

## **A THEORETICAL DEFENSE OF VOLUNTARY EUTHANASIA IN THE CONTEXT OF AIDS TERMINAL ILLNESSES IN ZIMBABWE**

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### **ABSTRACT**

This paper argues a case for voluntary euthanasia in view of the plight of AIDS patients in Zimbabwe, even though such a practice is perceived to be foreign to the African traditional worldview. It first shows that the HIV and AIDS pandemic has seriously challenged the capacity of Zimbabwe's health delivery sector to provide requisite cure and care to HIV and AIDS patients. Secondly, it argues that home-based care initiatives have failed to meet the challenges posed by the HIV and AIDS scourge. Finally, the paper argues for the moral justification of voluntary euthanasia as a panacea to the unbearable life of pain and suffering that characterizes the terminal stages of AIDS, primarily on the grounds of mercy and non-violence.

**Key Words:** Caregivers, Discrimination, Pandemic, stigmatization

### **INTRODUCTION**

The AIDS pandemic is perhaps the worst public health problem to have afflicted human race with devastating effects since the 1980s. It has presented serious and realistic challenges to Zimbabwe's health delivery system and the world, in general. The Ministry of Health and Child Welfare's estimates show that there are more than 1.8 million people living with HIV in Zimbabwe (The Standard, 2006). Zimbabwe's human population is estimated at 13 million. Therefore, the number of people living with HIV and AIDS is 14% of Zimbabwe's total population. This is a significant percentage of the Zimbabwe's total population and it is a matter of utmost concern within the health delivery system and the society at large. The AIDS scourge has put to test the capacity of Zimbabwe's health delivery system to meet the ever-increasing number and needs of AIDS related illnesses and complications for equitable and humane treatment.

It has also challenged the capacity of the health profession to respond to epidemics because it has exposed the limitations of clinical medicines that, up to now, have virtually little to offer to the terminally ill and dying AIDS patients. AIDS has no known cure to date. The failure of the medical profession to come up with a cure and cope with the AIDS pandemic has led to the critical need of home-based care initiatives to fill in the huge gap left by the inability of the health delivery system to cope with the rising number of terminally ill AIDS patients. However, home-based caregivers have also been morally and financially overburdened and overwhelmed by the rising number of HIV and AIDS patients and the poor economic situation. It is in view of this sad situation that this paper argues for voluntary mercy death as a panacea to the plight of the terminally and chronically ill HIV and AIDS patients.

## **THE IMPACT OF HIV & AIDS ON ZIMBABWE'S HEALTH DELIVERY SYSTEM**

AIDS has posed the greatest challenge to the human race's efforts to realize its full potential because of its devastating effects on its health and well-being. It has become the major cause of illnesses and death in Africa. In this regard, the World Health Organization Report indicates that AIDS is the leading cause of death in Africa, among all the major medical conditions, accounting for 22.6% of total deaths in the year 2000 (Zimbabwe Human Development Report, 2003). Its effects on Zimbabwe's health delivery systems is devastating (Bond, 2001) and has led to unprecedented pressure on the health delivery system as cases of AIDS illnesses are increasing on a daily basis. Home-based care programs have been muted in an endeavour to prop up the health delivery system whose inadequacies have been severely exposed by the AIDS scourge. The care of terminally ill AIDS patients has also morally and financially burdened family caregivers as a result of an increase in family members who are falling victim to the life-limiting disease. It is the contention of this paper, therefore, that voluntary euthanasia can be morally justified in an attempt to lessen the burden on both the health delivery system and the home-based caregivers.

Zimbabwe is one of the countries in the world with the highest HIV and AIDS prevalence rate. HIV has infected an estimated 1.8 million Zimbabweans, which is 14% of Zimbabwe's estimated total human population of 13 million people. Although the HIV and AIDS prevalence rate is said to be on the decline in Zimbabwe due to concerted campaigns to educate people on how to prevent themselves from getting infected and infecting others, it still remains one of the highest HIV and AIDS prevalence rates in the world. The prevalence rate of AIDS in Zimbabwe stood at 24.6% in 2004 and is reported to have declined to about 18.1%, according to a 2006 demographic health survey (The Chronicle, 2006b). The disease has not spared any race, gender, or age group.

The AIDS pandemic has seriously exposed and challenged the capacity of the health profession to cope with the disease of an epidemic proportion in that little has been done, so far, in trying to find a cure to the disease. To date, HIV and AIDS has no known cure. What the medical profession has managed to do, so far, is to come up with drugs called anti-retroviruses that help to reduce the effects of HIV and AIDS and slow down the progression of HIV to full-blown AIDS. Anti-retroviral drugs (ARVs) can prolong the life of an HIV/AIDS patient if taken regularly. A good diet is also crucial in enhancing the health of AIDS patients. ARVs are not a cure to HIV and AIDS, but have been proven to prevent an early death (The Standard, 2006).

However, the full wrath of HIV and AIDS has been felt among the poor because they cannot afford a regular dosage of the life sustaining and prolonging ARVs. Locally manufactured ARVs are more expensive because of the high costs of raw materials, as compared to imported ones. The imported ones were reported to be sold for at least Zimbabwe \$20,000, while locally manufactured ones were going for least Zimbabwe \$25,000 per monthly course (The Chronicle, 2006a). Some HIV and AIDS patients are not even aware that there are such drugs that can prolong their lives and improve their health. As a result, their health further deteriorates and they continue to face insurmountable difficulties in trying to come to terms with their condition, which is often characterized by stigmatization, pain, and suffering.

The failure of the majority of HIV and AIDS patients to access the ARVs means that more HIV patients are falling sick, thereby visiting clinics so often. The failure of HIV patients to access the life prolonging drugs means that they may die early or their condition will quickly develop into full-blown AIDS. This has put pressure on clinic and hospital beds, and

has become costly to the health delivery system because of the specialized medication that the chronically and terminally ill AIDS patients require in order to regain a better health. AIDS patients normally occupy hospital beds for long periods of time and have, therefore, proved to be a burden on the health delivery system that has to offer services to patients with other health conditions. The pressure exerted by HIV and AIDS patients on the health delivery system that is already struggling to provide efficient services to the nation is immense. As a result, the idea of home-based care was muted to fill in the gap left by the inability of the health delivery sector to cope with the increasing number of chronically and terminally ill AIDS patients.

### **HOME-BASED CARE & SUPPORT INITIATIVES**

Home-based care and support refers to all AIDS activities that are based outside conventional health facilities, namely hospitals, clinics, and health centers, but which may have strong linkages with the formal health and welfare sectors (Chiweza, 1997). These initiatives are meant for people who have life-limiting illnesses or illnesses that are no longer responsive to curative measures, such as full-blown AIDS. AIDS patients require long term care (palliative care) (Holmes, 2003) and this care cannot be provided by health institutions given the rising number of AIDS patients, as well as the length of time these patients are often bedridden. Every human being has a right to quality care irrespective of his/her health condition. Family members administer day-to-day quality patient care at home, while medical doctors and counsellors chip in when the need arises (Hubley, 1990). Home-based care is good for the patient because the home environment is familiar and family members are in a better position to understand and tolerate, among others, the unusual changes in moods and food requirements of the patient. Therefore, home-based care and support programs have greatly lessened the burden on the health delivery system to cure and give palliative care to AIDS patients, given the increase in people living with the disease and the inability of health institutions to cope with the pandemic.

The government of Zimbabwe recognized the catastrophic impact of the AIDS pandemic on its citizens and has declared HIV and AIDS a national disaster that requires the state's assistance in the welfare of people who are living with HIV and AIDS. It has, therefore, established a levy that is meant to assist in the delivery of care for people infected and affected by HIV and AIDS. All workers who are formally employed pay the AIDS levy to the central government. The Zimbabwe National AIDS Council (NAC), which is under the Ministry of Health and Child Welfare, distributes the funds obtained from the AIDS levy to various AIDS groups (National AIDS Council, 2004) throughout the country and also channels part of the levy to the ministry so that it buys antiretroviral drugs for the government's ARV scheme. However, the Ministry of Health and Child Welfare is failing to fully meet the demands for ARVs for those who are living with HIV and AIDS.

According to estimates, there are more than 1.8 million people who are HIV and AIDS positive in Zimbabwe and, out of these, about 600,000 are in dire need of ARVs, but only about 42,000 are accessing the drugs in both the private and public sectors because of foreign currency shortages (The Chronicle, 2006a). The price of ARVs is too high that the majority of AIDS patients cannot afford them. In addition, most family caregivers are financially incapacitated to afford the life prolonging ARVs, other medications for opportunistic infections, and special dietary requirements of the AIDS patient. This has made the life of AIDS patients miserable and filled with episodes of pain and suffering as their health further deteriorates.

AIDS patients, therefore, face a miserable death where they are not able to buy all the food and medication they need. These deprivations can lead to the degeneration of the condition of the patient to terminal illness. This complex interplay between poverty and a sickly health compounds the plight of AIDS patients in Zimbabwe. In addition, providing care to terminally ill AIDS sufferers is too demanding on family members and can lead to severe feelings of moral failure and resentment as the slow process of dying takes its toll on both the patient and the family caregivers. Although many people are made to hopefully believe that HIV and AIDS infection does not mean imminent death, the perpetual uncertainty, recurrent infections and illnesses, fragile health, and the slow and painful process of dying can, in themselves, impact negatively on the commitment of caregivers to continue offering care to terminally ill AIDS patients (Turshen, 1989). Family members of a terminally ill AIDS patient suffer greatly (Barnett & Blaike, 1992) because of the emotional attachment to the patient. They are also subjected to intense anger and resentment that is often directed at them by their dying relatives. They, therefore, experience an intense, emotional crisis that make their lives unbearable.

AIDS patients and their caregivers also face public humiliation (Bethel, 1995). Outsiders identify the AIDS patient with his/her family members. As a result, they tend to treat both the infected and the family members with utmost fear of being 'infected' as a result of associating with them. In most societies in Zimbabwe and elsewhere, if a member of a given family is known to be an AIDS patient, the whole family, including the caregivers, are shunned in churches and traditional gatherings because of the fear of getting 'infected'. AIDS patients and their caregivers, therefore, feel rejected and discriminated against by being treated as if they are outlaws. Benyenzaki points out that embracing or shaking hands with someone is important because not doing so is regarded as a sign of rejection and resentment (Dossier, 1990) in the African world view. Despite attempts to demystify the beliefs held by most people on how AIDS is transmitted, most people do not want to embrace, shake hands, or share a meal with an AIDS patient for fear of getting 'infected'. Treating AIDS patients with such suspicion will further worsen their already severely weakened health and alienate them from the moral community.

Surprisingly, AIDS patients also suffer rejection, stigmatization, and humiliation from parents and relatives. Stigmatization is a complex social and psychological process whereby certain persons are perceived as without social value, even threatening the well being of the dominant society (Jonsen, 1995). Family members and caregivers may get fed up with the unpredictable changes in moods and food requirements of the patient, huge medical bills, and the time they have to commit in giving the patient quality care. As a result, they may neglect the patient thereby compounding his situation.

In addition, AIDS patients have to endure both a disease that has no known cure and the stigmatized social response that can only make living with AIDS more difficult. Therefore, home-based care initiatives have failed to totally solve the multiplicity of challenges being faced by AIDS patients in Zimbabwe. Under such circumstances, a terminally ill AIDS patient may contemplate quitting life so that his isolation, pain, and suffering are ended.

The concept of home-based care, itself, promotes discrimination and segregation against terminally ill AIDS patients. It shows that the medical profession has resigned the life of AIDS patients to fate. When hospital staff tells a terminally ill AIDS patient to go home and be cared there, obviously, he will feel discriminated against. He will feel that he is being treated like an inferior being and this is emotionally and psychologically disturbing on the part of the patient. Terminally

ill AIDS patients may think that their continued existence is a burden to both the health sector and the home-based caregivers. As a result, they may rationally and competently opt for a mercy death.

### **VOLUNTARY EUTHANASIA & TERMINALLY ILL AIDS PATIENTS**

Euthanasia refers to a gentle and easy death. It is a term that comes from two Greek terms “eu” (good) and “thanatos” (death) (Boss, 1999). Proponents of euthanasia see it as “... the most humane intervention possible for patients whose suffering cannot be alleviated through other medical means” (West, 1993). Euthanasia is, therefore, a good death because it is the end of a patient’s pain and suffering. It is a term that is now being used to refer to killing of patients who are incurably ill and in great pain or distress, for the benefit of the one killed (Singer, 1993). The life of the one who requests to be killed is painlessly taken away because the patient dies through a peaceful and pain free way that is normally administered by a physician. Euthanasia is voluntary, if the person killed is rational and competent enough to request or give informed consent about a particular action that will lead to his/her death. So, voluntary euthanasia is administered at the request of the person killed. West (1993) argues that a patient’s right to request physician assisted death “...is based on the belief of self-determination and bodily integrity”. Patients have the right to refuse life-extending medical treatment if they do not see any sense in prolonging their misery on earth. Brock (1995) understands ‘self-determination’ as meaning “...people’s interest in making important decisions about their lives for themselves according to their own values or conceptions of a good life, and in being left free to act on those decisions.” Self-determination, so understood, would, therefore, implore us to respect decisions of fully informed and competent patients to refuse life-prolonging measures, albeit a miserable one, in favor of a quick death.

The devastating effects of AIDS in Zimbabwe have activated calls for voluntary euthanasia as a way through which perennial pain and suffering, gone through by the terminally ill AIDS patients, can be ended. In their terminal stage illness, AIDS patients experience unbearable emotional stress, pain, and suffering that they think that the desire to quit life is strong enough to override the desire to continue living. AIDS patients normally die a pitiable death after years of degenerating into physical and mental disintegration. Their lives become unpredictable (Daniel, 1998) as opportunistic infections deprive them of a sound health and a dignified life. It is our considered view, therefore, that if an AIDS patient rationally and competently feels and decides that his life must be ended, then physicians must assist him in ending his life. Refusing him the right to end his life is insensitive because it simply worsens his situation. Thus, voluntary euthanasia can be morally justified in the context of the terminally ill AIDS patients.

The French Father of Modern Surgery, Ambrose Pare, argues that surgeons must be courageous enough in their work despite the possible dangers (Jonsen, 1995) they expose themselves to in dealing with a disease that can easily be transmitted from one person to the other. Pare’s reflections on caring for people infected with a plague is coated in religious innuendos and it implores health care givers, physicians, and surgeons to take great risks in caring for the sick. In the sixteenth century, Paré (Jonsen,1995) noted that:

[Surgeons] must remember that they are called by God to this vocation of surgery: therefore, they should go to it with high courage and free of fear, having firm faith that God both gives and takes our lives as and when it pleases Him.

The AIDS pandemic has reactivated Pare's position on the duty of physicians to care for AIDS patients. It brings about the difficult question of the duty to treat terminally ill AIDS patients. Although physicians may accept treating AIDS patients, the fear of getting infected normally makes them reluctant to treat them. AIDS patients feel discriminated and segregated against because physicians do not give them the kind of attention that they deserve. Failure to treat AIDS patients in a humane way leads to the deterioration of their health and dignity as members of the moral community. In such a situation, an AIDS patient may opt for an assisted quick and pain free death and physicians must aide him in realising his goal.

In some countries, such as Netherlands, people who are suffering from incurable diseases and perennial pain and suffering may ask their physicians to assist in ending their lives in a pain free and dignified way (Singer, 1993). However, allowing physicians to assist in the death of patients would make them murderers. Most countries, including Zimbabwe, do not accept the role of physicians as killers, even in situations whereby a patient voluntarily requests the physician to end his life. Human life is considered good in itself and, therefore, not expendable for any purpose or goal. A person can waste away in a state of helplessness for a long period of time, but no mortal being is qualified to take away his life or consent to that patient's desire to die. At the same time, the physician is supposed to respect the patient's autonomy and self-determination when he decides to forfeit his life in favor of a quick and pain free death. The physician is, therefore, torn in between the legal sanction not to kill or aid the death of a patient and a patient's autonomy and self-determination to die. The Oath of Hippocrates that forbids medical practitioners from taking part in the death of patients says that "Never will I give a deadly drug, not even if I am asked for one, nor will I give any advice tending in that direction" (Boss, 1999). It is meant to discourage medical practitioners from arbitrarily taking patients' lives irrespective of the terminal stage of their illness. It also discourages physicians from facilitating the death of terminally ill AIDS patients, even if they request to be killed.

A medical practitioner is not even supposed to advise a patient to opt for mercy killing. Giving medical practitioners the responsibility to determine life and death may lead to a very serious abuse of euthanasia whereby physicians kill people on the pretext that the patient has asked to be killed. However, in certain circumstances where a terminally ill AIDS patient is experiencing severe bouts of pain and suffering and requests to die, he must be assisted to die. The physicians' refusal to accept a patient's request to be killed in a pain free way may be regarded as a form of injustice and violation of that patient's autonomy and self-determination. So, if a rational and competent patient freely chooses to die, it is morally right for physicians to assist him.

For Singer, if a rational and self-conscious being desires to end his life when he foresees a future of extreme suffering and pain, then the desire to die may take the place of the normal desire to continue living. The principle for respect of autonomy and self-determination requires us to respect rational moral agents' autonomous decisions to live their lives as they wish. Society and the medical personnel have no moral right to deny a terminally ill person's desire to quit life since he freely chooses to forfeit his life. A person may opt for mercy death because he foresees a future of gloom and doom if he continues to live. In actual fact, it is morally wrong for physicians to prolong the life of a terminally ill AIDS patient against his will. So, in the context of a terminally ill AIDS patient, the desire to live may be forfeited by a desire to die and the physicians ought to assist him to end his life.

Some people would argue that euthanasia is a concept that is foreign in the African worldview. This is so because among Zimbabwean societies and beyond, death of a person is dreaded and should be avoided by all means possible and, for this reason, people take traditional life prolonging concoctions. This also manifests itself through other methods of prolonging life, such as setting up a stone lintel in a secluded place where animals and people do not reach and upset the trap, namely curves, forest thickets, and mountains. The ritual involves crashing a rock into powder and the person who wants to live longer must take the mixture of the powder, concoctions, and porridge before he sets up the stone trap. This ritual ensures longevity of the person's life. As long as the trap is not upset, the person who would have set the trap would not die early. Some could even live for more than hundred years. At the same time, people fear the atomic solitariness of old age when one's peers are all dead that he wishes if he were dead because of the stress associated with his old age and fragile health. As a result of his poor health and solitariness, he asks his close relative to go and upset the stone lintel so that he can die. This can be equated to voluntary euthanasia whereby the one who no longer values life decides to quit it. In light of this, therefore, voluntary euthanasia is not new in Zimbabwe, but has been in existence since time immemorial.

The moral quandary faced by the relative asked to upset the stone lintel is similar to the one that faces a physician. Failure to accede to the demands of the sick to have an accelerated death is a form of injustice against the elderly or the patient. Among the Shona people of Zimbabwe, assisting in the death of a person who would have set up a stone lintel by upsetting it upon his request does not raise significant moral questions because it is something that is widely accepted in their way of life. Therefore, it is morally prudent for relatives and physicians to satisfy the wishes of the dying relatives to have a quick death, given the pain and suffering they undergo.

However, it is very doubtful whether a terminally ill AIDS patient's decisions can be said to be rational. For Aristotle (Norman, 1986), the proper function of a human being is only possible when one's rational faculty is able to suppress the appetites and inclinations. In the case of a terminally ill AIDS patient, it seems as if appetites and inclinations overpower the rational faculty so that his decision to quit life cannot be relied upon. The situation of a person who is chronically and terminally ill can be equated to that of a pregnant woman undergoing birth pains. She may even ask the nurses in attendance to kill her in order to end her temporary pain. However, if a terminally ill AIDS patient is asked, on different occasions, whether he really does require a mercy death and he remains consistent, then it is morally right for the physician to consent to his request to have a quick death for his own good.

The multiple problems faced by terminally ill AIDS patients invoke feelings of sympathy and mercy in the physicians. In Zimbabwe, health services have been heavily commercialized so much so that antiretroviral drugs and other medications are beyond the reach of many people in both rural and urban settlements. This has contributed to the ongoing trauma of AIDS patients. In view of the sorry state of health of terminally ill AIDS patients, physicians ought to consent to his desire to die on the grounds of mercy. The severe pain and suffering experienced by the patient must be enough to morally justify the patient's desire to quit life. It is actually a burden to both the patient and the caregivers, in terms of material and moral support, to prolong the life of the patient whose hope of recovery is slim. So, it is morally prudent to consent to a patient's desire to be killed.

It has been noted that even though ARVs can prolong life, they will never help in addressing the social issues that make life difficult for AIDS patients (Smith, 1991). ARVs do not address the problems associated with the social meaning of AIDS. They do not deal with the problem of stigmatization and segregation of AIDS patients in society and the attendant negative consequences they have on AIDS patients. Thus, people living with AIDS have to face an early death with little hope of survival, given a serious lack of adequate social support and the unavailability of medical cure for HIV and AIDS. The social and psychological traumas that AIDS patients have to contend with, therefore, justify their decision to quit life by opting for a mercy death, rather than perpetuating their misery on this earth.

Others have, however, argued that home-based care should be the only reasonable alternative to AIDS terminal illnesses in Zimbabwe. They argue that people who are terminally and chronically ill require compassionate care and not a quick death. Zimbabwe was the first country in Africa to set up hospice and palliative care services in 1979 (The Standard, 2006). Palliative care is long term care given to a person with life-limiting illnesses that are no longer responsive to curative measures. This form of care is aimed at improving the quality of life by reducing or managing pain and psychological and spiritual matters, as well as supporting the patient's family. Since everyone has a right to quality care, the people living with terminal illnesses in Zimbabwe must be counselled so that they do not choose a quick death. The effectiveness of counselling, in the context of a disease that has no known cure to date, is questionable. The low quality of life and unpredictable occurrence of opportunistic infections and the reality of a painful and slow death (Quill, 1995) make a permanent impression on the minds of AIDS patients than the counselling they receive from health workers. As a result, the AIDS patient who strongly feels that life is no longer worth living may justifiably opt for a mercy death.

Voluntary euthanasia is, therefore, morally justified in the context of terminally ill AIDS patients in Zimbabwe. The increasing number of AIDS patients in Zimbabwe has overwhelmed home-based caregivers in that AIDS patients have specialized medical and dietary needs, which most family caregivers cannot afford. They may also have fits of insanity so much so that the life of the family caregivers is stripped of human dignity as well. In addition, caregivers are often subjected to abuse and stigmatization at the hands of the members of society who think that the caregivers are as 'dangerous' as the AIDS patient and, therefore, cut any social ties with the infected and his caregivers. So, in such a scenario, an AIDS patient might think that his terminal and chronic condition of illness is a burden to his family and society and, therefore, elects to have a quick death must be allowed and assisted to die.

Most people would like to die a dignified death. The majority of AIDS patients die in abject poverty, unable to buy the food and medication they need (Katabira, Mubiru, & van Praag, 2001), and this state of hopelessness strips them of human dignity and is not worth it. When one's quality of life goes down as a result of chronic and terminal illness and suffering, the desire to continue living can be overridden by a desire to quit life. He may also require a very expensive package of treatment that the already financially burdened family members can no longer manage, given the long illness and the financial costs that goes with it. Therefore, if an AIDS patient rationally and competently believes that his illness has become a burden to himself, the family, and the society, he must be assisted in quitting life.

## **CONCLUSION**

The paper sought to argue a case for voluntary euthanasia in the face of an increase in terminally ill AIDS patients in Zimbabwe. As the number of people living with AIDS is increasing daily, clinics and hospitals are failing to cope with



the pandemic. Home-based care programs have been muted as a solution to the pressure exerted on the health delivery system by the AIDS pandemic. This initiative has helped to free a significant space in clinics and hospitals. The paper, however, argued that home-based care initiatives have failed to absorb the responsibility of caregiving, given a marked increase in AIDS terminal illnesses. Some of the problems faced by AIDS patients are too demanding that caregivers are not able to deal with them, such as the social implication of living with AIDS. It was also noted that the concept of home-based care is a clear sign of discrimination against terminally ill AIDS patients, thereby making their lives a tale of misery and suffering. It is this paper's position that AIDS patients living with terminal illnesses ought to be allowed to seek a quick death, even though doing so is perceived to be against African norms, if they competently and rationally request to die so that they can end their long term pain and suffering, as well as the burden their long term illness has on their family members and society.

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