ORIGINAL ARTICLE

The Right to Die Via Euthanasia: An Expository Study of the Shari’ah and Laws in Selected Jurisdictions

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ABSTRACT

The right to die, which prominently includes euthanasia with consent, is one of the issues that have been subject of intense debate over times. It has been a pertinent issue in human rights discourse as it also affects ethical issues pertaining to doctors. The reason is because the right to life, which represents the most significant aspect of human rights, appears to be in conflict with the right to die. It is notable here that right to life does not include right to die. The paper analyses the development, types and the legal and ethical debates concerning both the types of euthanasia. From there, it makes an expository study of the concept in the Shari’ah and in selected jurisdictions, and suggests that euthanasia should be allowed only in exceptional situations. While deciding on formulating a law prescribing these exceptional situations and enforcing the law, all aspects of euthanasia – medical, social, economic, ethical and legal – have to be taken into consideration. Law should have punitive measures for preventing misuse of the law.

Key words: Right to die, Euthanasia, Right to life, Life support system, Human rights

Introduction

Euthanasia connotes an easy, quiet and painless death to a process that involves intentional ending of the life of a patient suffering from incurable or terminal illness either initiated by the patient, privy or the doctor in charge. Because of the sanctity of human life enjoined by law, society and religion, issues pertaining to euthanasia became one of the most contentious issues today. Notwithstanding of the total facts, it may be at the request of the patient or his guardian if the patient is not in his senses, only in exceptional situations. Death, which is inevitable, has continued to be feared by human kind. Yet, nobody wants to live a life full of enduring sufferings. This sprang up the aphorism that man’s destiny must lie in his hands being an imaginary right to terminate one’s life through euthanasia on consent, i.e. physician assisted suicide.

The right to life represents one of the most important human rights in every jurisdiction. This is because a person can only enjoy all other rights if he is alive. All jurisdictions consider life as sanctimonious and thus make the right to life an essential part of human rights in international human right documents and constitutions of all countries of the world. [For example, Article 4 of the African Charter on human and Peoples’ Rights; section 33 of the Constitution of the Federal Republic of Nigeria1999; Article 21 of the Indian Constitution, and Article 5 of the Federal Constitution of Malaysian.] This creates a challenge to the proponents of right to die. This is because life and death is Allah’s domain, and that medical doctors will be playing with His right if they are to put an end the life of a willing terminally ill patient.

In militaries of some countries, there is a practice known as ‘save our souls.’ This signifies that the killing of soldiers captured by the enemies by the soldiers of the same country. This is done to prevent the soldiers from revealing secrets to enemies after being brutally interrogated. Thus, they would decide to bomb their own soldiers together with the enemies. It is also done to relieve the pains that their soldiers might be subjected to by the enemies. They, therefore, assist in quick death of their own soldiers together with their enemies. This is a form of assisted suicide or mercy killing. The law, however, has not developed to cover these situations at the war fronts. This shows that some questions still remain unanswered so far euthanasia is concerned.

There is a need to distinguish some related concepts from euthanasia. Euthanasia differs from assisted suicide, in which a patient voluntarily brings about his or her own death with the assistance of another person,
definitive summary of the Common law but was also a primary legal authority for 18th and 19th century Centuries later, Sir William Blackstone destroyed one’s self is contrary to Nature and a thing most horrible.

lethal dose of medication to a patient, or passive, such as when life-sustaining treatment is withheld or removed, allowing the patient to die in his underlying position (Kamisar, 2001). In either case, someone, other than the patient, is finally responsible for the patient’s death. Assisted suicide involves a more direct action by the person who dies under euthanasia. For example, in a case of assisted suicide, although a physician may prescribe a lethal dose of medication, the patient administers the medication to himself or herself. This paper examines in the development of the concept of euthanasia, its types, ethical concern of the practice of euthanasia, and to make an expository study of the position of the legal and regulatory framework of the positions in the West, some parts of Asia, Nigeria and Islamic law.

The Development of Euthanasia:

History has revealed that euthanasia has been accepted, in some or the other forms, by various groups or societies some decades back. In ancient Greek and Rome, assisting others to die or putting them to death was permissible in some situations. For example, in the Greek city of Sparta, newborns with severe birth defects were put to death. Voluntary euthanasia for the elderly was an approved custom in several ancient societies (Nancy B. v. Hotel-Dieu de Quebec, 1992, 86 FDLR 385, Canada). However, as Christianity developed in the West, euthanasia became morally and ethically repugnant and was seen as a violation of God’s gift of life. Today, most branches of Christianity, Judaism, and Islam condemn active euthanasia, although some permit restricted forms of passive euthanasia.

Euthanasia and assisted suicide have their roots in the beliefs and practices of the ancient Romans and Greeks, (Lawal A. H., 2008). To them, euthanasia did not imply the hastening of death. Their concern was whether or not the person died an easy death. They put much emphasis on dying good death. The Greek and Romans found the compassion needed when dealing with those who are terminally ill. They are allowed the least painful mechanism from their present situation, which was filled with a general feeling of discomfort and pain. The Romans and Greeks were sympathetic towards the act of euthanasia, provided it was done for the right reason, for example to end suffering during a terminal disease. They are in harmony with freedom to live to the extent that it permitted the sick and dying to end their lives.

For over 700 years, the Anglo-American common law tradition had criminalised or otherwise detested any form of assisting suicide. In the 13th Century, Henry de Bracton (Bracton, Laws and Custom of England 423 f. 150), one of the first legal treatise writers, observed that ‘just as a man commit felony by slaying another so may he do by slaying himself’. The real and personal property of a person who killed himself to avoid being convicted and punished for a crime were forfeited to the king.

Other late medieval eminent authors followed and restated Bracton. By the mid 16th Century, the court at Common Bench observed that ‘suicide is an offence against Nature, against God and against the King..... To destroy one’s self is contrary to Nature and a thing most horrible. (Hales v Petit, 1561-1562).’

Centuries later, Sir William Blackstone whose commentaries on the laws of England not only provided a definitive summary of the Common law but was also a primary legal authority for 18th and 19th century American lawyers, referred to suicide as ‘self murder.’

As years passed by, the American colonies abolished these harsh common law penalties. Zephaniah S., (1796), who later become the Chief Justice of Connecticut, where in 1766 opined that ‘there can be no greater cruelty than the inflicting of a punishment as the forfeiture of good, which must fall solely on the innocent offspring of the offender.’

Though deeply rooted, the state-assisted suicide bans have in recent years been re-examined and generally reaffirmed. This is because of advances in medicine and technology. A lot of people today are increasingly likely to die in institutions from chronic illnesses.

The concern of the public and policy makers are focused on how best protect dignity and independence at the end of life; with the result that, there have been many significant changes in state laws and in the attitudes these laws reflect (Vacco v. Quill, 521 US 793). Many states in the USA for example, are now permitting living wills surrogate health care decision-making and the withdrawal or refusal of life support system or sustaining medical treatment.

Euthanasia like any other practice, developed over times from a stage of explicit prohibition to the recent stage of acceptability in some places, while some other societies are giving it some little considerations by amending laws that generally used to prohibit it (People v. Kevorkian, 447 Mich 479). An example of this is the permission of living will in many states in the USA.

In 1920, the book “Permitting the destruction of life not worthy of life” was published. In this book, authors, Alfred Hoche, M.P, a Professor of Psychiatry at the University of Freiburg, and Karl Binding, a
Professor of law from the University of Leipzig, argued that patients who asked for death sentence should under very controlled condition, be supported to obtain it from a physician (Lawal, 2008). This book helped support involuntary euthanasia by Nazi Germany. This indeed marks the starting point in the agitation for Euthanasia.

**Types and Notable Cases on Euthanasia:**

For the purpose of analyzing the types of euthanasia, the paper seeks to put these different concepts under the two headings of (a) the doctor’s participation and (b) the patient’s involvement.

**A. The Doctor’s Participation:**

The doctor’s participation could be through: (1) administering lethal treatment (2) withholding life-sustaining support; (3) withdrawing life-sustaining support; or (4) assisting the patient to administer lethal treatment (physician-assisted suicide).

This four-fold classification of the doctor’s action cut across the distinction that is often drawn between actively taking steps to end life (such as administering a lethal injection or giving the patient the means of doing so) and passively withdrawing or withholding treatment such as removing or not attaching a patient to a ventilator. Sometimes, this distinction is expressed as killing and letting die or as active and passive euthanasia.

This four-fold classification relies on the distinction often drawn between the doctor providing assistance with the preparatory steps for ending life (such as giving a patient drugs with which he can commit suicide) and the doctor actually executing the life-ending action himself (such as administer a lethal injection or removing a ventilator). This is procedural distinction between the two, which will facilitate discussion on the ethical and legal debate.

A patient’s life could be shortened by the intentional administration of life shortening treatment or by the deliberate provision of assistance for patient to self-administered lethal treatment. The law on these issues is that the doctor commits murder if he causes a patient’s death by actively intervening with the sole intention of killing the patient. Where however the doctor does not intend the patient’s death but it occurs as a result of unintended side effect of the withdrawal, he is guilty of murder (Finnis, 1993).

A doctor commits a criminal offence under the law if a patient successfully takes his own life with the doctor’s assistance [R v. Adams, (1957) CLR 201]. The underlying ethical issue is that: should a doctor be allowed to administer anything other than treatment designed to cure a patient and palliative care? [R v. Nedrick, (1986), 8 Cr. App. R. 179] (that is, care mitigating the patient pain and discomfort but lacking curative effect).

In R v. Cox, 12 BMLR 38, Dr. Cox was facing with an elderly patient who repeatedly begged him to end her life and he did. She was suffering from a disease which was causing her extreme pain against which conventional pain-relief was proving to be ineffective. He administered a lethal dose of potassium chloride, a drug that stops the heart but has no therapeutic or pain relieving value. Since she was terminally ill and her body had been cremated, it was difficult to prove that the injection had killed her. Dr. Cox was therefore charged with attempted murder. He was convicted and given a 12 month suspended prison sentence. It might have been a different story if Dr. Cox's choice of life shortening drug had had pain-relieving or therapeutic value (Re T, 1993).

The continued criminalization of assisted suicide under section 2 (1) of the British Suicide Act 1961 remains ethically controversial. However, in law, a patient who refuses life-sustaining treatment is not treated as committing suicide. In Bland’s case, Lord Goff emphasized that ‘when a patient is refusing treatment, there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in doing so.’ It is that the patient has, as of right, (NHS Trust v. S., 1999), to decline to consent to treatment, which might or would have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient’s wishes (Re B 2002).

Therefore, a doctor who complies with a valid refusal of treatment is not viewed as actively ending or assisting in the ending of a patient’s life and is, in fact required to comply with a capacitated patient wishes.

**B Patient’s Participation:**

There are situations where the patient is apparently competent to consent or withhold consent and situation where the patient apparently lacks such competence. Where steps are taken to end the life of competent patient, these can be taken either with the patient’s consent or against the patient’s will. This is sometimes expressed as the distinction between voluntary and involuntary euthanasia.

Where the patient appears to have requested that action be taken to end his life or that life-saving treatment be stopped with full knowledge that his will lead to his death, explains what voluntary euthanasia is. Involuntary euthanasia is a situation when a patient’s life is ended without the patient’s knowledge. This may mean that the patient is kicking and screaming and begging for life, but in practice it usually means that the patient is
unconscious, unable to communicate, or is too sick and weak to be aware of what is happening or to take any action on his own behalf.

Where the patient appears to lack the competence to participate in an end of life decision, the decision to end the patient’s life is often referred to as non-voluntary euthanasia. Non-voluntary euthanasia captures those situations where the patient is simply not capable of understanding the choice between life and death.

Life prolonging treatment can be rejected by the patient either for the present time (contemporaneous refusal), or for a future time if the patient expects to lose lost capacity (an advance refusal). Conversely, a patient could make a contemporaneous or advance direction that a particular type of treatment is to be administered (Airedale NHS Trust v. Bland, 1993 AC 789). In addition, a patient who expects to lose capacity could seek to appoint a substitute decision maker (an appointed proxy) tasked with the responsibility for deciding when future treatment should be refused or tasked with the responsibility for interpreting the instruction that the patient leaves.

The courts have repeatedly declared that an adult with capacity has an absolute right to refuse medical treatment, even where this will result in death. In fact, the failure to respect a free and informed refusal given by a patient with capacity will constitute both the tort of the trespass and the crime of assault (Re AK, 2001). A patient dying of heart disease is entitled to refuse to continue taking anti-biotic to combat a life-threatening infection, no matter how strongly they are recommended by his doctor. The House of Lords in Bland’s case confirmed that complying with a valid refusal of medical treatment is not unlawful act but is legally required.

In Ms B’s case, the rupture of a blood vessel in her neck had paralysed from her neck down thus needed of a ventilator to breath. While her life expectancy remained normal, there was no real prospect of recovery. The doctors refused to comply with her request for ventilator to be removed. Ms B was left with no alternative but to apply to the High Court for a declaration. Butler P. Sloss emphasised on the well-established principle that an adult with capacity is entitled to refuse all life prolonging medical treatment. Completely satisfied the rule that plaintiff had capacity, the presiding judge declared that continued ventilation was unlawful. Ms B was transferred to another hospital where she died after being removed from ventilator.

Our focused had been on voluntary end of life made by those who have competence and capacity. It is therefore pertinent at this stage to examine the stands of that patience in permanent/ persistence vegetative state (that is patient who are not competent to decide their fate).

In the UK, like any other place in the world, there are between 1000 and 1500 diagnosed as being in a vegetative state from which they are not expected to recover. They suffered serious brain damage, which deprived them of the capacity for consciousness. Such patients are believed to be unable to see, hear, taste, smell or feel pain. Yet their brain stem continues to function, their heart continues to breathe, they sleep, they wake, and some even appears to smile and frown. And with adequate care, the patient can remain in a vegetative state for years or even decades.

Patients who have been in such a wakeful state of unconsciousness for a sustained period of time were first described as being in persistent vegetative state over thirty years ago. After a vegetative state has persisted for a certain length of time, modern practice is to describe it as permanent to signify a prognosis of irreversibility.

In 1994, the Multi-Society Task Force in the United States (Multi Society Task Force on Permanent Vegetative State Report 1994) declared that it was reasonable to assume a permanent vegetative state (hereafter PVS) after one year in traumatic cases and after six months in non-traumatic. The Royal College of Physician has recommended longer period of six months for the latter type case. According to the group, the diagnosis of PVS “may reasonably be made when a patient has been in a continuing vegetative state for more than twelve months or following other cases of brain damage for six months”

In Herczegfalvy V. Austria, 1993, 15 EHRR 437, it was held that a measure was a therapeutic necessity couldn’t be regarded as inhuman or degrading. The Court further opined that the withdrawal of treatment from patients in PVS in accordance with a reasonable body of medical opinion was for a purpose in accordance with the best interest of the patient.

Ethical Concern on Euthanasia:

Many ethical questions for experts in the field of medicine have been raised on the issue of euthanasia. In the United States, the ethical code of physicians has long been based in part on the Hippocratic Oath (Beauchamp, 2008). This requires physicians to do no harm. However, since medical ethics are refined over time, the definitions of harm change. The right of patients to refuse life-sustaining treatment before the 1970s, (passive euthanasia) was controversial. As a result of various court decisions, the right is nearly commonly acknowledged today, even among conservative bioethicists.

The debate on active euthanasia is intense, mainly because of the opposition it receives from religious groups and many members of the legal and medical professions. Those who oppose voluntary active euthanasia argue that health-care providers have professional obligations that prohibit killing (Smith, 2005). They maintain that active euthanasia is contradictory to the roles of nursing, i.e. being caring and healing. They argue further
that allowing physicians to engage in active euthanasia creates intolerable risks of abuse and misuse of the power over issues concerning life and death. They conceded that particular instances of active euthanasia might occasionally be morally justified. However, opponents argue that permitting the practice of killing would, on balance cause more harm than benefit.

The approach of opponents of physician assisted suicide (PAS) and voluntary lethal treatment Voluntary Lethal Treatment (VLT) is to appeal to the allegedly harmful consequences of legalization. One fear is that of abuse, whereby PAS and VLT will take place without proper informed consent (Diane Pretty’s Case, 2001. In this case she was allowed by the European Court of Human Rights that she has no right to choose to die.) because patients can be coerced, their mental illness or incompetence will be overlooked, or optimal palliative care will not be offered or available. Other fears are directed at the wider consequences of allowing PAS and VLT, such as the likelihood that psychological distress will be caused to surviving family members or to patients who fear that their doctor will kill their will.

Those who argue in support of voluntary active euthanasia opine that, in certain cases, relief from agony and pains (rather than preserving life) should be the primary concern of health-care providers (Beauchamp, 2008). They argue that the rights of patients should be respected and his decisions on euthanasia be respected. They argue further that since society has acknowledged a patient’s right to passive euthanasia (for example, by legally recognizing refusal of life-sustaining treatment), active euthanasia should be given similar recognition. They lay emphasis on circumstances in which a patient’s condition has become overwhelmingly burdensome for him. They argue that in such a situation, pain management for the patient is inadequate, and only a physician seems capable of bringing relief. They also point out that almost any individual freedom involves some risk of abuse and argue that such risks can be kept to a minimum by using proper legal safeguards. Proponents of the legalization of PAS and VLT often appeal to patient autonomy and argue that legalization is required to realize maximal patient autonomy. (Lawal, 2008). Thus, whether euthanasia is right or wrong, or whether it should be allowed or prohibited depends on the legal and regulatory framework in various jurisdictions. The paper will, therefore, make an expository study in selected jurisdictions.

Position of Euthanasia in the Selected Jurisdictions:

Here, the paper makes an expository study of the positions of the legal and regulatory framework on euthanasia in some countries of the world, where the issue of euthanasia has been raised one time or the other.

Position in the West:

In the United Kingdom euthanasia is illegal. Anyone found to be assisting suicide is seen to have committed an offence and can be convicted of assisting suicide or attempting to do so. Although two third of Briton think it should be legal, a recent the Assisted Dying for the Terminally Ill Bill (2006; between 2003 and 3006 four Bill were presented before the legislature for legalising assisted euthanesia, but all were rejected) was turned down in the lower political chamber, the House of Common by a 4 to 1 margin. Currently, Dr. Cox is the only British doctor to have been convicted of attempted euthanasia. He was given a 12 month suspended sentence in 1992.

In 1995, the Northern Territory of Australia became the first jurisdiction to explicitly legalize voluntary active euthanasia. However, the Federal Parliament of Australia overturned the law in 1997.

In the United States, euthanasia is illegal in most States. Attempt to legalize euthanasia and assisted suicide resulted in ballot initiatives and legislation bills within the United States of America in the last twenty (20) years. However, four states had already legalized it the U.S. Margaret, 1997).

On December 5, 2008, the Montana State District Court Judge Dorothy MacCarter ruled in favour of a Terminally Ill Billing residence who had filed a law suit with the assistance of Compassion and Choices, patience’s right group. The ruling states that competent ill patient has the right to self-administer lethal doses of medication as prescribed by a physician. Physician who prescribed such medications will not face legal punishment.

Ballot measure 16 in 1994 established the Oregon Death with Dignity Act (Oregon, 1988-1995) which legalizes physician assisted dying with restrictions, making Oregon the first U.S state and one of the first jurisdictions in the world to officially do so. The law survived an attempted repeal in 1997, which was defeated at the ballot by a 60% vote. And in 2005, the United State Supreme Court ruled 6-3 to uphold the law after hearing argument in the cases of Gonzales v Oregon.

In 1999, the Texas State passed the Texas Futile Care Law. Under the law, Texas hospital and physicians have the right to withdraw life support measures, such as mechanical respiration, from terminally ill patient when such treatment is conceived to be both futile and inappropriate.

In 2001, Netherlands legalized active euthanasia and assisted suicide, formalizing medical practices that the government had tolerated for years. Under the Dutch law, euthanasia is justified (not legally punishable) if the physician follows strict guidelines. It is justified if (1) the patient makes a voluntary, informed, and stable
request; (2) the patient is suffering unbearably with no prospect of improvement; (3) the physician consults with another physician, who in turn concurs with the decision to help the patient die; and (4) the physician performing the euthanasia procedure carefully reviews the patient’s condition. Officials estimate that about 2 percent of all deaths in The Netherlands each year occur as a result of euthanasia.

In 2002, the Parliament of Belgium legalized active euthanasia under limited conditions (Adams, 2003). Like the Dutch law, the Belgian law allows physicians to perform euthanasia only for patients who are suffering unbearably with no hope of improvement. The patient must make a voluntary, well-considered, and repeated request to die, and the request must be put in writing. Other physicians must be consulted to confirm the patient’s condition. Additionally, each act of euthanasia must be reported to a government commission for review.

In Albania, euthanasia was legalized in 1999. It was stated that any form of voluntary euthanasia was legal under the Right of the terminally ill Act. Passive euthanasia is considered legal should three or more family members consent to the decision.

In Italy, euthanasia is criminal offence. However, public plea is set to change government policy towards it. In September 2006 Plerigiogio Welby sent a videotape to Italy’s president, Giorgio Napolitanio asking to be granted the right to euthanasia. Welby a 60 years old man suffers from progressive muscular dystrophy and is on a respirator, he is fed by a feeding tube, and communicates through a voice synthesizer. The president responded with a letter saying that he hoped euthanasia would be discussed in parliament.

In Switzerland, deadly drug may be prescribed to a Swiss person or to a foreigner, where the recipient takes an active role in the drug administration (Article 115 of the Swiss Penal Code).

Position in Some Parts of Asia:

In a first step towards legalizing euthanasia, the law commission of India, Ministry of Law and Justice has recommended legislation that would permit a terminally ill patient family to request a physician’s assistance in euthanasia. If the physician agreed, the request will be considered by a government-appointed committee of three expert physicians to investigate into it.

In Thailand, the National Health Act has come into force as of 20 March 2007. The Act contains the provision in relation to euthanasia as follows: “A person shall have the right to express in a written form the intention not to receive the public health service as provided for prolonging the death in the final stage of his or her life or for extinguishing the suffering occurred from illness.”

The legal framework in Malaysia on euthanasia is yet to develop fully. At the moment, where a person intentional causes hastens the death of another, he is said to have committed the offence of murder especially if there was no consent of the patient (Section 300 of the Penal Code (Amendment Act, 1989 Act 727). The position is still the same if the patient consents (Section 299 of the Penal Code (Amendment Act, 1989 Act 727) at it amounts to culpable homicide. Thus, the law precludes active steps to terminate an ill-patient life. The major ingredient of the offence is intention. Where this is established, the reason for such intention has no relevance in law.

Position in Nigeria:

The position of the Nigerian law on euthanasia is crystal clear. Customary law in Africa in general and Nigeria in particular considers suicide as a taboo and an abomination. However, this is not to refute the fact that euthanasia is totally unknown to Africans, as history presented a form of euthanasia practiced in the ancient times, where the people see it as an act of self respect, self determination and bravery, and instances of this were popular during the slave trade and inter-tribal wars.

It is important to state here that a type of compulsory euthanasia was practiced by the beleaguered Nupes in Niger state of Nigeria as well as other ethnic groups in Nigeria during the inter and intra tribal wars of the 18th-20th century. During this period, infants who due to some illness or physical pain (including acute hunger and thirst) and who cried ceaselessly, while their family or parents took refuge in a cave or other hideouts were killed to avoid possible discovery by the marauding slave traders.

Indeed, this type of compulsory euthanasia was commonly practiced. Parents while fleeing from their military adversaries as a rule flung away their own little children when the cries became too loud and long not to attract the attention of the enemy, and abandoned them to die. More so, in the Oyo Kingdom, during the pre-colonial era, if the Are Ona Kaka Fo (the person in charge of war) should lose a war, he would be required to commit suicide. Nevertheless, suicide is seen as offence under the Nigerian criminal law.

It is however, a fact that the African society generally negates the use of euthanasia. This rejection is even more pronounced in Nigeria because of the religious consciousness of the populace. Eighty –five percent (85%) of Nigerian could be said to be either Christians or Muslims and as such that affect people’s negative perception towards euthanasia.
The most prominent problem euthanasia is going to face in Nigeria is that of the cultural belief of the people. Many African societies would criticise PAS viewing both the practice and policy as morally unacceptable, because life is believed to be sacred and depriving a person of a life is generally thought to be an abomination. Attached to this cultural problem is the position of Islam (Qur’an 5:32; Qur’an 6:51 and Qur’an 4:29) and Christianity (Burdette, 2005) which totally rejects the idea of euthanasia as they both regard it as one of the greatest sins that a man could ever commit, while enjoying their adherents to shy away from such act.

Another challenge that the legalization is bound to face is that of abuse. This fear of abuse is fundamentally covered in the slippery slope theory (Attal, 1981). The claim here is that allowing these practices will lead to a shift towards increased instances of induced or assisted death in circumstances where appropriate treatment exists, where the patient is not terminally ill, where patient is not ill at all and where the competent patient has not provided any consent at all. The slippery slope theory could even posses a more dangerous effect in a country like Nigeria where there is a large scale of illiteracy and inadequate access to genuine information.

A major setback that the legalization of PAS may face is the difficult hurdle of law-making that it must cross. This will even be more difficult because there is no known movement, society or organization that carries the right to die banner in Nigeria. Therefore, there is none to lobby on the ground of the House for the advancement of the legalization of PAS in the country. If by luck or work, it crossed the legislation-making hurdle, it will also be a major assignment on the part of lawmakers and the draftsmen to understand the intricacies involved in making legislation for euthanasia. This is a problem because experts on this subject are needed and unfortunately there are few in Nigeria who will help to synthesize the entire public on the legality or otherwise of the concept of euthanasia.

Shari’ah Position:

In Surah al-Hajj, Allah (s.w.t.) says: “It is He who has given you life, then He will cause you to die, and then will bring you back to life. Man is indeed ungrateful The Holy Qur’an, 22: 66. Further verse in the Holy Qur’an: “We give life and cause death, and to Us all will return” (The Holy Qur’an 50:43). This means that to Allah (s.w.t.) belongs life. It is only He who can take it. Any unjustifiable means of taking it is haram and amounts to murder. Thus, in Surah al-Nisa’, Allah (s.w.t.) says: “Whoever kills a believer intentionally will be punished in hellfire where he will stay for eternity. He will incur the wrath of God, who will curse him and have a terrible penalty in store for him (Quran 4: 93).”

The Prophet’s (s.a.w.) traditions also show that killing a human being is one of the greatest sins. He was reported as saying: “The most serious of cardinal sins are ascribing a partner to God, killing a human being, being undutiful to one’s parents, and making a false statement, and in another version of the hadith “and giving a false testimony” is added. The Qur’an in prohibits a person from committing suicide. In Surah al-Nisa’, Allah (s.w.t.) stated to the effect: “Do not kill yourselves as God has been to you very merciful” (Qur’an, 4:29). Thus, the sanctity of human life is inviolable in Islam. Islam prohibits killing a human being with no justification, and prohibits committing suicide. Thus, Islam does not recognise killing a person to ease his suffering even though it is at the request of the person notwithstanding the nomenclature given to it such as, active voluntary euthanasia, assisted suicide or mercy killing and the procedure involved. The Prophet enjoins a person in such circumstance to make Dua’ by supplicating Allah to take his/her life only if that would be better for him/her. In fact, Allah (s.w.t.) will use the pains suffered by that person to cleanse his sins. A person in such situation should persevere patiently with the available medical treatment. As stated in Surah al-Zumar, where Allah (s.w.t.) stated to says: “And those who patiently persevere will truly receive a reward without measure, (Quran 39:10)” the reward is not only in this world but also in the hereafter. Based on the preceding discussions, we can say Islam prohibits all kinds of euthanasia.

Conclusion:

Right to life does not include right to die. It is for this reason that there have been long discussions on all kinds of euthanasia, including with consent of the ailing person. It developed with the development of time as a result of the advancement in science and technology. The law, therefore, draws a distinction between actively and passively taking a patient’s life. Both withholding and withdrawing life support system or any other life-sustaining treatment are, in law, omissions. No legal wrong is committed by an omission, unless there is a legal obligation to act, which will be absent where a patient validly refuses treatment or where the treatment is not in the patient’s best interests. This represents the positions in the some jurisdictions, especially in a number of the Western countries.

End of life decisions involve demands for increased patient’s autonomy with respect to his life. Some patients fear that their lives will be sustained beyond the point that they consider compatible with a meaningful existence. Thus, they wish to refuse life and prefer to die in pain or distress not capable of being addressed by
modern palliative care. Yet, others request voluntary lethal treatment (VLT) and physician assisted suicide (PAS) simply as a means of exercising their autonomous decision that their life is no longer worth living.

Again, there seems to be no moral difference between killings and letting die. Thus, the attempt at differentiating between active and passive euthanasia appears to be of academic level only. It is suggested that both passive and active euthanasia should be declared illegal. They may be allowed only in exceptional situations taking all factors – social, medical, economic, moral and legal - into consideration. There should be punitive measures for preventing misuse of the law.

This area is a very sensitive proposition, as it deals with death, which is quite irreversible in the event of any mistake. Thus, necessary care must be taken by all those concerned to avoid later complications. However, where the patient’s death is inevitable and the pains become unbearable, the dignity of the individual, his decision to choose death over painful life and the intractable pain he suffers may justify the rightness of euthanasia.

However, Islamic law presents the best policy on the issue of euthanasia. Killing a person for the purpose of easing his pains, in whatever name, has no basis in Islamic law. It is prohibited and should not be encouraged under any guise, even if it is at the request of the patient. A Muslim has not only to live in this world but also in the hereafter for eternity. The patient perseverance in the period of pain earns him a great reward in the hereafter. The authors are of the opinion that this aspect of Islamic law should be reinterpreted within the premises of the Qur’an and Sunnah on the basis of collective ijtihad to let the patient suffer the agony of pain, let the close relatives of the patient in stress, or to let him or his relatives choose to continue with life support system or to withdraw it. The social, economic, and medial dimensions of euthanasia, which have not been discussed in this paper, should also be reconsidered. Unless we take all related factors together, we cannot reach to viable rules governing euthanasia.

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