, is considered as a serious violation to human rights and a big threat to one’s personal dignity.⁹⁷⁰ Thus, the level of poverty and food insecurity can be evaluated by high rate of malnutrition, morbidity and mortality, and Nigeria is not free from such insecurity.⁹⁷¹

iv). *Environmental Degradation and Effects of Pollution:*

Due to the recent numerous technological advancements in the world, Dokun Oyeshola is afraid of their devastating effects in over-stressing a high valued biodiversity beyond the limits of its resilience, stability and carrying capacity.⁹⁷² Today, Nigeria is seriously affected by the adverse effects of the scientific innovations. Such are responsible for the unpredictable climatic variability, droughts, floods, oil spillage and pollutions with hazardous substances to human life, health and entire ecosystem.⁹⁷³

6A. 3.0. Public Health: Recommended Ethical Solutions

As part of collective efforts to effectively address both the current and future challenges related to the public health, the United Nations have launched the Sustainable Development Goals (SDGs). Fundamentally, the objective of these goals in their entirety is intended towards building a better sustainable and habitable world. These goals are basically formulated to tackle some major ethical public health issues like poverty, hunger and food security, health, water and sanitation, etc.⁹⁷⁴ Interestingly, all these goals concentrate mainly on the five “P’s”, namely – *People, Planet, Prosperity, Peace, and Partnerships (human solidarity)* – as the summaries of the 17 (SDGs). According to the Nigerian daily news, *Guardian Newspaper*, reports that these

practical initiatives are targeted to ensure that the right choices are implemented to improve and safeguard the life and dignity of the future generations with more visionary sustainable means.⁹⁷⁵

A team of notable ethicists led by James F. Childress made a painstaking effort to provide a conceptual framework of public health ethics that is applicable not only in the United States but can as well be applied in other places across the globe. In a nutshell, the framework consists of general moral considerations in public health ethics. Thus, they propose that:⁹⁷⁶

- i). The respect for personal autonomy makes it mandatory to seek for voluntary informed consent, for examples on the area of vaccination, etc. This implies that ethics of public health should always endeavor to promote and respect the rights of each person in the society.⁹⁷⁷
- ii). In respect to the principle of beneficence, every activity in the public health should be geared towards producing maximum benefits. So, maximal balance of benefits over potential harms and other costs (often called utility) should not be taken for granted. In other words, all the public health policies and activities should strive towards making positive impacts to the lives of the people in the society.⁹⁷⁸
- iii). Again, relying on the principle of non-maleficence, all efforts must be harnessed in avoiding, preventing and removing harms.
- iv). With the notion of justice, both benefits and burdens should be equitably and fairly distributed.
- v). As an element of transparency, disclosing of information, speaking honestly and truthfully as in the case of pandemic, is highly recommended.
- vi). Lastly, under public health, trust is very important in dealing with people.

Nevertheless, with regards to control and prevention of diseases like malaria, Agyepong et al., opine that a public health strategy must include efforts to eliminate or reduce breeding sites, screening doors and windows, apply insecticide sprays to treat mosquito nets, providing immediate treatments of disease infections.⁹⁷⁹ In this respect, Jonathan Watts believes that Nigeria can only respond effectively to detect, track and contain such disease outbreaks with a viable health system.⁹⁸⁰ Life is fragile! Very interesting to note that one of the top priorities in the area of public health is the application of preventive measures to diseases that may cause high rate of morbidity and mortality. No matter the capacity of any healthcare system, if diseases are not prevented, the treatment outcome may be unimaginable than expected. Due to the fragility of human life, it then calls for more collaborative efforts to ensure that human life is not exposed to extreme harms or risks due to disease spread, etc. Therefore, I still maintain that prevention is better than cure!

6B. 0. The issue of unjust Mortality and Medical Futility in Clinical Practice

Introduction:

Life has a limit! According to Martin Heidegger, human life is, in one way or the other, subjected to some kinds of precarious situations in the world. This assertion from a renowned existentialist, tries to justify the fact that, no matter the trajectory of one's life, one's existence will surely be marked by a solitude and finitude; hence, each person is a 'being-in-time'.⁹⁸¹ Naturally, while reflecting on the end-of-life experiences, human beings are entangled to feel the primordial anxiety on how to overcome them. Despite such difficult moments in one's life, people frantically attempt to pinpoint a final sense on the meaning life. This is what Heidegger refers to as 'allure' or 'character of exactness'.⁹⁸² Besides, one of the most basic inalienable human rights is the right

to life, which presupposes the right to preserve it. As such, once there is life, there is automatically an inevitable death that terminates the life of each person. In other words, death is the summary of all human activities on earth, including all medical efforts that are based on the respect to ‘dignity’ to improve, promote and care for human life and health.

Some people like me would agree with Philip A. O’Hara that even when faced with serious illness or at the verge of death, the dignity of each person is not lost.⁹⁸³ This is because, the dignity of human person is an intrinsic value, deeply rooted in the person’s nature.⁹⁸⁴ So, the concept of personal dignity suggests a right for a person to be valued and respected for their own sake, and to be treated ethically. From a philosophical viewpoint, death which is the deepest cause of a primordial anxiety can be seen as the ultimate existential moment in one’s life. Therefore, to ensure that each person has a dignified end-of-life, this dissertation at this juncture will devote enough time to discuss on few major ethical issues at the end-of-life: the concepts of death and dying, euthanasia, physician assisted suicide, palliative care, etc.

6B. 1. 0. *The Concept of Death and Dying: An inevitable necessary End*

The term ‘death’ with its dying process is one of the few inevitable certainties in life. It is a common phenomenon for every person or thing that exists and lives. Though, it is not so easy for scholars to define “death” in few words. As a result, some people would prefer to define death by simply distinguishing it as the opposite of life, which presents it as a moment at which life ends. Faced with multiple ambiguities in understanding the term ‘death’, Samir H. Mohammad et al., believe that the concept itself is an important key to human understanding of the phenomenon.⁹⁸⁵ Today, the use of sophisticated life-sustaining equipment in modern medicine seem to beg for numerous criteria towards defining death from both medical and legal standpoints. All these pose

a kind of difficulty in formulating a single unifying definition of death. Amidst lack of a consensus, there are various definitions and interpretations of the concept of death.

Nevertheless, Robert Kastenbaum identifies death and dying as ‘a single event’ which can take place in a person, at a specific moment, place and in a particular way.⁹⁸⁶ Again, he further avers that death is a ‘condition’ and a ‘state of existence or non-existence’, that refers to a condition of irreversibility in that state of organism, incapable of performing the vital functions of life.⁹⁸⁷ Lastly, he views death as the separation of the soul from the body. So, death which seems to be the opposite of life, potentially consists in the union thereof.⁹⁸⁸ In this light, the Dorland’s Illustrated Medical Dictionary defines death as the cessation of life. This implies the permanent cessation of all vital bodily functions. Thus, from the legal and medical perspectives, this irreversibility is in threefold: (1) irreversibility in total cerebral function, (2) irreversibility in spontaneous function of the respiratory system, and then; (3) irreversibility in spontaneous function of the circulatory system. With this definition, death can be understood as the permanent irreversible cessation of all biological functions capable of sustaining a living person or thing.⁹⁸⁹

Many people who had the opportunity to witness the terrible dying experiences of their loved ones, are convinced that death is fraught with a lot of intricacies and mystery beyond human reason. Hence, to understand the full meaning of death is not absolutely guaranteed. On this note, David DeGrazia would question at what exact point in time does a death occur to mark the end of life. Attempting to provide answers by himself, DeGrazia postulates that a human being is declared dead only when the heart and lungs are irreversibly unable to function.⁹⁹⁰ This notion of irreversibility is further clarified in the two reports presented by the Harvard Medical School Ad hoc Committee (1968) and the President Commission Report of 1981, respectively. The report by the Harvard ad hoc Committee on Brain Death makes a concise explanation on the

characteristics of an ‘irreversible coma’, or ‘brain death’. This includes: 1- unreceptivity and lack of responsivity - it refers to patient total unawareness to external stimuli and unresponsiveness to painful stimuli; 2- No movements or breathing – a situation where all spontaneous muscular movements, respiration and response to stimuli are absent; 3-No reflexes – fixed, dilated pupils; inability for the eye to show sign of life even when hit or turned; lack of response to noxious stimuli; in-elicitable tendon reflexes.⁹⁹¹ Thus, death implies absolute cessations of vital bodily functions, which makes the decomposition of the human organs, possible.⁹⁹²

The concept of ‘death’ and ‘dying’ are further analyzed by Philippe Ariés by which he highlights some aspects related to human attitudes towards them. For him, there are four important dimensions of death and dying, namely: the tamed death, the death of the self, the death of the other and forbidden death.⁹⁹³ With regards to “tamed death”, he maintains that death does not always occur as a surprise. Instead, due to serious illness or health conditions, some people may be fully convinced that their journey to the end-of-life is so imminent, and so, this awareness gives them the opportunity to begin to prepare to die. Thus, those who experience ‘tamed death’ hardly die without having had time to realize that they were about to die.⁹⁹⁴ In serious ill cases, death is mainly expected on the deathbed, in silence and without much of complaints or hesitations. To ensure a dignified end-of-life, death at this point can be spiritually prepared by a pastor or hospital chaplain, who presides and coordinates the protocol to be followed. Both the parents, children, relatives and friends are gathered for the last respect and recommendations, to say ‘good-bye’ and, after which, the person gives up the ghost. Such a death is familiar and tamed.⁹⁹⁵

Another phase of death is what Ariés describes as the ‘death of self’ or ‘death of one’s own’. This suggests a kind of death mentality that allows the dying person to be focused and

more concerned with oneself at the hour of death, the heart may be filled with sober reflections and maximum awareness. Such a mood throws the dying person into lonely self-isolation from the world of reality, with a bit of anxiety and a great deal of indifference. With the “death of one’s own,” Ariés believes that it gives an individual the opportunity to reconcile himself with others, prepare oneself to be ready to confront the inevitable death.⁹⁹⁶ Also, with what he terms as ‘death of others’, Ariés reflects more on traumatic experience of losing loved ones and the intolerance of such separation. Hence, there is always deep sense of sadness and despair associated with the loss of a beloved person.⁹⁹⁷ Lastly, the notion of ‘forbidden death’, according to Ariés, refers to the kind of death that is highly influenced by the effects of science and technology, with the capacity to alter the course of human life.

Today, with the advancements in modern medicine, Ariés agrees that death can be medicalized, institutionalized or professionalized. Therefore, this issue of ‘medicalized death’ has proved that the natural pattern for humans to die can as well be altered. Nowadays, there is an over-growing confidence in medicine and medical technology as the all-important means for controlling and making sense of death. As such, death is viewed as a technical phenomenon which can be obtained by the cessation of care. In sum, Ariés concludes that death has been dissected, cut to bits by a series of little steps, which finally makes it very difficult to know which step is real step to death.⁹⁹⁸

6B. 1. 2. *The Concept of Death in the African/Nigerian Perspective:*

The fact remains that the perceptions and conceptions about death “onwu” (Igbo), according to Lesiba Baloyi et al., depend on the different backgrounds. These backgrounds fundamentally refer to certain ethnic, religious and cultural affiliations, philosophical presuppositions and assumptions, or people’s worldviews.⁹⁹⁹ Likewise, the African perception of

death is based on natural transition from the visible to the invisible spiritual ontology where the spirit or soul “muo” (Igbo), the essence of the person, is not destroyed by death itself. Instead, it continues to exist and live in communion with the ancestors in the life beyond the physical realm. Such a continuous existence signifies an inextricable spiritual connection between the two worlds of human existence - *physical* and *metaphysical*.¹⁰⁰⁰ On this point, John S. Mbiti alludes that the being of an African does not exclude the strong spiritual tie or closeness with the other world known as the ‘living-dead’.¹⁰⁰¹ Thus, the essence of this relationship between the living and the dead is for one to be in a state of immortality of life.¹⁰⁰²

Reflecting on the ‘human ontogenesis’, Bame A. Nsamenang notes that an African worldview envisions the three major phases of selfhood in each person’s life cycle: *spiritual*, *social or experiential* and *ancestral* selfhoods.¹⁰⁰³ He then elaborates these selfhoods of human existence thus: The *first* is the ‘spiritual selfhood’ which begins at conception, or by the process of reincarnation; the *second* is a ‘social or experiential selfhood’, though begins at conception but it is witnessed at birth and with the rite of incorporation of the new-born into the society till death. Lastly, the *third* is the ‘ancestral selfhood’ that begins immediately after the physical death of a man.¹⁰⁰⁴ However, within this consideration, the African worldview strongly believes that these selfhoods do not exist as autonomous, independent and in isolation.¹⁰⁰⁵ In the thoughts of Nhlanhla Mkhize, these three different phases of personhood are collectively interdependent, interrelated and co-exist in a collaborative way; hence the concept of collective or interdependent self.¹⁰⁰⁶ Therefore, for an African, death does not necessarily imply an end to life, instead, it marks the beginning of another phase of existence.¹⁰⁰⁷ In all ramifications, Lydia Dugdale accepts that death is still so fascinating and titillating, and most people lack the courage to confront the finitude – death – because it is beyond their comprehension.¹⁰⁰⁸

As already indicated, death is now medicalized, institutionalized, and professionalized.¹⁰⁰⁹ Therefore, in respect to some controversial ethical issues related to the end-of-life, it becomes so imperative at this point to discuss on the notion of ‘medicalized deaths’ like euthanasia and physician-assisted suicide. No doubt, such deaths in clinical settings can cause more tensions between the respect to the ‘personal dignity’ and ‘solidarity’ of few persons that might involve themselves in some medical malpractices to ensure unjust mortality. Hence, a threat to human life, a violation of one’s dignity and fundamental rights to life!

6B. 2. 0. Clinical Deaths: The notions of Euthanasia and Physician-Assisted Suicide

Introduction:

As earlier noted, the issue of inevitable death together with its dying process, remains a common phenomenon most people are not only afraid of but are not very comfortable to discuss about it. This is because, according to people like Ernest Becker, death is poignant, impregnable to evoke a keen sense of sadness, mourning, regret, etc. It is so titillating and fearsome. As such, the fear of death can haunt any conscious person to avoid its fatality and may prefer to overcome it or by denying it is as the final destiny for a mortal being.¹⁰¹⁰ Unfortunately, it is not the common destiny for each person to die without so much of pains and sufferings. So, to get rid of such kind of inhuman misery before dying, some patients in critical conditions with incurable illnesses or injuries may seek other medical options to terminate their lives. To end their lives through painless means, Grzybwska P. Filiberti notes that such procedures are likely to be either violent, unethical and unjustified.¹⁰¹¹

Meanwhile, the primary goals of medicine, according to Franklin E. Payne, are: *first*, to diagnose the patient’s illness; *second*, to subscribe to an objective ethical value of medical

treatments; *third*, to manage, relieve pains and sufferings of the patients; and *lastly*, to always endeavor towards rehabilitation and preservation of human life.¹⁰¹² All these are in view of assisting the patients to enhance their respective quality of life by alleviating pains and suffering, provide cure when it is possible, or palliative care when cure is no longer possible.¹⁰¹³ Dealing with the end-of-life issues like euthanasia and physician-assisted suicide are capable to stir up some unique ethical questions than providing answers.¹⁰¹⁴ Some common terms like ‘mercy killing’ for ‘euthanasia’ and ‘physician assisted suicide’ are frequently used to describe such process of medicalized deaths. Of course, the advocates of such medicalized deaths would argue that they are necessary options for patients suffering from terminal diseases to end their lives.¹⁰¹⁵ On the contrary, the ‘Pro-Lifers’ who are firm and uncompromised opponents of a self-chosen death would truncate this argument on the ground that they are not only immoral, unethical, but wholly against the pillars of ‘critical reason’ which include: *analysis, interpretation, evaluation* and *self-direction*.

Though, ethicists would settle with a palliative care for the patients with terminal illness as a mediating point between these two opposing groups on the end-of-life issues. For them, this is best interdisciplinary medical caregiving approach aimed at optimizing quality of life and mitigating suffering among people with serious complex illness, to ensure a dignified end-of-life.¹⁰¹⁶ Therefore, before discussing on the palliative care, as a matter of great necessity, I would like to clarify first these two concepts: euthanasia and physician-assisted suicide.

6B. 2. 1. *The concept of Euthanasia:*

One of the worst traumatic experiences in life is to watch a loved one, with no ray of hope in sight to recover from serious illness, passing through excruciating pains before giving up. For some people, since death is an inevitable occurrence for all living beings, it is not

justified to allow patients to be in such critical conditions full of pains and agony. The argument based on one's own right to end one's life has caught the fancy of many, but it is a sufficient reason to elicit fierce, divided and often passionate opinions as a solution to end one's life. In this respect, the concept of euthanasia as remarked by Dharmender K. Nehra et al., has become increasingly touted as a beguilingly simple solution to the tragedy of an incurable terminal illness. Thus, euthanasia is simply defined as an act that is objectively intended to bring about a gentle or an easy death in situations of challenging incurable painful diseases.¹⁰¹⁷

Etymologically, the term 'Euthanasia' is a derivative from two Greek words "*eu* – good or well" and "*thanatos* – death", which simply refers to "a good death". Originally, euthanasia suggests a condition of a good, gentle and easy death¹⁰¹⁸, specifically for those suffering from the intractable pains of incurable diseases, or who are in the state of irreversible coma.¹⁰¹⁹ Other terms like "a good death", "death with dignity", "planned death", and "assisted death", or "aid-in-dying" have been implored to refer to euthanasia. The noun euthanasia has changed into the transitive verb "to euthanize", which refers to a skillful alleviation of suffering by a physician who provides the required conditions that can facilitate a gentle death.¹⁰²⁰

The term 'euthanasia' portrays the meaning of all activities or decisions by qualified medical personnel with the deliberate intent to hasten the death of another person, especially by an act of commission, and at the request of the competent person to limit his or her pains and suffering. Then, Sjef Gevers tries to clarify the concept as an intentional or deliberate killing by a medical expert at the request of a patient, whose life is no longer felt to be worth living.¹⁰²¹ The history behind the practice of euthanasia is very long, ranging from the ancient Graeco-Roman to Judeo- Christian era, and then till the present age. Up to this time, as Marvin Kohl rightly hints that, the meaning of euthanasia has not changed to refer to a painless inducement of a quick

death.¹⁰²² In this sense, Tom L. Beauchamp et al., clearly point out that all the activities of euthanasia have the tendency for an individual to deliberately kill a fellow human being painlessly, but for no other personal reason beyond a painless exit of one in critical condition.¹⁰²³ Then, both Marvin Khol and Paul Kurtz conceive euthanasia as a mode or an act of inducing or permitting death painlessly as a relief from suffering.¹⁰²⁴ Although, the group of Tom L. Beauchamp frowns at such unethical intention because it would constitute what he terms as a ‘murder simpliciter’ which is quite different from ‘euthanasia’ in the real sense of the word.¹⁰²⁵

6B. 2. 1. 1. *The Different Types of Euthanasia:*

There are three major types of euthanasia, namely: *voluntary*, *nonvoluntary* and *involuntary* euthanasia. Basically, euthanasia may be classified according to whether a person gives informed consent or not,¹⁰²⁶ as ‘consent’ is considered as an essential element in every activity that may justify euthanasia.¹⁰²⁷

i). *Voluntary euthanasia*: This is a type of euthanasia conducted with an explicit consent from the patient. In the case of voluntary euthanasia, it is believed that a competent patient in critical condition must not only express the desire to die, but also should request to be killed. For the advocates of euthanasia, this is the surest means to die, since it is so glaring that the patient anticipates an imminent death.¹⁰²⁸ Today, it is no longer a news that an active voluntary euthanasia is legalized in both Belgium, Luxembourg and the Netherlands, while passive voluntary euthanasia remains legal throughout the United States of America.¹⁰²⁹

ii). *Non-voluntary euthanasia*: Unlike the voluntary euthanasia, once the life of a patient with serious terminal illness is ended by a medical agent, without obtaining the consent of the patient, then, it is regarded as a ‘non-voluntary euthanasia’. Such practices are so evident in the children’s euthanasia processes, and it is globally condemned as illegal, unethical and unjustified

means to terminate one's life.¹⁰³⁰ A typical example of a non-voluntary euthanasia is in a situation whereby the life of a patient who is in irreversible coma, unable to express his or her wishes for an imminent death, is terminated by medical personnel, with a presumed reason that the patient could wish to die. Such an end to one's life is what Jonathan Glover interprets as a direct homicide or murder, not euthanasia per se.¹⁰³¹

iii). *Involuntary euthanasia*: This refers to a type of euthanasia that can be executed against the expressed wish of the patient.¹⁰³² Such euthanasia practices are likely to occur, especially when a patient though capable to wish to die but has not yet indicated such, either because the patient has not been consulted to assent to die, or that he or she still wants to live. But in the event the patient is killed by a physician in the process, then the case is a clear involuntary euthanasia or murder.¹⁰³³ However, there is basically no justification yet for involuntary euthanasia no matter the reasons since a person does not give an explicit consent to be killed. The likes of Hazel Biggs conclude that this as a pure deliberate murder, or 'murder simpliciter' rather than euthanasia.¹⁰³⁴

iv). *Passive and active euthanasia*:

When terms like *passive* and *active* are associated with euthanasia, they may be full of ambiguity, misleading and unhelpful. Hence, they need brief clarifications. So, an 'active voluntary euthanasia' is when competent patients make an official request to die, and they are assisted by physician(s) with lethal injection to hasten their death. In other words, an active voluntary euthanasia results from acts of commission, like the administration of medications such as barbiturates, opioids, etc., by a doctor that may hasten the process of dying.¹⁰³⁵ Moreover, a case of voluntary euthanasia could also be as well 'passive', if there is a shortening of life as unintentional side effect of a pain relief approach. The patient may accept to take pain-relieving medications that are likely to reduce pain but can also lead to an unexpected premature death.¹⁰³⁶

The case of ‘passive non-voluntary euthanasia’ occurs, for instance, when the life-support of a patient who is in the state of coma is turned off by an attending physician in view to shorten life.¹⁰³⁷ According to Harris N.M., passive euthanasia entails the withholding or withdrawal of extraordinary medications such as antibiotics or life-support equipment, necessary for the sustenance of life.¹⁰³⁸ So, a passive euthanasia involves more of acts of omission which may lead to the withdrawing of life-supporting measures like artificial feeding and artificial respiration.¹⁰³⁹

6B. 2. 1. 3. *Arguments in support of Euthanasia:*

i). *Autonomy*: The proponents of the practice and legalization of euthanasia base their argument on the patient’s “rights to one’s own body”, hence one can decide on what happens to one’s life.¹⁰⁴⁰ This personal right to life invariably includes the right to die. Relying on this personal right, it means that each person has the autonomy to decide on how, when and where to shorten his or her life, in order to reduce or eliminate the unpleasantness due to pains and sufferings. In effect, people like Coombs B. Lee reasons that to refuse a terminally ill patient’s request to die, is invariably a violation of his or her fundamental rights.¹⁰⁴¹

ii). *Dying with dignity*: The concept of ‘personal dignity’ is one of the main points that forms that the title of this dissertation. As such, I reaffirm that no person loses his or her dignity even at point of death. Thus, the supporters of euthanasia are convinced that “dying with dignity” is a strong reason that push a lot of people to seek for euthanasia, especially when life seems to lose its quality and value due to serious illness. A lot of patients suffering from terminal ailments would prefer to have a dignified end-of-life. To die with pride, dignity and not being slowly deteriorated by disease, Dan W. Brock sees euthanasia as a ‘psychological insurance’ that can facilitate the elimination of anxiety in the patients who face the uncontrollable pains and suffering before death.¹⁰⁴²

iii). *Death is a private matter*: Another strong argument in favor of euthanasia is that death is considered as a private issue. No matter how caring and dependent human beings are in the society, each person has his or her own life to live, which comes to an end with the inevitable death. Therefore, since death is a necessary end for each person, then, it is argued that one can request for euthanasia as a personal matter to end one's life.¹⁰⁴³

6B. 2. 1. 4. *Arguments against Euthanasia*:

i). *True autonomy is against euthanasia*:

As earlier indicated that advocates of euthanasia base their argument on personal autonomy, which implies that one's views and choices should be respected at all costs. This position is truncated based on the ground that it is an exaggerated notion of autonomy.

According to St. John Paul II (Pope), in the encyclical *Evangelium Vitae*, argues that this is a distorted notion of freedom which not only threatens but also destroys the idea of solidarity among peoples.¹⁰⁴⁴ To redirect the misconceptions on the concepts of 'freedom and right' as extensions of autonomy, Benedict Ashley et al., state that such fundamental right is not an absolute one to control one's own life, because life is a sacred gift from God. Therefore, human beings are morally charged to be custodian to life but not destroyers of life.¹⁰⁴⁵

ii). *False compassion and mercy*: One of the reasons that supports the practice of euthanasia is based on 'compassion and mercy' towards the terminally ill patients as a means to liberate them from acute pains and sufferings. For those who are anti-euthanasia, this argument is baseless, because such sign of mercy and compassion are false, or perversion of mercy and compassion.¹⁰⁴⁶ Outside being provided with proper medical treatments, the patients approaching their end-of-life still need love and proper palliative care. Being very close to them, showing

them human love, care and warmth at their last stage of existence are true signs of mercy and compassion, but not to send them to their early graves.¹⁰⁴⁷

iii). *Sanctity of life*: In support of euthanasia, some people may base their argument on the ‘quality of life’, that once life seems to lose its quality, it is better to dispose of it, immediately. However, this position is seriously countered by the anti-euthanasia group using the notion of ‘sanctity of life’. The intrinsic nature of the sanctity of life makes it imperatively inviolable, and as such, nothing can justify the termination of human life, no matter the circumstance, by fellow human beings.¹⁰⁴⁸ Life is sacred! Therefore, to opt to do away with human life through the practice of euthanasia is not only wrong, but it is a serious violation against God and dignity.¹⁰⁴⁹

Lastly, in his own counter arguments, Emanuel Ezekiel vehemently opposes euthanasia with the following reasons. *First*, he believes that not all deaths are painful, euthanasia fails in this respect as a means to eliminate pains and sufferings. *Second*, he points out that there are various justifiable alternatives available like cessation of active treatments, combined with the use of effective pain relief, which are more preferable to euthanasia. *Third*, the distinction between active and passive euthanasia is morally significant to be clarified, because the latter is permissible and ethically justified in extraordinary ill cases. *Lastly*, he argues that to legalize euthanasia will place society on the danger of rolling on a slippery slope, which is capable to result into unimaginable and unacceptable consequences in the future.¹⁰⁵⁰ Therefore, if euthanasia is finally legalized, then it will seem like empowering law abusers, and such may increase the distrust of patients towards the doctors. Such a kind of ‘mercy killing’ might cause a big decline in medical care and cause victimization of the most vulnerable candidates in the society.¹⁰⁵¹

6B. 2. 2. *Physician Assisted-Suicide:*

A group of ethicists led by Lukas Radbruch defines 'Physician-Assisted Suicide' (PAS) as a deliberate intention of a medical expert to assist a patient in critical ill situation to bring about the end of his or her life, at that patient's voluntary request.¹⁰⁵² In the activities associated with the PAS, a competent patient makes the voluntary request to be assisted to die, imminently. Just as its name suggests, a qualified physician must indicate his readiness to assist a dying patient to achieve the goal of hastening his or her death, by making necessary provisions of the lethal drugs or prescriptions.¹⁰⁵³ With this definition of PAS, Tom L. Beauchamp and his colleague, James F. Childress, succinctly differentiate it from all forms of euthanasia. Thus, in the PAS, it is the attending physician that provides the means to hasten death, while it beholds on the patient to execute the main act of ending his or her life.¹⁰⁵⁴ Unlike in the case of euthanasia, the physician plays an indirect role in PAS, while the patient is considered as the direct agent of his or her own demise or misfortune. Therefore, some ethicists would argue that the moral responsibility of the physician is lessened by the direct action of the patient in PAS, that makes it to be different from euthanasia.¹⁰⁵⁵

Despite the ethical justifications of PAS, still people like John J. Paris criticize the medicalization of PAS as part of a transformation of medicine from a caring profession into a business designed to serve certain unethical demands in medical services.¹⁰⁵⁶ Besides, major religions like the Roman Catholic Church would acknowledge the fact that moral decisions regarding a person's life must be made according to one's own clear conscience and faith.¹⁰⁵⁷ While condemning medicalized deaths like euthanasia, the Catholic Church explicitly points out that one's concern for the suffering of others is not a sufficient reason to decide whether it is appropriate to act upon voluntary euthanasia.¹⁰⁵⁸ According to Pope Francis, death is a glorious

event and should not be decided by anyone other than God. So, to defend life means defending its sacredness.¹⁰⁵⁹ As implied in the fifth commandment, the act of physician-assisted suicide contradicts the dignity of human life, but cessation of treatments may be ethically permitted and justified. The case of euthanasia is unacceptable because it is perceived as a serious sin or moral evil, as it goes against the 5th Commandments, which states thus: “Thou shalt not kill”.¹⁰⁶⁰ In view to alleviate pains and sufferings, and to offer an alternative to the PAS, it is recommended that terminally ill patients should be ready to journey towards an end-of-life while receiving the love and mercy of their family members, friends, caregivers, etc.¹⁰⁶¹

6B. 3. 0. Medical Futility and Enhancement of Palliative Care: *The Tronto Models*

6B. 3. 1. *The Concept of Medical Futility*

Medicine has its limitation! It is a big lift in modern medicine that with the recent scientific breakthroughs, it has the capacity to alter the course of human life. According to Atul Gawande, medicine has everything in its domain to care for human life and health without too much of problems.¹⁰⁶² Though, medicine in its limitation cannot provide an absolute solution to human life and death. Hence, once serious illness strikes, coupled with multiple debilitations or dementia at old age, then things begin to fall apart in the life of a person, and the reality of death remains predictable and inevitable.¹⁰⁶³ In such critical moments in one’s life, the process of dying and decisions at the end-of-life become issues of difficult ethical conundrum in medicine with regards to withdrawal or withholding of treatments deemed medically futile.¹⁰⁶⁴ Such scenarios can be more complex when the team of physicians are in total disagreements with the family members (including the patient) on the potential risks-benefits of the treatment, or at worse, when cultural disparities are involved in the divergence of ideas. For people like James J.

Walter, such terms like ‘medical futility’ can be used to indicate the moment for the cessation of treatments, either by withholding or withdrawing of all medical treatments.¹⁰⁶⁵

The term ‘futility’ is not a new concept in medicine. It is on record that Hippocrates had advised physicians to discontinue or refuse treating the patients who are being overmastered by their respective sicknesses, especially when it is so evident that medicine is powerless to improve their health conditions.¹⁰⁶⁶ For further explication, the word ‘futile’ is derived from the Latin lexicon ‘*futillis*’ which means ‘leaky’. So, as the word ‘futile’ stands for a specific action, then ‘futility’ refers to the relationship between an action and a desired goal. Thus, a futile action, as Lawrence Schneiderman and others remark, is considered to be leaky, untrustworthy, vain effort, or failing to achieve a desired end due to some intrinsic defect. In other words, *medical futility* can be easily understood as a clinical action that is ineffective to offer any useful purpose to achieve the expected goals of medicine for a given patient.¹⁰⁶⁷

In this perspective of medical futility, a deliberate termination of one’s life or the life of another is adjudged to be morally wrong and ethically unjustified. Therefore, since the decisions like the cessation of treatments may ensue in the process, Teresa Yao equally recommends that terminally ill patients should receive palliative care to assist them both psychologically and spiritually, to ensure a dignified end-of-life. Really, I so much welcome her opinion that such are better options at the expense of euthanasia or physician-assisted suicide.¹⁰⁶⁸ Basically, with the circumstances surrounding the concept of ‘medical futility’, James J. Walter hints that it is very difficult to reduce it just into a single category. According to his postulations, there are two major types of medical futility – *physiological* and *qualitative* – which ought not to be confused nor conflated. In this first type, ‘*physiological medical futility*’, it is only a qualified medical professional that has the responsibility to determine if a proposed or requested medical

intervention is futile or not.¹⁰⁶⁹ Thus, a physiological medical futility refers to any proposed medical intervention that cannot medically achieve a desired goal, nor be of great benefits to the patient despite producing a medical benefit.¹⁰⁷⁰

The second type is known as '*qualitative medical futility*', which can be evaluated in relation to the desired medical goals, either clinical or personal.¹⁰⁷¹ For instance, granted that the insertion of a feeding tube for a patient in a permanent vegetative state is meant to feed and hydrate the patient to sustain only biological life, but it may not improve the quality of life. At such critical moment, both the patient and his relatives might reason otherwise that this clinical effort is a futile venture. Hence, such a therapy is not worth pursuing, because based on 'quality-of-life judgment', it does not offer any sign of hope on the improvement of quality of life.¹⁰⁷²

The aspiration of a good physician in the clinical settings is to achieve the expected principal medical goals, by producing maximum benefits, not necessarily medical effects, for the patient.¹⁰⁷³ For Jane M. Trau, the effects of medical treatment have direct impact on the patient's disease, organs, etc., precisely it is a kind of pathological condition that focuses on the causes and effects of diseases.¹⁰⁷⁴ It is good to note that the benefit of every medical therapy is geared towards affecting the holistic treatment of the patient, which is capable to impact positively on the overall patient's life plan, beliefs, goals, wishes, etc.¹⁰⁷⁵ Based on the notion of benefit, any definition and judgment on medical utility should not exclude the values of the physician, patient, family, etc. Hence, all medical interventions should be evaluated depending on their *effectiveness, benefits, and burdens* to the patients.¹⁰⁷⁶

The term 'effectiveness' in clinical context, can be exclusively determined by the clinician's objective assessment which is likely to alter the course of disease diagnosis and prognosis. As a clinical component, effectiveness is mainly based on medical knowledge on the

patient's disease history, age, quality of life, or nomics that would be ancillary though not *per se* determinative.¹⁰⁷⁷ Similarly, 'benefit' as Walter J. writes, can also be determined by the patient himself or family members. The determination of benefit can be either subjective or objective but should be consistent on the evaluation of the patient's age, quality of life and the entire financial aspect of the therapy.¹⁰⁷⁸ Lastly, the notion of 'burden' is closely related to both the physical, fiscal, and emotional consequences of proposed treatments. Just like benefit, burdens may be both objective and subjective, which can as well be defined by patients or their surrogates in consultation with the physicians.¹⁰⁷⁹

In a broad sense, the concept of futility may not be free from the real dangers of abuse, either overt or covert. Even in the situation of medical futility, there is a strong opinion that proper care cannot be totally futile. For instance, a patient in critical condition whose end-of-life is so imminent, needs to be accompanied all through the rest of his or her life with love, compassion and care. Therefore, both comfort, relief of pains and sufferings, and attention to the patient's needs are all morally mandatory till death. Hence, the term 'futility' is not a sufficient justification to advocate for assisted suicide, or any other forms of euthanasia.¹⁰⁸⁰

6B. 3. 2. *Enhancement of Palliative Care*

With the critical analysis on medical futility, it is very clear that once medicine seems to have exhausted its maximum potentials by offering no relative hope of improvement on the health of the patients, all therapeutic procedures should be stopped. This simply means that all the on-going treatments must be withdrawn, while the new interventions be withheld. Just as Gordon D. Rubenfeld pertinently clarifies that, it is only the treatments that are being withdrawn or withheld, not 'palliative 'care' or approach.¹⁰⁸¹ Such decisions at the end-of-life demand a good collaborative effort (human solidarity) between the medical team and the patients

(including the family members) in view to continue with the enhancement of palliative care.¹⁰⁸²

In such fiduciary obligation, Pellegrino asserts that it is ethically acceptable that physicians are not obliged to continue with the treatments that may be ineffective or harmful to the patients.¹⁰⁸³

Also, it is not just enough to say “no” to patients concerning futile treatments, rather Robert M. Veatch et al., propose the need to dialogue and seek for alternative medical approaches.¹⁰⁸⁴

Again, palliative care which is likely to provide comfort care to critical patients is not a futile but will serve this purpose. Therefore, according to Nancy S. Jecker et al., patients in hopeless futile cases should be guaranteed palliation, pain control, and not to be abandoned to die without dignity.¹⁰⁸⁵

The concept of ‘care’, as defined by Nel Noddings, gears toward assisting other people in dire situations of practical needs. It is important to add that every element of care in this context should be devoid of selfishness or self-centeredness. This implies that proper care must lead to some type of specific actions emanating from one person to the other, i.e., for *‘patient’s best interest’* or *‘patient-centeredness’*. So, the act of caring in human interdependence and interrelationships ought to be understood as a basic to human existence and consciousness. For him then, the first two stages of caring are, “caring-for” and “caring-about”.¹⁰⁸⁶ In affirmation to this clarification on the concept of care, Berenice Fisher insists that ‘caring’ is to be conceived as a species activity that includes all human acts. Succinctly, such human acts should anticipate for the entire well-being of those in need of care in the society for possible good co-habitation. So, the issue of caring in this context continues to revolve around all human activities in this life-sustaining web. Absolutely, caring for others, especially for patients in dire situations, is a burden oriented, full of challenges and risks.¹⁰⁸⁷

With regards to palliative care, the group led by Sean R. Morrison understands it as an approach that is mainly applied to improve the quality of life of the patients suffering from life threatening diseases. This approach provides massive support to the patients and their families, through prevention and relief of physical, psychosocial and spiritual suffering.¹⁰⁸⁸ Today, palliative care is gaining more prominence as one of the best options to relieve pain and suffering, improve quality of life, reduce medical expenditures, and even prolong life. For people like Camilla Zimmermann et al., palliative approach is recognized as the standard of care for patients facing incurable malignancy and other life limiting illnesses.¹⁰⁸⁹

6B. 3. 3. *Palliative care in Africa/Nigeria:*

Remarkably, the notion of palliative care in this context is globally relevant, but it is relatively a new discipline in African countries like Nigeria. Palliative care in a sense, as articulated by Faith Mwangi-Powell, is still taking gradual steps since its progress and development are seriously affected by a lot of challenges. One of these challenges is that, the concept of pain management is not yet fully integrated as an area of specialization into the continents' healthcare systems.¹⁰⁹⁰ Expressing the same feeling of dismay, Jan Stjernsward et al., write that across the continent of Africa, the response towards the end-of-life cares has been a kind of piecemeal with governmental and non-governmental organizations playing a range of roles to them.¹⁰⁹¹ Just recently, palliative medicine is offered as an undergraduate course at the College of Medicine, at the University of Ibadan, and as postgraduate diploma in a privately owned University in Ilorin, Kwara State, both in Nigeria, respectively.¹⁰⁹²

However, be it that as it may seem, lack of recognized care centers does not imply that Africans do not care for their loved sick brethren. Those who are so much acquainted with the African cultures may not be surprised that hospice centers are not so common in this region. As I

had earlier clarified that, the communal life in Africa implies that the people naturally believe in a ‘*compassionate solidarity*’ towards those in specific needs in life. Due to this spirit of communalism in Africa, most palliative cares for patients, especially those in futile situations, take place at their respective homes under the watch of their closed relatives. Again, Odimegwu Onwumere hints that in the African context, there is a kind of popular cultural belief on “*death denial*” among patients, their relatives, and healthcare professionals.¹⁰⁹³ This is the reason that, outside the cares in the family homes, most of the spiritual homes, faith-based healing centers and herbal remedies would be profusely patronized at a great cost to the patient, hoping that ‘*miracle-do-happen*’.¹⁰⁹⁴

With a strong belief that ‘miracle-do-happen’ coupled with the special regard and respect they people have for the ‘dignity’ of life, it would be unthinkable to seek for the practice of euthanasia and physician-assisted suicide at such critical times. Such unethical and illegal practices are outrightly condemned, forbidden and prohibited by the cultural norms or laws of the people. Thus, I am fully aware and ever ready to defend the fact that Africans are ready to care, provide, and show love to the sick to ensure a dignified end-of-life. Therefore, since the continent still has a long way to go with this kind of palliative care or approach, Jan Sternsward et al., make clarion call to this generation of healthcare providers to provide patients with this multi-sectorial and multidisciplinary approach of care in Africa.¹⁰⁹⁵

6B. 3. 4. *Palliative Care: Application of ‘Tronto Models’ of Care:*

The notion of care, according to Sara Ruddick, shows that it is an ongoing process. It is an act or perspective that considers the other’s needs first, which arises from good and proper disposition of a caregiver.¹⁰⁹⁶ In the same vein, Virginia Held views care as an inner disposition that stems from the spirit of compassion or benevolence. By this, she tries to state that care is

more of a moral obligation in the context of human social relationships than the mere description of an individual disposition.¹⁰⁹⁷ Medically, once a cure is no longer possible, then palliative care can be introduced as the last resort.¹⁰⁹⁸ Thus, once treatment has gone beyond ordinary to extraordinary means to support a patient, every assistance should be left within the realm of palliative care. So, the primary goal of palliative care is to relieve pains and suffering of the patients, in view of ensuring a dignified end-of-life.¹⁰⁹⁹ Likewise, the Catechism of the Catholic Church clearly articulates that those whose lives are diminished or weakened deserve special respect, love and adequate care. As such, palliative care is viewed as a special form of disinterested charity that ought to be encouraged, since dependency is part of life.¹¹⁰⁰ According to Nectoux M., et al., caring in this sense implies a relationship of assisting the patients by means of interpersonal therapeutic process.¹¹⁰¹

To provide proper care for the dying patients, Berenice Fisher and his colleague, Joan C. Toronto propose the basic features or elements of care. These features include ;1- ‘caring about’ or ability to notice the need to care; 2- ‘taking care of’ or engaging in practical responsibilities or steps to care for others; 3- ‘care-giving’ which calls for the practical activity of care that ought to be executed in concrete reality; and lastly, 4 – ‘care-receiving’ which simply suggests the expected response of that which is cared for in the caring process.¹¹⁰² Leveraging on these features, Joan C. Toronto then formulates her own proper models of care which revolve around the four basic ethical elements of care, viz: ***attentiveness, responsibility, competence, and responsiveness.***¹¹⁰³ According to her categorization, Joan C., maintains that the first moral aspect of model of care is ‘attentiveness’. This requires human sensitivity or ability to recognize the needs to care for others like patients in critical stage of life. So, care ethics would claim that ignoring or being indifferent to people’s needs, is considered as a moral evil. This is clearly

illustrated in Hannah Arendt's account of 'banality of evil', as manifested by Adolf Eichmann, during the Nazi killings or horrible experience.¹¹⁰⁴

The second model of care is 'responsibility', and its equivalent element is 'taking care of'. It simply attempts to project 'responsibility' into a central moral category. This element of care is considered as a practical set of implicit cultural practices, rather than a set of formal rules or series of theories.¹¹⁰⁵ Also, the third model of care emphasizes on the importance of 'competence' of care as a moral notion. Thus, it all depends on the result of the actions to be taken, to determine the level of moral competence in caring. So, all intentions to care must be morally good in themselves worthy to be actualized. The last is 'responsiveness', which showcases an important aspect of moral problem within the caring relationships. For instance, care in this context, is naturally concerned with conditions of vulnerability and inequality. The moral precept of responsiveness, as Robert Goodin notices, requires an absolute alert to the possibilities of abusing the patients, which may result with their conditions of vulnerability.¹¹⁰⁶

Thus, in such accompaniment while providing adequate care, the following steps are highly recommended: 1- Ability to listen to the patient's agony expressed in words, cries, fears, and silences; 2 – The need to show respect for the other, in her or his body, beliefs, mystery, and unshakable solitude; 3 – Being efficient enough to apply the highest level of competence toward the patients, and; 4 – the need for spiritual support that provides 'a breath of life' until the end-of-life.¹¹⁰⁷ At this point, I can easily make my submission that, palliative care is meant not to hasten nor postpone death, but it offers a kind of support system to help patients live as actively as possible until a dignified death occurs. This is the primary role of palliative care.¹¹⁰⁸

Conclusively, it is so glaring that every human life moves on a direct steady pathway to its end. As such, the best medicine can offer to humanity is to promote, improve and protect life

and health of each person. All these can be achieved by curing diseases that may threaten life and health, alleviate both terminal and chronic pains and sufferings due to illness. These are the primary goals of medicine.¹¹⁰⁹ However, in serious ill cases, a treatment may produce a futile result to a terminal patient. At this critical point, a terminal patient may request for some therapeutic options for the disease management after diagnosis. A competent patient and the family can decide for caregiving, continued treatments, hospice or palliative care, and at worse, to end his or her life by requesting for euthanasia or physician-assisted suicide. Although, in the whole scenarios, medical professionals, especially in Nigeria, are ethically obliged to make recommendations on the services available to terminal patients.¹¹¹⁰ Even when all the interventions are medically futile, patients still have time to prepare for advance care planning like ‘advance directives’ and ‘living wills’ that can facilitate end-of-life decisions and cares. Since the imminent death is inevitable, patients can still strive to experience a dignified end-of-life.¹¹¹¹ Most people like ethicists believe that palliative care offers the patients a good opportunity to make the right decisions regarding their treatment goals and quality of life.¹¹¹² Therefore, no matter the conditions a terminal patient may be into, there is no justification to compromise with the goals of medicine to satisfy one’s wishes, interests, requests, etc. Hence, death must not be hastened, either by the process of euthanasia or physician-assisted suicide. With special respect to personal dignity, and relying on human solidarity, I vehemently agree that life at this stage can be managed and cared for through palliation till the end-of-life.

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Chapter Seven

7.0 Conclusion

Evaluation:

So far, it is so evident in the foregoing bioethics critique that human life is a sacred gift from God. Basically, this is the hallmark of the sanctity and dignity of human life. As such, the ethical implications of these assertions invoke the obligations to care, protect and improve the quality of life at all stages of human existences. I am confident to note that it is only medicine that has the capacity to care, safeguard and improve the quality of life than any other known human disciplines. According to John Saunders, medicine is a science and an art that calls for solidarity of persons while caring for human life and health. With the recent advances in this field, contemporary medicine has broken bounds into biomedical sciences, biomedical research, genetics, medical technology.¹¹¹³ Very fundamental to every medical activity is the respect to life and dignity of human person. Indeed, one of the major roles bioethics plays in modern medicine is to ensure that both human life, dignity, rights and value are accorded with utmost respect in all biomedical activities. According to Rizwan Taj, et al., bioethics contributes to the rights and responsibilities of both the patients and physicians as persons in the fiducial caring relationships. Its significance replicates in different aspects of medicine, e.g., clinical care, scientific research with human beings and overall community (public) health.¹¹¹⁴ Obviously, in this bioethics critique that focuses more on the Nigerian healthcare system, the dissertation has done so well to touch these three major aspects of medicine. So, the application of bioethics as Hans Jonas clearly remarks, is to ensure that medicine does not fail to respect the moral values in its practices, otherwise this might cost its most dazzling triumphs not worth having.¹¹¹⁵

The care for human nature is the foundation of medical practice. As such, bioethics

still has major roles to play and will continue to exert enormous influence on the recent evolution of traditional medical ethics. Its relevance and applications to modern scientific evolutions and research with humans are vital, and so, should not be undermined. It is quite interesting that the scope of bioethics continues to expand its horizon in response to the ethical challenges in the societal dynamics, medical technology, health care practices and on the issues related to the end-of-life. This expansion or evolution of bioethics is in a double sense: *globalization* and *concrete operability*. Despite this expansion in scope and applications, bioethics is criticized as deeply rooted in and largely dominated by the Western thoughts and cultures. This dominance, as observed by Mkhize N., has given rise to most of conflict of interests, especially in the global collaborative biomedical activities.¹¹¹⁶ In other words, the Western approach to bioethics gives rise to a kind of ‘one-size-fits-all’ set of principles. For instance, some of the issues that fall under the purview of western bioethics are - *doing good* (beneficence), *avoiding harm* (non-maleficence), *respecting people and their communities* (autonomy), and *justice* - are principles of global concern, but their applications are situated within different cultural contexts.¹¹¹⁷

In a pluralistic society, diversity is an undeniable reality. Today, the entire humanity can boast of more than 6 billion people who speak over 6000 languages, living in about 200 countries, with multiple ethnic, social, religious, political and cultural backgrounds. So, to think of the globalization of bioethics, all these different human backgrounds should be given proper attention for their respective voices to be listened to, at least. This tries to state that, it will be very difficult for the modern pluralistic society to adopt a kind of uniform ethical posture, opting for the plurality of cultures, beliefs, opinions, etc.¹¹¹⁸ Most often, bioethical concerns may be considered as global issues. By implication, it shows that bioethics itself should not be

exclusively viewed as the domain of a particular group of people. This is because, as Godfrey B. Tangwa clearly remarks that, core bioethical values are considered essentially the same for all human communities leaving aside each community's customs, cultures and preferences.¹¹¹⁹ In this light, Van R. Potter sees in bioethics as “the application of ethics to all of life”.¹¹²⁰ Therefore, it is expected that bioethics as a discipline needs to expand more of its vision and horizon in more broad sense to accommodate different ways of moral thinking in a diversified humanity, regardless of location, race, culture, etc.¹¹²¹

The objective of applying bioethics in the healthcare system is primarily intended to provide quality care, to reduce, or if possible, to eliminate all medical malpractices within the area of clinical medicine and scientific research investigations with human beings. Above all, this objective also includes disease prevention in the sector of public health. So, it beholds on new bioethics to analyze each problem before determining the right procedures.¹¹²² However, the application of bioethics, especially in a heterogenous and developing countries like Nigeria, is still fraught with multiple challenges due to a lot of differences among peoples from different ethnic backgrounds. The fact remains that, posterity can bear witness that multiple efforts have been made to upgrade the Nigerian health sector, which ranges from operating with more qualified medical personnel and infrastructures, supported with big financial budgets from the government or NGOs to the formulation of medical codes, but still, much is yet to be accomplished.¹¹²³ Therefore, the following positive practical steps have been proffered to enhance and improve the application of bioethics in a multicultural milieu (for example in Nigeria), namely:

7.1: Culture and Cultural Competence:

(Bio)ethics is culture bound. The relationship between bioethics and culture

is an inseparable one. For instance, bioethics is applied in human communities, and each human community has its own moral codes such as laws, norms, traditions, cultures, etc. As such, any society that functions without these moral indices will automatically slide down into an unfortunate abyss of failure and total collapse. While discussing on the topic “Bioethics takes root in Nigeria”, Steve Goldstein notes that bio(ethics) has the capacity to increase the awareness on the importance of respecting a ‘collective humanity’. This can be understood as a unified diversity among peoples. For him, the mastery of other culture will make it easy for the application of bioethics in most scientifically and medically rigorous activities to avoid malpractices.¹¹²⁴ As such, Ben Gray rightly advocates for the need to be acquainted with different cultures and its related concept of cultural competence.¹¹²⁵ This is because, ethics for David R. Matsumoto, is culturally bound with regards to values that are real and normal.¹¹²⁶

Again, as bioethics is related to basic human rights, it has also evolved to the point of giving an almost unlimited due respect to all human beings, regardless of their cultural backgrounds, etc.¹¹²⁷ To clarify further, some cultures may be so willing to encourage and legalize abortion, euthanasia, or physician-assisted suicide, while a traditional African may look at any of these as grievous transgressions that must be resisted by all means.¹¹²⁸ So, any deliberate effort to terminate the pregnancy or kill another person is considered as a direct murder, serious violation against life, dignity, and above all, against God Himself. In a reverse situation, female circumcision in the western world is viewed as causing harm and an unethical practice, while in some African countries, some forms of it may be seen as a harmless normal cultural practice.¹¹²⁹ Though, global bioethics is expected to acknowledge and respect different cultural realities, it must not compromise with the key moral values. To achieve this objective, bioethics should engage in critical ethical reasoning through the means of dialogue or

deliberation process, but not as set of principles that must be imposed or maintained. Hence, there is need for cultural competency for bioethics to record more success in the pluralistic society like Nigeria.¹¹³⁰

Besides, the value of respecting other cultures implies that healthcare purveyors must dispose themselves to accommodate essentially pluralistic perspectives of other cultural differences.¹¹³¹ By so doing, they will be able to refrain from assuming that their patients share their own perspectives. To provide culturally competent care, clinicians need to think proactively to make their patients from other cultural backgrounds to feel at home and be able to communicate in their language as well. This, no doubt, will demand for an ongoing learning process and flexibility.¹¹³² In conclusion, Tom L. Beauchamp insists that cultural competence like ethical relativism, opposes any form of imperialism of clinicians' imposing their views on others.¹¹³³ At this point, I would equally suggest that some 'rigid cultures' need to be disposed and receptive to accept the fundamental bioethical principles for the promotion of life and dignity of human person.

7.2: Bioethics Training / Awareness

Basically, the primary purpose of education is meant to increase and improve human knowledge, virtue, behavior, responsibility, etc. Likewise, I am sure that a bioethics academic program will be an essential tool for character development, knowledge, skills and behavior that may serve to enrich the trainees' moral sensibilities. Reflecting on its pedagogic goals, Cletus T. Andoh believes that such an awareness training in bioethics will equip the trainees to be able to identify with conflicts of values, increase their sensitivity to morally perplexing issues, and then be able to address them, bioethically.¹¹³⁴ Also, Andoh attests that studies like these will equip the learner with bioethical awareness, attitudes, knowledge, confidence, decision-makings

capabilities, objective moral reasoning, etc., to be able address biomedical challenges, ethically and justifiably. As such, teaching bioethics should be considered as a moral imperative, especially in the developing countries due to the recent scientific innovations.¹¹³⁵

No doubt, medical training is so tedious with a long period of moral uncertainty for many people. Unfortunately, my little interactions with some medical experts and students in Nigeria and beyond reveal that, a lot of them still need to upgrade their level of knowledge of biomedical ethics. As an attempt to save them from such an embarrassing ignorance in medical field, Delese Wear suggests that all those closely working in the field of medicine should be properly exposed to the knowledge of biomedical ethics as a means to get rid of any possible unintended medical malpractices, either in clinical settings or in the area of scientific research with human beings.¹¹³⁶ It is very interesting to note that there are such ongoing programs already, specifically meant for medical students, health professionals, ethics committee members, and others, precisely at the University of Ibadan, Nigeria. Though, according to the report released by MacLawrence K. Famuyinwa, the number of students enrolled for the program is still not encouraging.

However, the objective of such training is to build the capacity for ethical review of clinical issues and scientific research studies, to strengthen ethics committees, to form pool of bioethics professionals and academics in Nigeria and beyond.¹¹³⁷ It is good to know that there are ‘Nigerian Institute of Medical Research (NIMR)’ and ‘Advance Research Ethics’ training in Southern Africa (ARESA) that promote responsible research by offering a postgraduate Diploma/Masters level educational program to the interested healthcare professionals from different parts of the world. Therefore, for Andoh T., all efforts should be harnessed to improve bioethics training and awareness on bioethical issues in the Africa region. So, appropriate

structures for deliberation and action on bioethical issues must also be put in place.¹¹³⁸ For people like Temidayo O. Ogundiran, such should be considered as a top priority, which can be achieved through the organization of ethics conferences, workshops, national bioethics conferences, the public media and Non-Governmental Organizations (NGOs).¹¹³⁹

7. 3. *Formation of Bioethics Committee*

The formation of an Ethics Committee in any healthcare system is to ensure that medical practices and experimentations with human beings respect all ethical standards articulated both in the national and international bioethical laws or policies. Of course, the establishment of research ethics boards, as pointed out by Ogundiran O., has not absolutely resolved all the ethical problems of biomedical research.¹¹⁴⁰ However, the approval and justification of medical activities are mainly based on the application of bioethical principles. This approval, as William W. May observes, does not exclude the potentiality of risks, violation of rights and integrity of the individuals, with special reference to informed consent.¹¹⁴¹ So, once there is a lack of adequate preparation at the beginning of a scientific investigation, there is a likelihood that the outcome may be unethical and invalid. Consequently, in most of the unregulated medical activities, the life and health of human persons are always exposed to unexpected high risks. In effect, to ensure the safety of life, especially for the participants in scientific research, May W., opines a thorough ethical review of entire procedure before the commencement of the scientific research.¹¹⁴²

As earlier noted, it is to be recalled that the ‘Pfizer Troval’ trial is one of the incidents that provoked peoples’ consciousness to emphasize more on the establishment of an independent monitoring research ethics committee in Nigeria. This incident is also known as “the perfect storm of events”. During this period, there was one of the largest ever epidemic of

meningococcal meningitis in Nigeria with about 300,000 cases and 30,000 fatalities.¹¹⁴³ As of the time the Pfizer firm came with her team of researchers, with the dual missions “to manufacture Troval drug and conduct its trial”, there were yet “no” functional ethics research committees in some of the country’s medical institutions. Unfortunately, Jacqui Wise observed that without any monitoring ethics committee on the Pfizer trial, the five children that were given trovafloxacin died, and the same thing happened to the other six that received ceftriaxone.¹¹⁴⁴ As earlier noted above (cf. 5A. 2. 2.), the Nigerian government termed this trial as ‘an illegal and unethical trial of an unregistered drug’.¹¹⁴⁵ It was judged unethical because people like George J. Annas discovered that Pfizer did not obtain neither authorization from the Nigerian government nor informed consent from the parents,¹¹⁴⁶ before giving the unproven drug to nearly 100 children and infants.

Therefore, it is the responsibilities of an ethics committee to ensure that medical malpractices are reduced, or if possible, eliminated, and that voluntary informed consent of the human participants for research is given before the commencement of a research, etc. According to Lawrence K. Altman, provided the patients or participants in research understand the details (risks – benefits ratio) of any ethical issues in medicine, then the voluntary informed consent may be given, freely.¹¹⁴⁷

7. 4: *Bioethics: Towards Formulation of Stringent Policies*

According to Bethany J. Spielman, in his work titled “Bioethics in Law”, the application of bioethics helps to conceptualize ethical problems, elucidate essential values, and influence in the establishment of legal doctrines, policies, codes, processes, etc. As for him then, two things that must stand out in the application of bioethics for utmost consideration are – *respect to personal dignity and human solidarity (collaboration)*. This is to ensure consistency in

the institutional responses to certain issues that bioethics may or may not be able to resolve alone.¹¹⁴⁸ With special regard to the dignity of human person, and relying on the principle of human solidarity, I equally admit that it is very necessary that each government (Nigeria) should play more active roles to improve its health sector to ensure more positive results in caring for the life and health of her citizens. Thus, it requires a network of ‘human solidarity’ with other non-governmental agencies, groups, individuals, and private sectors. In this respect, the WHO conceptualizes that, a constituted authority (government) is a guardian of social commitments and values such as dignity, solidarity, justice and equity.¹¹⁴⁹ Invariably, this clarion call by the WHO implies the formulation and implementation of stringent policies to improve and regulate service deliveries in the health system. The WHO also notes that the ministries of health are obliged to engage in periodic assessments of the health systems in terms of equity, quality improvement, and efficiency and population satisfaction with their respective health services.¹¹⁵⁰

Today, there are many healthcare policies in Nigeria, but the major problem lies in the implementation of these policies.¹¹⁵¹ In this respect, Akin Oyemakinde laments that there is no serious strong institutional (bioethics) framework for regulating the quality and standards in the health system.¹¹⁵² Considering the contemporary bioethical challenges, he advocates for an urgent review of old policies and formulation of new national health policy to reflect new realities and trends in modern medicine. Such a new policy will equally consider on how to realize the unfinished health plans of the Millennium Development Goals (MDGs) and the new Sustainable Development Goals (SDGs).¹¹⁵³ The overall objective is to strengthen the Nigeria’s health system, especially within the primary healthcare sub-system, to deliver effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians.¹¹⁵⁴ For the healthcare system to bear a new outlook, it is now highly imperative for all

the three levels (federal, state and local) of government, in partnership with other non-governmental actors, to ensure the widespread dissemination and implementation of the health policy.¹¹⁵⁵ As previously remarked, Lawrence Gostin affirms that the goal of bioethics and health policy are intended to protect and promote the health of individuals and the human society at large. This can be achieved in ways that should respect personal dignity, human rights, including the right to self-determination, privacy and nondiscrimination. Hence, since modern health policy is challenged with complex legal, ethical, and social questions, bioethics is meant to provide an ethical framework for the development of sound health policy for better treatment and scientific research outcomes.¹¹⁵⁶

Permit me to reiterate my position that the essence of this bioethics critique is not meant to undermine the previous efforts made by healthcare personnel in places like Nigeria, nor as an opportunity to engage into unnecessary debates or comparisons with other cultures. For clarity of purpose, it is specifically intended to show the importance and urgency for the proper application of bioethics in a healthcare system that appeals for more positive transformations, respect to human life, personal dignity, and value. As far as I am concerned, there is a great need for human solidarity to ensure better results for the patients' safety. It then suffices to add that, if medical knowledge should be considered as the basis in caring for life and health, I can easily affirm with Bakul J. Parekh that bioethics remains the essence of the practice of medicine. This is because, once proper bioethics are applied to medical activities, it will look like a 'proverbial icing' on the cake. According to Parekh J., for medicine to succeed in its endeavors to care for human life and health, it must rely on bioethics that respect the values, attitudes, preferences, interests and personal dignity of each patient.

As for me, when *medicine* and *bioethics* come together, it is the latter that makes the former to look more “humane” in the treatments of life and health. This is because bioethics as new concept, is capable to address most of the controversial ethical issues emerging from modern medicine and scientific technology.¹¹⁵⁷ Evidently, the bridge between bioethics and medicine is highly essential, natural and imperative. In its multidimensional nature, this “Bioethics Critique” has offered the dissertation best opportunity to make certain ethical analyses and recommendations towards improving healthcare system, with special reference to Nigeria, for better clinical practices, scientific research with human participants, addressing public health issues, and ensuring a dignified end-of-life. Hence, this is the objective of the dissertation: ***A Bioethics Critique of the Healthcare System in Nigeria: Personal Dignity and Human Solidarity.***

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