AN AFRICAN PERSPECTIVE ON ADVANCE DIRECTIVES

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CERTIFICATION

This is to certify that this thesis, titled "An African Perspective on Advance Directives" was carried out under my supervision by Joseph Young ANIAGA.

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DEDICATION

I dedicate this research work to God, the giver of life, and to Late Msgr. (Prof.) F. A. Adeigbo.

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ABSTRACT

Advance directives, a form of oral or written statement in which people declare their treatment preferences in the event that they lose decision-making capacity, are known to exist in various cultures of the world. Existing studies on advance directives in Western medical tradition place great emphasis on individual autonomy to the neglect of communal and other associative ties characteristic of the practice in African tradition. This study, therefore, interrogated the practice of advance directives with a view to bringing to the fore an African perspective – consensus advance directives – represented in Igbo tradition, which is communal in nature.

The study adopted, as framework, Menkiti's notion of the human person which states that the individual is defined by reference to his environing community. Ten relevant texts in Bioethics, especially Meilaender's *Bioethics* (BI), Kuhse and Singer's *A Companion to Bioethics* (ACB), Beauchamp's *Contemporary Issues in Bioethics* (CIB) and six on African thought, particularly, Nwala's *Igbo Philosophy* (IP), Menkiti's *Person and Community in African Traditional Thought* (PCAT) and Metuh's *African Religions in Western Schemes* (ARWCS) were purposively selected. These texts dealt extensively with advance directives and the idea of personhood. Conceptual analysis was used to clarify key terms like advance directives, personhood and community. Critical method was employed in interrogating existing debates on advance directives which emphasised individual autonomy, freedom and choice. Reconstructive method was used to evolve an autochthonous African perspective, herein referred to as 'consensus advance directives'.

Texts on Bioethics revealed that Western culture places emphasis on the autonomy of individual persons, perceived as 'liberty and 'right-claim' holders (BI and ACB). This personalistic conception of the human person is an expression of the Western humanistic tradition, which places premium on atomistic individualism (ACB and CIB). The individual reserves the right to self-determination, and in case of debilitating disease, the liberty to choose the type of healthcare and medical treatment in consonance with his personal convictions, values and beliefs (BI and CIB). Texts on African thought showed that the individual is defined by reference to his environing community, and in case of

medical treatment, people need consensus of the community in arriving at a holistic healthcare decision (IP). This is substantiated by proverbs and aphorisms in Igbo thought such as *Umunna bu ike* (community is strength), *oria ofu onye bu oria ikwu na ibe* (a kinsman's sickness is sickness on the patrilineage) and *nwanna ibi dara na egosiya umunnaya* (one with a diseased scrotum first shows it to his kinsmen). Critical intervention revealed that among the Igbo, decisions concerning the individual's health are taken not without the participatory knowledge and input of the kin group. The centrality of the community in the individual's wellbeing, further indicated the place of 'consensus advance directives' among the Igbo.

The individual in Igbo culture achieves healthcare goals and other aspirations through the fraternal relationship that community affords. Therefore, the African perspective on advance directives as represented in Igbo thought is consensual in nature.

Keywords: Advance directives, Igbo culture, Individual and community, *Umunna*, Medical treatment

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INTRODUCTION

Medicine is the science or practice of the diagnosis, treatment, and prevention of disease; it is a drug or other preparation for the treatment or prevention of disease. It encompasses a variety of health care practices evolved to maintain and restore health by the prevention and treatment of illness.[1] This is the driving force behind the researches in the field of medicine which has made medical science to constantly advance into providing ever better health practices and technologies that helps to promote human life.

In recent times, however, "a new method by which patients can decide what happens to them with regard to what kind of treatment they receive when they are terminally ill or incompetent to take decisions on their own, has emerged. In the medical literature, this new method is referred to as advance directives.[2] Advance directives refer to "instruments which are intended to conclusively establish an individual's preferences in writing with respect to the degree of medical care and treatment he or she desires to receive". The primary goal or objective of advance directives is to provide a means by which a patient is able to determine through the written directives, how he or she wants to be treated when incapable of making decisions regarding preferred treatment[3].

Significantly, while it may seem plausible to practice and promote the practice of advance directives in the world beginning from its starting point, the African society may appear hostile to this practice. Not only will this hostility be expressed in the possible uncommonness (the novelty of advance directives) when Africans become much aware of it, but very few Africans are likely to subscribe to it only on the basis of their being influenced by the globalisation process. To a large extent, therefore, traditional practitioners may not pursue the practice of advance directives since it disrupts their age-long idea of human dignity, coming from their general understanding of the human person, human life and sickness.

From the foregoing ambivalence on the universal acceptance of advance directives, this study assumes its formulation. Its task becomes that of finding exactly what lies behind the African's hostility to advance directives and predict the future

approval of it based on some discovered conditions. In undertaking this task, we shall adopt the Igbo culture as a guide, that is, as providing the basis for the conclusions we shall reach in the work.

In human history, available theories on medical advance directives in existing literature as far as western medical tradition is concerned, place great emphasis on the autonomy of the individual, which empowers them with freedom and choice. This tendency finds easy expression in the positivistic approach to rationality, validity, and other considerations with regard to human life. This forms a basis for what has come to be known as western medical advance directives. The emphasis on the individual and his rights is in contrast to a rather holistic/communalistic perception of reality that underlines the African worldview. This holistic worldview of traditional African culture is absent in most western literature concerning advance directives. This creates a lacuna in the history of research in this area. The Igbo metaphysics creates an ontological base made up of a holistic perception of reality that presents the individual who gives the directives as in union with a hierarchy of being in both space and time- the living, the dead (ancestors), the unborn and the entire community of beings.

In addition, obvious is the fact that contrary to the expectations from the West, advance directives is very foreign to Africans. Were it to exist, it will not be in the form in which it is known today. While it is very possible that some societies in Africa practised some aspect of the Western-type of advance directives in line with the culture, pieces of evidence gathered reveal that referring to advance directives in its present form and nature is alien to Africa. Taking the Igbo society as a medium to look at Africa's present limited acceptance of advance directives, this study attempts to unveil the presuppositions of the African/Igbo's rejection of advance directives. It shall further more look at the perception of advance directives in bioethics.

This study aims at elucidating the meaning of advance directives as it is understood in the bioethics literature. This will help to provide an African understanding to advance directives, using the Igbo culture as a reference point. With this veritable information, the study will advance the argument that the form of advance

directives that will conduce to African cultural ethos will be a "consensus advance directives."[4]

At this point in the discussion, we need to reiterate the point that human life is holistic and consists of a network of realities found in relationships, interactions, memories, identity, fellowships and communality. Therefore, the human person, from an Igbo perspective (as we also find among other Africans), does not own himself or herself exclusively; hence, the nature of the human person must be considered in relationship with others. For this reason, although the Igbo may not be averse to the idea of advance directives, however, all such directives must be in agreement with the living worldview of the people to which a person belongs. In other words, the form of advance directives that the Igbo, and by implication other Africans, are likely to support will be "consensus advance directives."[5] This is the form of directives in which the family and relations of the sick person will have to agree upon after due deliberations and consultation with the elders of the community. Sometimes, because of the nature of the African world, the people may even have to resort to the *dibia* to help consult or elicit the opinion of the preternatural forces in the ancestral realm of beings.

The Igbo believe that the human community is inhabited by a host of beings, both corporeal and incorporeal. Corporeal beings are by nature bodily, physical and somatic. Incorporeal beings are disembodied, spiritual and ethereal. Again, corporeal beings are earthly, mundane and tangible while incorporeal beings are mystical, divine and intangible. A constant interaction is said to exist between these two types of beings or realms of existence, that is, the terrestrial and the celestial. Again, it is said that in trying to reach a decision on important matters of human existence, the opinions of these two modes of beings are counted as vital.

The Igbo believe that life is a gift from God (or the gods, as the case may be). They also believe that it is only God (or the gods) that has prerogative to life. For the Igbo, therefore, since God is the one who gives life, it is he only that can decide whether a person's life should continue, be prolonged or be terminated. The statement is true and well-taken. But since truth, like the coin, sometimes has two sides to it, the other side to this truth is that the Igbo also believe that the relationship between persons

and the gods is mutual and reciprocal. What this means is that for the Igbo, human beings can sometimes differ in their thinking or opinion with the gods, the ancestors or the preternatural forces with whom they have mutual concourse. A popular Igbo aphorism says, "onyekwere, chi'aekwere," meaning: "if a person says, yes, his *chi* will say yes." A person's *chi*, or personal god, is usually taken to be evenhanded, thus allowing that individuals have rights to make certain decisions on their own. Perhaps, this explains why, sometimes, a sick person who is undergoing serious pain may voice a wish to die rather than continue to live in misery and unconscionable anguish.

From the literature, no evidence exists to show that the traditional Igbo practiced advance directives. The only type of directive that is common to the Igbo culture is that which a dying father gives to his son or sons, signifying where and how he would want to be buried when he dies. This type of directive is long-established among the Igbo. Usually, the person giving the directive will point to the exact place or location, in his *obi* or compound, where he wishes to be buried when he dies. Among the Igbo, the parting wishes of a dying parent are taken to be a sacred ordinance that must be obeyed or complied with. What is true here about the Igbo, with regards to the type of directives that are given by parents to children, is also true of other African people in general. But in saying this, we are not oblivious to the fact that cultural values are not static but change from time to time.

For example, the responses we got from the interviews conducted in the course of this study, show that among the contemporary Igbo, opinion varies as to whether advance directives should be practiced or not. There were forty Igbo respondents interviewed during the study. Fifty-five percent of the respondents rejected advance directives, saying it is against Igbo culture. Thirty percent of the respondents was undecided on whether advance directives should be practiced or not. Fifteen percent of those interviewed gave a positive nod to the practice. From the responses given that there are more people who oppose the practice than approve of it. The crucial question to ask is this: what does the above analysis tell us about the nature of culture and people's worldview? The answer to the question is to restate the old fact, which is that culture is not static but dynamic.

The Igbo are famed for receptivity and adaptability to change or new trends. If this claim is true, it is to be expected, that expos to modern education and new trends in medicine help the Igbo to have new perspective to medical procedures that aim to ameliorate pain and lessen the suffering of the incurably sick. It is to be expected also that many will approve of advance directives not only for themselves but for dear relations who are suffering pain and disease. Our findings from the field support this conclusion. However, the type of advance directives which the Igbo, or any other African for that matter, is likely to support is the type we have characterised in this work as "consensus advance directives." What is "consensus advance directives"? This is the form of directives that takes into account the consensus of opinion of one's family, relations and community as a whole. By community in the African context is meant not only the living members of the group but also those members in chthonian mode of being, such as the ancestors and a horde of other relations in the spirit world.

One of the effects of globalisation is that it has reduced the world into one global village where people from different parts interact and are able to appreciate the values of others. Even though advance directives developed from the Western culture, it surely has implications for Africa. The reason is that just as cultural influences are spreading from one part of the globe to the other, it will not come as a surprise if advance directives becomes something that other cultures will someday embrace as part of their medical decision making process. It is also to be expected that Africa will not be immune from such influences. Studying the subject, therefore will help the African community to prepare also for that imminent day. It will also help to provide us with knowledge on how to respond to the critical issues that are likely with regard to the ethical dilemmas that may result from the practice of advance directives. More importantly, the theoretical knowledge to be gained from the study will help allay from any negative outcomes that the practice of advance directives may have on our cultures.

This study contributes to general human knowledge in not only providing us with knowledge on advance directives as an emerging issue in modern medical practice, but also in enabling us to know the African perspective on the subject. It also contributes to knowledge by enhancing our understanding of the inherent problems and possible advantages of advance directives as an emerging trend in modern medicine,

especially in bioethics as a field of study, otherwise known as the ethics of medical research and treatment.

In this study, we shall adopt the Igbo culture and employ it as guide in explaining how Africans are likely to view the whole issue of advance directives. The justification for this is that cultures are not wholly autarchic but also possess some universal elements. Again, the researcher's familiarity with the essential elements in the Igbo culture is another reason for adopting the culture. Having said this, it is important to mention that the way we conceive of the human person will help shape our perspective of the whole issue of advance directives as Africans.

In terms of the methodology to be used, this study adopts the analytical, critical and systematic methods of philosophy. As with all qualitative research, a good use of library-based materials, such as books, journals and internet resources, were employed in the execution of the project. Also, because of the special nature of the study, series of interviews were conducted with some Igbo-speaking persons across Nigeria. With these interviews, we were able to elicit vital opinions on advance directives. Apart from the Igbo-speaking respondents, some non-Igbo were also interviewed. This was done in order to find out how different groups from within Nigeria would respond to the issue of advance directives.

Chapter one is concerned with the idea of advance directives. Here, attempt is made to give a general view of advance directives connecting it with its history, types, nature and the controversies surrounding its nature. In relation to the issues to be discussed, some ethical theories are tackled in the second chapter with the view to showing how they affect the choice and practice of advance directives either negatively or positively. Since the African person is expected to deploy advance directives, the make-up of the Igbo person in terms of the totality of his being as reference point for Africans is being examined in chapter three of this work.

After arriving at a better understanding of the human person according to the Igbo, chapter four focuses on the Igbo perspective of advance directives. The preoccupation was with the factors that will affect the African choice of advance

directives and what their choice will look like at present and in the future. Chapter five gives a general view on the place and role of advance directives in preserving and caring for human life. The summary and conclusion will come afterwards.

The argument at the end of study will show that with the controversies surrounding the dignity of human; death, hospice and hospitality, the plausibility of advance directives is equivocal; some Africans will not subscribe to it at present due to its conflict with their traditions. However, with the growing globalisation, Africans may subscribe to it as "Consensus Advance directives" and will accommodate all the influences of the community in the life of the individual who is signing the advance directives.

END NOTES

[1]Medicine, Oxford English Dictionary Online. Oxford University Press. September, 2014. Retrieved November, 20, 2014

[2] Gregory W. and Rutecki, M.D. Advance directives: an evangelical critique of advance directives. *Biblical Medical Ethics*, 8.3:1-100.

[3]I am indebted to Dr Demola Lewis of the Department of Linguistics and African Languages University of Ibadan for the invention of this phrase, which holds much meaning for the African understanding of the issues that this study discusses.

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CHAPTER ONE

THE IDEA OF ADVANCE DIRECTIVES

1.0 INTRODUCTION

The notion of advance directives is worth explicating, given the nature of this work. In this chapter, therefore, the meaning of advance directives, as well as its types and origin, shall be discussed. Since advance directives appears to be similar to euthanasia, the discussions in this chapter will equally bring out the differences between both concepts and possibly draw the similarity. Advance directives shall be critically examined in order to show its advantages and disadvantages. This chapter concludes with an exposition on the dignity of the human person which is very necessary, given the fact that the whole issue of advance directives concerns and touches on the value of the human person.

1.1 THE MEANING OF ADVANCE DIRECTIVES

The ordinary understanding of Advance Directives will have it that it is an instruction or guidelines set ahead of time, especially when it is needed. It is a plan, in form of instructions, made for its application in the future. In this sense, we can say that advance directives is a statement made in advance of an illness about the type and extent of treatment one would want, on the assumption that one may be incapable of participating in decision-making about treatment when the need arises. According to Alexander Morgan Capron in his article "Advance directive,"

> Advance directives provide a means to express wishes of any sort (for example, that particular treatments be used or not used, or that all possible treatments are to be provided) but they are usually thought of as a means to limit life-prolonging treatment, especially in the United States, where interest in advance directives originated and has been most intense[1]

William May defines advance directives as "a document by which a person makes provision for health care decisions in the event that, in the future he or she is no longer competent to make such decisions for himself or herself."[2]As such, advance directives refer to 'instruments' which are intended to conclusively establish an

individual's preferences in writing with respect to the degree of medical care and treatment he or she desires to receive. Here, we should point out that advance directives is a part of a process known as "advance care planning." It is a process in which patients ideally, in consultation with physicians and loved ones, plan in a thoughtful and reflective manner for medical care in the event of future incapacity to make such plans.

Advance directives are oral or written statements in which people declare their treatment preferences in the event that they lose decision-making capacity.[3] It is a sort of medical directive usually written even though it can come in oral declaration: the person involved may name a person to make a decision on his/her behalf, give instructions on what treatment should or should not be provided, or both.

Thus, advance directives may allow patients to prevent unwanted and burdensome treatments when struck by terminal illness, as well as permanent or profound mental disability. Although advance directives could refer simply to signing a form or written document, say, in a doctor's or lawyer's office, ideally, it creates an opportunity for patients to explore their own values, beliefs and attitudes regularly as they concern decisions at the end of their lives. In this sense, patients may speak with loved ones, physicians, spiritual advisers, and others during this process.[4] Perhaps this explains why Gilbert Meilaender defines it as "an attempt to extend our autonomy into a future time when we are no longer autonomous."[5]

From the understanding of advance directives above, it is clear that one of the primary purposes, if not the main purpose, of advance directives is to support the individual in making end of life decisions, which to a large extent, promotes the principle of self-determination. As a result, patients can gain a sense of control over their medical care and their future, obtaining the reassurance that they will be treated in the manner that is consistent with their preferences when they become incapable to make decisions regarding how they should be treated at this time of their lives. In this way, advance directives is seen to promote the fair treatment of incompetent individuals by providing a mechanism through which prior wishes regarding life sustaining treatment can be communicated. By providing guidance that is in keeping

with the wishes of an individual, advance directives also reduces the difficulties faced by the loved ones of patients in life-threatening situations. Such directives help to reduce or resolve disagreements between clients and their families.

Also, practitioner-patient communication is enhanced through the use of advance directives by providing a focus for the discussion of significant issues around end-of-life treatment decisions. The expectation is that advance directives will increase the probability that loved ones and healthcare providers will make decisions in accordance with patients' value and goals. Whether or not this expectation is always met is another matter altogether. Although advance directives often focus on situations in which the patient would want to forgo treatment, they sometimes state circumstances under which a patient would want treatment.

Consequently, the primary goal or objective of advance directives is to provide a means by which a patient is able to determine, through the written directives, how he or she wants to be treated when incapable of making decisions regarding preferred treatment.

1.1.1 MANAGEMENT OF ADVANCE DIRECTIVES

For a directive to be enforced, it is first necessary that the clinical team be aware that such a provision exists. It could be recorded in the individual's computerised or manual notes. Notably, a form for this purpose is available from the National End of Life Care Programme website.[6]

Just as a will has an executor, so a directive may have a health care proxy. This person may also have 'lasting power of attorney'.[7] Such a provision is common when a person is no longer competent to manage his or her own financial affairs. The role of the proxy is to see that the wishes of the individual are carried out. He or she does not have the power to make decisions. The wishes of the patient may not be overruled by relatives.

An advance directive does not have to be drawn up by a solicitor but neither does a will. However, in both cases, the involvement of such a professional should

substantially reduce the chance of an oversight that would result in failure of the will to be observed. A will usually has to be signed by the author and co-signed by two independent witnesses who are not beneficiaries of the will. It is sometimes said that only one witness is required for an advance directive, but to replicate a will, two may be safer. The two witnesses should be people who do not stand to benefit from the estate.

An advance directive can be rescinded or updated at any time; however, at the time that it is implemented, the individual is in no position to offer an opinion. If the contents are changed, all old wills should be destroyed.

1.1.2 THE PROVISION OF THE ADVANCE DIRECTIVES

One basic fact about the advance directives is that before the document is drawn up, it is highly recommended that one's family or very close friends be made witnesses and judges over the document, for it is a valid legal document that cannot be overruled by family. The matters that are considered before providing the document concern the persons'/patient's medical state during illness, such as physical impairment, loss of consciousness/or coma, great pains, or terminal illness. The document, thus, will state the nature of medical attention/action he or she will prefer on those medical situations mentioned above. The statement reads thus:

> I (name) of (address) wish the following to be considered in the event of my incapacity to give or withhold consent for medical intervention. If ever I am unable to communicate and have an irreversible condition and I am expected to die in a matter of days or weeks, or if I am in a coma and not expected to regain consciousness or if I have brain damage of disease that makes me unlikely ever to recognise or relate to people then I want treatment only to provide comfort and relieve distress, even if this may shorten my life. I do not want treatment that can only prolong dying. I consent to any acts or omissions undertaken in accordance with my wishes and I am grateful to those who respect my free choice. I reserve the right to revoke or vary these conditions but otherwise they remain in force. If I am certified brain dead, should any of

> my organs be of value to others, I give consent to their removal for the purpose of transplantation.[8]

This document ends with the specifications of persons/offices where it shall be filed after the signature of the patient. Also, there will be the signatories of the witnesses who testify that the document was effected in the patient's freewill and without duress.

An advance directive can be made by anyone who is over 18 years old and is of sound mind and cares about the issues involved.[9] Some people are likely to choose the option, including those with incurable cancer, those with a progressive neurological disease and those with mild memory loss, as they are still of reasonably sound mind but at risk of progressing to dementia. It is recommended that one must have fully and sufficiently thought about the advance directive and what commitment it requires of all the parties involved – medical practitioners, the patient and his/her relations. This becomes very necessary given the case that by its nature, only the patient who duly authorises it, or the person charged with making decisions for the patient, is the only person that can alter it. No one else can alter it irrespective of the situation (and even when it is considered expedient to do otherwise). Any action made against the stipulations of the document will warrant a legal action.

1.2 THE ORIGIN OF ADVANCE DIRECTIVES

Advance directives, as a medical legal practice developed in the United States of America as a response to the increasing difficult health conditions where the sick patient has little or no contributions to make in relation to how he or she is given medical attention, at those critical health conditions. The recognition of human freedom as well as the right to decide the course of what happens to one's life spurs on individuals to fashion out ways in which they could actually decide the nature of the medical attention they will receive at those critical moments of their illness, especially when they have lost consciousness.[10] In line with this, Alexander Morgan Capron avers that:

> Indeed, advance directives arose initially as a response to the decision-making paralysis, born of guilt and uncertainty that often occurs when the question is whether to forgo the medical interventions sustaining the life of someone who is longer able to make his or her own views known. Recognizing that physicians, nurses and other health-care workers, as well as patient's next of kin, often it difficult to withhold further interventions, much less to withdraw those already being undertaken.[11]

Advance directives began to be developed in the United States in the late 1960's. Advance directives were created in response to the increasing sophistication and prevalence of medical technology. Of U.S. deaths, 25%-55% occur in health care facilities. Numerous studies have documented critical deficits in the medical care of the dying; it has been found to be unnecessarily prolonged, painful, expensive, and emotionally burdensome to both patients and their families.[15]

Aggressive medical intervention leaves nearly two million Americans confined to nursing homes, and over 1.4 million Americans remain so medically frail as to survive only through the use of feeding tubes. As many as 30,000 persons are kept alive in comatose and permanently vegetative states. Cost burdens to individuals and families are considerable. A national study found that: "In 20% of cases, a family member had to quit work;" 31% lost "all or most savings" (even though 96% had insurance); and "20% reported loss of [their] major source of income." Yet, studies indicate that 70-95% of people would rather refuse aggressive medical treatment than have their lives medically prolonged in incompetent or other poor prognosis states.

As more and more Americans experienced the burdens and diminishing benefits of invasive and aggressive medical treatment in poor prognosis states – either directly (themselves) or through a loved one – pressure began to mount to devise ways to avoid the suffering and costs associated with treatments one did not want in personally untenable situations. The first formal response was the living will.

The living will is the oldest form of advance directive. It was first proposed by an Illinois attorney, Luis Kutner, in a law journal in 1969. Kutner drew from existing

estate law, by which an individual can control property affairs after death (i.e., when no longer available to speak for himself or herself) and devised a way for an individual to express his or her health care desires when no longer able to express current health care wishes. Kutner's goal was to facilitate "the rights of dying people to control decisions about their own medical care." In describing Luis Kutner's "living will", Alexander Morgan Caprion says that:

> Just as a "will "signifies a document through which a person leaves instructions for the disposition of his or her estate after death, Kutner's "living" allows a person to give instructions for medical care in the final days of life. In particular, through a living will people while still competent are able to state that they do not want their dying process prolonged once they become unable to express their wishes directly…Kutner and other advocates of the living will frankly admitted that it was not legally binding because they believed that its real strength lay in the reassurance-indeed, courage- it could provide to a patient's family, spiritual adviser and physicians to forgo life-prolonging treatment when death was near.[13]

In 1968, the first living will legislation was presented to a state legislature. Walter F. Sackett, a doctor elected to the Florida legislature, introduced a bill that would allow patients to make decisions regarding the future use of life-sustaining equipment. The bill failed to pass in 1968. Sackett reintroduced the bill in 1973 and it was again defeated. While Dr.Sackett was introducing living will legislation in Florida, Barry Keene was presenting similar bills in the California legislature.

Keene's interest in living wills was based on personal experience. In 1972, Keene's mother-in-law was unable to limit medical treatment for a terminal illness even after having signed a power of attorney. Keene was elected to the California State senate in 1974. The living will legislation he designed was defeated that same year. Keene reintroduced the bill in 1976 and in September of that year California became the first state in the nation to legally sanction living wills. Because this form of "will" was to be used while an individual was still alive (but no longer able to make decisions)

it was dubbed the “living will.” Within a year, forty-three states had considered living will legislation and seven states had passed bills.

Advance directive legislation has subsequently progressed on a state- by-state basis. By 1992, all fifty states, as well as the District of Columbia, had passed legislation to legalize some form of advance directive. The first court decision to validate advance directives was at the state level. The decision was handed down by the New Jersey Supreme Court in 1976. In Case 70 N.J. 10, 355 A 2nd 647, Chief Justice Robert Hughes upheld the following judicial principles:

1. If patients are mentally unable to make treatment decisions, someone else may exercise their right for them.
2. Decisions that can lead to the death of a mentally incompetent patient are better made not by courts but by families, with the input of their doctors.
3. Decisions about end-of-life care should take into consideration both the invasiveness of the treatment involved and the patient's likelihood of recovery.
4. Patients have the right to refuse treatment even if this refusal might lead to death.

The case in which Judge Hughes ruled was the request by Joe Quinlan to make legally binding health care decisions for his daughter, Karen Ann Quinlan. As a result of the case, Karen Ann Quinlan was gradually weaned from mechanical ventilation. In the U.S.A., The Patient Self-Determination Act (PSDA) went into effect in December 1991, and required health care providers (primarily hospitals, nursing homes and home health agencies) to give patients information about their rights to make advance directives under state law.Living wills proved to be very popular, and by 2007, 41% of Americans had completed a living will. In response to public needs, state legislatures soon passed laws in support of living wills in virtually every state in the union.

However, by the late 1980s, public advocacy groups became aware that many people remained unaware of advance directives and even fewer actually completed them. In part, this was seen as a failure of health care providers and medical organizations to promote and support the use of these documents. The public’s

response was to press for further legislative support. The most recent result was the Patient Self-Determination Act of 1990, which attempted to address this awareness problem by requiring health care institutions to better promote and support the use of advance directives.

The U.S. federal government has evidenced its interest in advance directives through two of its bodies, the Congress and the Supreme Court. The U.S. House of Representatives in 1991 enacted the Patient Self- Determination Act. The Act stipulates that all hospitals receiving Medicaid or Medicare reimbursement must ascertain whether patients have or wish to have advance directives. The Patient Self-Determination Act does not create or legalize advance directives; rather, it validates their existence in each of the states.

It was not until 1990 that the United States Supreme Court agreed to hear a case on the legality of advance directives. The Supreme Court had been reticent to hear cases on advance directives, reflecting to some degree the belief that advance directives are determined at the state rather than federal level. In 1990, the Court heard Cruzan vs Director. The case, similar to that of Karen Ann Quinlan, involved the desire to discontinue the percutaneous gastrostomy feedings of Nancy Cruzan. The United States Supreme Court decided in favour of the individual right to refuse treatment, even life-sustaining treatment. The Supreme Court refused to hand down a specific decision on medical treatment in the case. Following the opinion of the Supreme Court, the case was referred back to the Missouri Supreme Court. The Missouri Supreme Court heard testimony of a verbal advance directive that was deemed to be sufficient evidence to support the refusal of medical treatment.

However, as living wills began to be better recognized, key deficits were soon discovered. Most living wills tended to be limited in scope and often failed to fully address presenting problems and needs. Further, many individuals wrote out their wishes in ways that might conflict with quality medical practice. Ultimately, it was determined that a living will alone might be insufficient to address many important health care decisions. This led to the development of what some have called “second generation” advance directives – the “health care proxy appointment” or “medical power of attorney.” This is so because:

> Limitations of this sort in instruction-type directives (living will) generated interest in finding better means to permit patients to exercise some control over medical decisions even after they lose decisional capacity. As it happened, during the latter part of the 1970s, many jurisdictions adopted statutes that allow people to execute what in the United States is called a "durable power of attorney" and in Great Britain and some other countries is termed a "continuing power of attorney". Such documents are "durable" or "continuing" in that they survive the incompetence of the principal: indeed, they may provide that the authority of the agent comes into being only when the principal loses the capacity to make decisions. These laws were enacted to enable people, especially the elderly with small estates, to appoint one of their children or another trusted person to manage their finances and other affairs if they become unable to do so, without the burden of having to seek a formal court appointment of a conservator.[14]

The Durable power of the attorney type of advance directive was drawn from existing law – specifically from business law. Power of attorney statutes have existed in the United States since the days of "common law," that is, laws brought from England to the United States during the colonial period. These early powers of attorney allowed an individual to name someone to act in their stead. Drawing upon these laws, "durable powers of attorney for health care" and "health care proxy appointment" documents were created and codified in law, allowing an individual to appoint someone to make health care decisions in their behalf if they should ever be rendered incapable of making their wishes known.

The appointed health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if still capable of making and communicating health care decisions. The primary benefit of second-generation advance directives is that the appointed representative can make real-time decisions in actual circumstances, as opposed to advance decisions framed in hypothetical situations, as recorded in a living will. This new advance directive was heartily endorsed by the American public, and supporting legislation soon followed in virtually

all states. It is regarded as a more useful document than a living will. Its major advantage lies in the fact that the agent (appointed representative) can step into the shoes of the patient and make decisions in the light of the existing medical situation and the suggestions of the attending medical practitioners.

From the foregoing, we deduce that advance directive, as a medical practice, developed in the United State of America. But it has spread to other parts of the world including Africa, such that many of these peoples are buying the idea and are thus subscribing to it. Although in some places, the practice is less-appreciated, it is predominantly practiced in the USA because of its widespread liberalized culture.

1.3 TYPES OF ADVANCE DIRECTIVES

There are basically two types of advance directives; these are the living will (also known as instructional directives) and the durable power of the attorney, which is also referred to as proxy directives.

The Living Will

The living will, "this is a signed, witnessed or notarised document that allows a person or patient to state that specific life-sustaining treatments be withheld or withdrawn if he or she is in a terminal condition and unable to make health care decisions."[15] In establishing a living will, one attempts to describe in advance the possible medical conditions that might occur in the future, and one attempts also to stipulate how one would want to be treated or not treated under those conditions. Developed at a time when the main concern in medical practice was how to deal with the problem of medical "paternalism"[16], the living will has often been conceived as an instrument of refusing treatment. It is seen as a reaction to the "heavy hand" of medical paternalism. The living will was first given legal standing by the state of California in the United States of America in 1976. In principle, however, there is no reason why one could not use such an instrument to express a desire for treatment, even for all possible treatments.[17] In many cases, models of a living will are promoted by supporters of euthanasia because they see and interpret it as the death warrant of a living person. However, this goes against the primary intentions of living wills in advance directives.[18]

Durable Power of the Attorney

The durable power of the attorney is a situation where there is a signed document in which the patient or client designates another to make health care decisions for him or her in the event that he or she becomes incompetent.[19] The durable power of the attorney as a type of advance directive demands a lot of trust from the one making the directives. This is because this involves entrusting one's life to another in certain conditions. Another name for durable power of the attorney is proxy directives. This type of directives is only if the patient has lost decision making capacity.[20] Proxy directives, however, do not indicate the patient's wishes, preferences, or the type of treatments he or she might have decided under the circumstances at hand. As a result, instructional directives that are the living will attempt to fill this gap. Instructional directives identify situations in which patients would want or would not want to specify treatments. As such, instructional directives apply only under the circumstances specified in the document. For example, a patient's instructional directives or will might read thus, "if I am permanently unconscious or terminally ill, I would not want to undergo cardiopulmonary resuscitation." Finally, instructional directives are such that people have the opportunity to provide more comprehensive information about their values and goals in relation to their lives in general and to medical care in particular.[51]

In all, the goal of advance directives, whether in its proxy or instructional form is to ensure that certain states of affair do not impair an individual from attaining his or her values, goals and wishes even when the individual is incapable of making reasoned decisions as a person.

1.4 THE DIFFERENCES BETWEEN ADVANCE DIRECTIVES AND EUTHANASIA

From the foregoing discussion, one is likely to think that advance directives and euthanasia are the same. This is not the case. Euthanasia, also regarded as "mercy killing", is an action or an omission which of itself, or by intention, causes death, in

order that all suffering \may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used.[22]

Euthanasia is the wilful, direct or indirect killing of the incurable sick, be it at their request or the request of the parents, guardians or any other legal representative in the case of incurable who are incapable of deciding for themselves, e.g. infants, the irrevocable comatose and mental defectives.[23] It is worth noting that one can kill a person mercifully or commit euthanasia by an act of omission as well as by commission. Euthanasia is committed by omission when there is a deliberate denial of required medical attention on the basis of the doubt of recovery; it is by commission when there is an introduction of other medical action or practice that will enhance the death of the patient.

The difference between advance directives and euthanasia is seen in the fact that advance directives is given when the patient is competent in a very good state of mind. The client or patient instructs in writing or orally, (if he or she finds himself or herself in a vegetative or demented state or situation) that these or those treatments should either be carried out or abandoned. This is in form of his willing will or a durable power of the attorney where he or she appoints someone to act on his behalf. Advance directives is futuristic in nature.

As for euthanasia, the idea or thought occurs when one is seriously sick, going through excruciating pains, or when the pains become so unbearable that one would prefer to die to being alive. Such an individual could request his or her doctor to end his or her life by withdrawing a life sustaining medical practice. As said earlier, advance directives concerns medical practice to be carried out when one is no longer medically competent to make choices of treatment. This choice of treatment is made by the patient alone ahead of time and not in the face of danger. On the contrary, in euthanasia, the choice of medical action could be made by the patient, the medical practitioners or even the relations, when there is doubt of recovery in a terminal illness. In other words, while advance directives is futuristic, euthanasia is immediate directive.

Their similarity could majorly be that they are both geared towards carrying out some medical action during the time of serious illness for the good of the patient, either

proposed by the patient ahead of time or at the point of medical need or proposed on behalf of the patient. Whatever seemingly good reasons that may be used for the support of advance directives and euthanasia, it is worthy to note that both medical practices are not supported by some cultures and religious traditions, such as African culture and the Christian religious tradition.

1.5 A CRITICAL RESPONSE TO THE PRACTICE OF ADVANCE DIRECTIVES

Even when it seems that advance directives is worth making and prescribing, it has, however, been criticised on many grounds. One is the claim that advance directives places too much emphasis on the idea of individual autonomy which does not favour all the peoples of the world. While it is encouraged by the culture of some people, it is highly prohibited by some others. For instance, the western world may encourage this individual autonomy, regardless of the community, but the African society shuns it because the African people believe that the individual is not autonomous; rather, he is a part of the community and the community must influence his actions in life. Hence, Lanre-Abass (2008) argues that the problem of "atomistic individualism" makes advanced directives that which is not in consonance with African cultural values.[24]

As a core issue in contemporary medical practice, especially in biomedicine, advance directives raise a number of ethical questions in terms of the ideals of freedom and responsibility, in the treatment of patients by doctors. Physicians often feel duty-bound to preserve life under almost all circumstances, regardless of quality, even if they are uncertain that their attempt serves the patient's best interest. However, do all patients accept this position? That is, when patients are terminally ill, do they all allow physicians alone to determine the course of treatment? Do patients have the right to determine how they are to be treated irrespective of what the medical report says?

Many other objections have been raised in relation to the use of advance directives. In a 1991 article, Alan S. Brett argued that an advance directives document cannot possibly direct the case that is to be given in a real clinical situation. If a patient writes a very general directive, stating, for instance, that "If I have no reasonable chance to recover, I direct that no life-sustaining treatment be used", decision makers

will have to determine how much of a chance recovery is "reasonable" or how much of the recovery will be worth trying for, and what precisely are "life-sustaining" interventions.[25] Even if one specifies a list of treatments to be forgone in a number of detailed scenarios, this too creates problems. First of all, no matter how specific the document is, it is unlikely to capture all circumstances of a real clinical situation.

Also, patients might not truly understand the specific treatments that they are listing in the document, running the risk of erroneously requesting or foregoing a treatment that may be curative to their medical case.[26] This raises the question of whether one can truly give advance directives in regard to how he/she wants to be medically attended to. This question raises doubt about the reason and validity of advance directives, given the inconsistencies it may have regarding whether such directive can truly direct physicians on the grounds of the vagueness and difficulty of interpretation of the patient's directive. If, however, the patient or the client had engaged in discussions with doctors and proxies about his or her values and wishes, then decision makers will be in a better position to interpret the document and to make medical decisions in keeping with the patient's values.

A related objection is the concern that patients can never know what exactly they would want under conditions that they have not experienced, or that they may change their minds. In this vein, advance directives may lead to inappropriate treatment decisions if situations arise that a person could not foresee or consider at the time of writing the directive. For example, when an advance directive is being applied, previously requested treatment may be of no benefit; it may, however, be the reverse that a person may refuse a future treatment option based on the understanding that the situation would be hopeless, and it then happens that the circumstance takes an unexpected turn for the better.

More so, individuals may change their minds regarding the type of treatment they want but may forget to change their advance directives. This could result in such persons receiving treatments that do not portray their recent values, beliefs and goals, and hence are against their wills.[27] These offer valid reasons why advance directive require cautious examination. It is clear that advance directive apply when patients

have lost decision-making capacity, often for what is anticipated to be an indefinite period of time. For the simple fact that these patients can no longer express their preferences, the choice is either to listen to their previous wishes about the situation or to apply some standard external; to the patients' wishes such as the provider's opinion or some societal consensus.[28]

It would seem most respectful to patients to rely on their previously stated wishes to make treatment decisions, unless there is good reason to believe that they do not understand what was written in the directive. However, there are still a number of ethical issues that arise in this connection: the question of autonomy of decision of the patient, the issue of responsibility, the question of freedom of choice, the question of the place of the informed opinion of physicians, and so on.

Furthermore, the advance directives could be negatively affected by some factors. First, advance directives cannot be used to explicitly request for illegal medical attention, such as suicide, euthanasia, and so on. Also, it cannot be used to refuse treatment for a mental health condition (doctors are empowered to treat such conditions under Part 4 of the Mental Health Act).[29] Again, a doctor may not follow an advance directive on certain conditions, such as when the patient/individual makes changes which invalidate the directive (eg. a change to a religion which prohibits the refusal of treatment), when there have been advances in treatment which may have affected the initial treatment (unless the individual specified in the directive that such advances would be declined) or even when there is ambiguity in the wording of the directive (eg. the wording is not relevant to the current medical condition). In addition, a directive may be invalid: if there is reason to doubt its authenticity (for example, if it was not witnessed), or if there is doubt as to the person's state of mind (at the time of signing).

1.6 THE ADVANTAGES OF AN ADVANCE DIRECTIVE

Despite the negative attention given to advance directives, it has been favoured on a number of reasons. An advance directive enables individuals to think about what they would like to happen to them in the event that they lose the capacity to take

informed decisions about their medical care. Examples of such decisions include: the use of intravenous fluids, the use of cardiopulmonary resuscitation, the use of life-saving treatment (whether existing or yet to be developed) in specific illnesses where capacity or consent may be impaired - for example, brain damage, perhaps from stroke, head injury or dementia. It could also be used in specific medical procedures/practices, such as blood transfusion for the benefit of one's religious/cultural practice. Even if a directive is not eventually issued, the topic may motivate the individual to discuss future arrangements with his/her doctor, family and friends.

An advance directive is legally binding in the sense that a doctor, who gives patients life-saving treatment against their wishes expressed in a directive, faces legal action. However, as the use of advance directives becomes more commonplace, controversies are bound to arise (e.g the rights of terminally ill pregnant women)[30] and the legal issues continue to be the subject of debate.[31] Again, practitioner-patient communication is enhanced through the use of advance directives, by providing a focus for the discussion of significant issues around end-of-life treatment decisions. By providing guidance that is in keeping with the wishes of an individual, advance directives also reduces the difficulties faced by the loved ones of patients in life-threatening situations. Such directives help to reduce or resolve disagreements between clients and their families. Thus, advance directives seem to be appreciative of the dignity of the human person as universally understood to a very large extent. To this reason, it has been widely supported especially in the western world.

1.7 THE DIGNITY OF THE HUMAN PERSON

The dignity of the human person lies in the fact that he or she has been endowed with natural intelligence which allows him or her to create meaning in his existence in the exercise of his innate freedom through the courses of action ordered by the will. Above all existents in the world, man is the only being who is free and has the natural capacity to order the course of his actions in ways personally decided that will guarantee self-realisation, self-governance, self-control and self-fulfilment. Man, unlike other living beings, has the capacity of self-determination and self-consciousness, the ability that makes him a thinking being in total awareness of his environment, while

preferring ways to better the environment. Animals and other living beings act upon instincts, but man has intelligence and acts according to the order of reason. Even when he does not act according to reason, it is not the case that he could not have acted otherwise rationally; but animals cannot act other than by their instincts.

The celebrated Philosopher Descartes asserts that every man can think since *Cogito Ergo Sum*. Also, arguably all men think rationally, for "thinking is a characteristically human activity."[32] Some proponents of human freedom have typically maintained that humans are naturally in "a *State of perfect Freedom* to order their actions as they think fit without asking leave, or depending on the will of any other man"[33] Human freedom becomes a reality because the conscious being is capable of becoming what it is not but hopes to become. This is true because, according to him, "Man first of all exists, encounters himself, surges up in the world and defines himself afterwards".[34] For Sartre, what we call freedom cannot be clearly distinguished from the nature of human reality. Human beings are freedom. Freedom is the being of man. It is intrinsic to the sort of beings we are, for at each moment, we are creating ourselves anew.[35]

Human beings also have the basic natural capacity or potentiality to deliberate among options and make free choices, choices that are not determined by the events that preceded them, but are determined by the person making the choice in the very act of choosing. For St Augustine, being endowed with freewill implies that human beings have the power to choose their actions without any constraints. Hence, they are responsible for any action they take.

Human beings are rational creatures by virtue of possessing natural capacities for conceptual thought, deliberation, and free choice, that is, the natural capacity to shape their own lives. With intelligence, human beings set values for themselves in life. Also, the spiritual and material elements (spirit or soul, mind and body) of the human person make him stand above all creatures. The spiritual elements make him a being and the only worldly being that has connection with the spiritual realities. Hence, man is transcendental in nature.

On the personalistic approach, therefore, the human person must be seen as a subject and never as an object. The human person is at the centre of the world; as such, he/she carries out several actions in the world. Human persons are links between the material and the spiritual, endowed by the Supreme Being with the freedom and the capacity to re-create the world in God's image.[36]

In sum, humans constitute a special sort of animals. They differ in kind from other animals because they have a rational nature, a nature characterized by having the basic, natural capacities (possessed by each and every human being from the point at which he or she comes to be) for conceptual thought and deliberation and free choice. In virtue of having such a nature, all human beings are persons and all persons possess the real dignity that is deserving of full moral respect. Thus, every human being deserves full moral respect.

This understanding of the dignity of the human person makes the proponents of advance directives to affirm the individual's right to think about his life and his inherent right to be respected in his decisions in his presence or consciousness or absence or unconsciousness.

1.8 CONCLUSION

Advance directive is a medical but equally a legal document; an instruction by which a person makes provision for health care decisions, in the event that in the future he or she is no longer competent to make such decisions for self. The primary purpose of advance directive is to provide a means by which a patient is able to determine, through the written directives, how he or she wants to be treated when incapable of making decisions regarding preferred treatment. While this document is drawn up by the patient with the awareness of the medical practitioners and the relations, no one, except the patient or the person he has charged with such responsibility, can alter the provisions therein.

Advance directives and euthanasia appear the same. But while advance directives are medical decisions taken ahead of the projected period of sickness, euthanasia is made at the time of the danger of the sickness. An advance directive is

rejected because it is in congruent with some cultures and religions like the African Culture and Christianity. But even at that, some persons subscribe to it because it enables individuals to think about what they would like to happen to them in the event that they lose the capacity to take informed decisions about their medical care. Hence, it promotes the dignity of the human person. The dignity of the human person lies in the fact that human beings have been endowed with natural intelligence. This allows him to create meaning in their existence in the exercise of their innate freedom through the courses of action ordered by the will. On this basis, advance directives becomes more appealing even to many nations of the world.

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[16]"Paternalism" From Latin *'Pater'*, "father" is the position that health care professionals should take a parental role toward patients and their families. According to this position, professionals have a superior knowledge of medicine; therefore, they and they alone are privileged because of their long and specialized training to decide what is best for patients and their families.

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CHAPTER TWO

PRINCIPILISM

2.0 INTRODUCTION

It is a clear fact that no action or omission of man is judged in a vacuum. Every action or omission is judged within a given number of ethical theories. This is so because man, a rational being, is also a moral, social and religious being whose action or omission is capable of causing happiness or pain. These ethical principles are: Autonomy, Beneficence, Non-maleficence and Justice. Thus, principilism is the umbrella term that covers these four moral principles. In other words, it is a system of ethics based on the four moral principles. In this chapter, therefore, we shall first try to understand, in brief, the meaning of ethical theories; then, we shall focus on the four moral principles and try to make a case for each in order to see how their work within this system of principilism.

2.1 ETHICAL THEORIES

Writers in bioethics believe that human beings would justifiably have more confidence in their individual and communal moral judgment if only they could justify them on the basis of a comprehensive ethical theory. The ambition of an ethical theory is to provide an adequate normative framework for processing and ideally resolving moral problems. Some ethical theories include: "utilitarianism, Kantianism, virtue (or character) ethics, the ethics of care. Some knowledge of these theories is indispensable for a reflective study in bioethics. This is because a sizable part of the field's literature draws on methods and conclusions found in these theories."[1]

2.2 UTILITARIANISM THEORIES

Utilitarianism is rooted in the thesis that an action or practice is right (when compared to any alternative action or practice) if it leads to the greatest possible balance of good consequences or to the least possible balance of bad consequences in the world as a whole.

Utilitarian hold that "there is one and only one basic principle of ethics: the principle of utility. This principle asserts that we ought always to produce the maximal

balance of good consequences over bad consequences. The classical origins of this theory are found in the writings of Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873). The human welfare is to be promoted by minimizing harms and maximizing benefits."[5]

In Igbo culture, a man or woman is held in high esteem when he or she strives towards contributing to the development of the community by participating even in little things like clearing public paths when the community calls for such. On the other hand, an Igbo community could even ostracise a man or woman who has brought harm or shame to the community. For instance, a man or woman caught stealing in the farm especially is made to dance round the market square while the people boo.

2.3 KANTIAN THEORIES

The utilitarian conceives of the moral life in terms of producing what is valuable. A second type of theory which departs significantly from this approach is often called deontological. It holds the view that some features of actions, other than or in addition to consequences, make actions obligatory. This theory is now increasingly regarded as Kantian, because of its origins in the theory of Immanuel Kant (1724 – 1804).

Kant believed that an act is morally praiseworthy only if done neither for self-interest reasons nor as the result of a natural disposition, but rather from duty. That is, a person's motive for acting must be recognition of the act as depending on duty. Kant tries to establish the ultimate basis for the validity of moral rules in pure reason, not in intuition, conscience, or utility. He thinks all considerations of utility and self-interest morally unimportant, because the moral worth of an agent's action depends exclusively on the moral acceptability of the rule of the basis of which the person is acting. In stating the principles of his moral theory, Kant draws a distinction between a categorical imperative and a hypothetical imperative. A hypothetical imperative takes the form "if I want to achieve such and such a valued end, then I must do so and so. These prescriptions – so reminiscent of utilitarian and pragmatic thinking – tell us what we must do, provided that we already have certain desires, interests, or goals".[3]

Kant's categorical imperative, also called the moral law, is expressed in several ways in his writings. His first formulation may be roughly stated thus: "Always act in such a way that you can will that everyone act in the same manner in similar situations." This imperative is categorical, Kant says, "because it admits of no exceptions and is absolutely binding." That is, it gives instructions about how one must act. An example is: "if you want to regain your health, then you must take this medication" or "if you want to improve infant mortality rates, then you must improve your hospital facilities." These imperatives are not commanded for their own sake. They are commanded as means to ends that have already been willed or accepted.

Kant's view is that "wrongful practices, including invasion of privacy, lying, theft and manipulative suppression of information, are "**contradictory,**" that is, they are not consistent with the duties and institutions they presuppose. In cases of lying, for example, the universalisation of rules that allow lying would entitle everyone to lie to you, just as you would be entitled to lie to them. Such rules are inconsistent with the practice of truth telling that they presuppose.

Kant's second categorical imperative is a requirement to 'never treat persons' as means. It is one more frequently invoked in medical ethics. This may be expressed thus: "Treat every person as an end and never solely as a means."[4] This principle requires us to treat persons as having their own established goals. Deceiving prospective subjects in order to get them to consent to participate in some therapeutic research, for instance, is one example of the violation of this principle. Similarly, Kant's categorical imperative demands that:

> persons like one in the vegetative state be treated with the respect and moral dignity to which all persons are always entitled, including the times when they are used as means to the ends of other. To treat persons merely as a means, strictly speaking, is to disregard their personhood by exploiting or otherwise using them without regard, to their own thoughts, interests and needs. It involves a failure to acknowledge that every person has a worth and dignity equal to that of every other person and that this worth and dignity cannot be compromised for utilitarian or any other reasons.[5]

2.4 VIRTUE THEORY

In discussing utilitarian and Kantian theories, we have looked chiefly at obligations and rights. Beyond obligations and rights, we also reflect on the agents who perform actions, have motives and follow principles. Here, we commonly make judgment about good and evil character in persons: "Virtue ethics gives good character a prominent place."[6]

Virtue Ethics descends from the classical Hellenistic tradition represented by Plato and Aristotle. Here the cultivation of virtuous traits of character is viewed as morality's primary function. Moral virtues are understood as morally praiseworthy character traits, such as courage, compassion, sincerity, reliability and industry. In virtue ethics, the primary concern is with what sort of person is ideal, while action is considered to have secondary importance. People are viewed as acquiring virtues much as they do skills, such as carpentry, playing an instrument, or cooking. They become just by performing just actions and become temperate by performing temperate actions. Virtuous character is cultivated and made a part of the individual, much like a language or tradition.[7]

However, an ethics of virtue is more than habitual training. One must also have a correct motivational structure. A conscientious person, for example, does not only have a disposition to act conscientiously, he or she also has a morally appropriate desire to be conscientious. The person characteristically has a moral concern and reservation about acting in a way that would not be conscientious.

Imagine a person who always performs his or her obligation, because it is an obligation, but intensely dislikes having to allow the interest of others to be important. Such a person does not cherish, feel congenial toward, or think fondly of others. He or she respects them only because obligation requires it. This person can, on a theory of moral obligation, such as Kants' or Mill's, perform a morally right action, have an ingrained disposition to perform that action, and act with obligation as the foremost motive. It is possible (1) to be disposed to do what is right. (2) to intend to do it, and (3) to do it, while also (4) yearning to be able to avoid doing it. If the motive is important, a

vital moral ingredient is missing. If a person characteristically lacks this motivational structure, a necessary condition of virtuous character is absent.

Virtue ethics seem "only of intellectual interest, but it has practical value in that a morally good person with right desires of motives is more likely to understand what should be done to perform required acts, and to form moral ideals than is a morally bad or indifferent person. A trusted person has an ingrained motivation and desire to do what is right to care about whether it is done. Whenever the feelings concerns and attitudes of other are the morally relevant matters, rules and principles are not as likely as human warmth and sensitivity to lead a person to notice what should be done. From this perspective, virtue ethics is at least as fundamental in the moral life as principles of basic obligation."[8]

Indeed, it is doubtful that virtues can be adequately conceptualised without some background assumptions about right action. For example, seeing truthfulness as a virtue seems inseparable from seeing truth telling as a prima facie obligation. If we ask why one should generally be truthful, it seems evasive to say, "Because virtuous people are that way," A more adequate response would show how truthfulness displays respect for people's autonomy, tends to promote certain benefits and ordinarily avoids certain kinds of harm. All these theories aim at introducing what we call principilism.

2.5 WHAT IS PRINCIPILISM?

Principilism is a system of ethics based on the four moral principles of:

(1) Autonomy: Free will of agency
(2) Beneficence – To do good
(3) Non-maleficence – Not to harm
(4) Justice – Social distribution of benefits and burdens

Advocates for principilism argue that from the beginning of recorded history most moral decision makers have descriptively and prescriptively used these four moral principle that they are part of, or compatible with, most intellectual, religious and cultural beliefs.[9]

2.6 **AUTONOMY:** - Respect for persons

The word autonomy is derived from "the two Greek words "autos ("self") and 'nomos' "rule" 'governance,' or law'). It was first used to refer to the self-rule or self-governance of independent Hellenic city-states. Autonomy has since been extended to individuals and has acquired various meanings, as such as self-governance, liberty rights, individual choice, freedom of the will, and being the cause of one's behaviours."[10]

According to the contemporary issues in bioethics, "one principle at the centre of modern bioethics is respect for autonomy. It is rooted in the liberal, moral and political tradition of the importance of individual freedom and choice. In moral philosophy, personal autonomy refers to personal self-governance: personal rule of the self by adequate understanding, while remaining free from controlling interferences by others and from personal limitations that prevent choice. Autonomy, thus, means freedom from external constraints and the presence of critical mental capacities, such as understanding intending and voluntary decision-making capacity."[11]

To respect an autonomous agent is to recognize, with due appreciation, that person's capacities and perspective, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs. The moral demand that we respect the autonomy of persons is expressed as a principle of respect for autonomy: autonomy of action should not be subjected to control by others. The principle provides the basis for the right to make decisions, which in turn takes the form of specific autonomy-related rights. For example, in the debate over whether autonomous informed patients have the right to refuse self-regarding, life-sustaining, medical interventions, the principle of respect for autonomy suggests a morally appropriate response. The principle further covers even simple exchanges in the medical world, such as listening carefully to patients' questions, answering their questions in the detail that respectfulness would demand, and not treating patients in a patronizing fashion.

Respect for autonomy has historically been connected to the idea that persons possess an intrinsic value independent of special circumstances that confer value. As

expressed in Kantian ethics, autonomous persons are ends in themselves, determining their own destiny, and are not to be treated merely as means to some ends. Thus, the burden of moral justification rests on those who would restrict or prevent a person's exercise of autonomy. To respect the autonomy of self-determining agents is:

> to recognize them as entitled to determine their own destiny, with due regard to their considered evaluations and view of the world. They must be accorded the moral right to have their own opinion and to act on them (as long as those actions produce no moral violation). Thus, in evaluating the self-regarding actions of others, we are obligated to respect those people as persons with the same right to their judgments as we possess to our own, and they in turn are obligated to treat us in the same way. [12]

Some contemporary writers in ethical theory have maintained that autonomy "is largely a matter of having the capacity to reflectively control and identify with one's basic (first order) desires or preferences through higher level (second order) desires or preferences."[13]

To respect an autonomous agent is to hold views, to make choices, and to take actions based on personal values and beliefs. "Such respect involves respectful action, not merely a respectful attitude. It also requires more than obligations of non-intervention in the affairs of persons, because it includes obligations to maintain capacities for autonomous choice in others, while allaying fears and other conditions that destroy or disrupt their autonomously action. Respect, on this account, involves treating persons to enable them to act autonomously, whereas disrespect for autonomy involves attitudes and actions that ignore, insult or demean others autonomy and thus deny a minimal equality to person."[14] Kant argued that "respect for autonomy flows from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own destiny."[15]

To violate a person's autonomy is to treat that person merely as a means, that is, in accordance with others' goal, without regard to that person's goals. Such treatment, Kant argued, is a fundamental moral violation because autonomous person's ends in themselves are capable of determining their goals.

John Staurt Mill was more concerned about the autonomy or, as he says, the individuality of persons in shaping their lives. He argued "that citizens should be permitted to develop according to their personal convictions, as long as they do not interfere with a like expression of freedom by others, but he also insisted that we sometimes are obligated to work to persuade others when they have false or ill-considered views."[16]

Mill's position requires both non-interference with and an active strengthening of autonomous expression, whereas Kant's entails a moral imperative of respectful treatment of persons as ends rather than merely as means. In the final analysis, these two profound different philosophers both provided support for the principle of respect for autonomy.

Autonomy and Consent in Health Care

Consent has long occupied an important role in health care because valid consent legitimises authority and conduct, that otherwise would not be legitimate and provides access that otherwise would be unobtainable. However, consent occurs under various conditions. It may be perfunctory or grudging, and it often occurs under intense pressures that may render it invalid. Informed consent captures only one form of consent relevant to health care ethics.

Another form is tacit consent, which is expressed passively by omissions. If residents of a long term care facility are asked whether they object to having the time of dinner changed by one hour or not, a uniform lack of objection constitutes consent (assuming they understand the proposal and the need for consent). Similarly, implicit or implied consent is inferred from actions. For example, consent to one medical procedure is often implicit in a specific consent to another procedure. Presumed consent is still another variety. Although if consent is presumed on the basis of what we know about a particular person, it closely resembles implied consent. By contrast, if it is presumed on the basis of a general theory of human goods or a theory of the rational will, the moral situation is both different and problematic. Consent should, therefore, be referred to as "an individual's own actions and in actions."[17]

In relating autonomy to advance directives, one has the right to decide how one should be treated, since and one is not subjected to any control by others. In the West, the emphasis is on autonomy, but in Africa, the emphasis is on communalism. Here, the individuals do not have the absolute right in making decisions on how to live and to end one's life. It has to be done in conjunction with others that is, the family and the community. There is, therefore, a conflict between autonomy and communalism. Which we intend to proffer a solution to at the end.

2.7 BENEFICENCE AND NON-MALEFICENCE

The welfare of patients is the goal of health care. Clinical therapies are aimed at the promotion of health by cure or prevention of disease, and this value has long been treated as a foundational value in medical ethics. Among the most quoted principles in the history of codes of medical ethics is the *maxim primum non nocere* "Above all, do no harm". In the light of this, "many current medical and nursing codes assert that the health professional's 'primary commitment' is to protect the patient from harm and to promote the patient's welfare."[18] The term 'beneficence' connotes acts of mercy, kindness, and charity. Altruism, love and humanity are also sometimes considered as forms of beneficence.

Beneficence refers to "an action done for the benefit of others. It refers to the character trait or virtue of being disposed to act for the benefit of others; and the principles of beneficence refers to a moral obligation to act for the benefit of others. Many acts of beneficence are not obligatory, but a principle of beneficence in our usage asserts an obligation to help others further their important and legitimate interest."[19]

The most famous example of beneficence is found in the New Testament parable of the Good Samaritan, according to Luke, 10:25-37 which illustrates several problems in interpreting beneficence. In this parable, a man travelling from Jerusalem to Jericho was beaten by robbers who left him "half dead." After two other travellers passed by the injured man without rendering help, a Samaritan who saw him "had compassion, and went to him and bound up his wounds brought him to an inn, and took care of him" In having compassion and showing mercy, the Good Samaritan expressed an attitude of caring for the injured man and also took care of him. Both his motives

and his actions were beneficent. However, the parable suggests that positive beneficence is more an ideal than an obligation, because the Samaritan's act seems to exceed ordinary morality. More so, "suppose that the injured man, when encountered by the Samaritan, had pulled out an advance directive indicating that he wanted to die if wounded on the dangerous road from Jerusalem to Jericho. Then the Samaritan would have faced a dilemma to respect the injured man's wishes or to take care of him against his wishes. Our beneficence then is sometimes an admirable ideal of action that exceeds obligations, and at other times it is appropriately limited by other moral obligations. But are we obligated to act beneficently."[20]

In addressing the question above, it is worth noting that the acts of beneficence play a vital role in the moral life quite apart from a principle of obligatory beneficence. No one denies "that many beneficent acts, such as the donation of a kidney to a stranger, are morally praise worthy and not obligatory. Similarly, virtually everyone agrees that common morality does not contain a principle of beneficence that requires severe sacrifice and extreme altruism in the moral life – for example giving both of one's kidney for transplantation. Only ideals of beneficence incorporate such extreme generosity."[21]

Some writers set limit by distinguishing the removal of harm, the prevention of harm, and the promotion of benefit. For instance, in developing "the obligation to assist," Peter Singer distinguishes preventing evil from promoting good. He contends that "if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it.[22] Singer's criterion of comparable moral importance set a limit on sacrifice. We ought to donate time and resources until we reach a level at which giving more, would result in harm to ourselves.

For Michael Slote, "One has an obligation to prevent serious evil or harm when one can do so without seriously interfering with one's life plans or style and without doing any wrongs of commission."[23]

(1) According to the principles of Biomedical Ethics, "Although non-maleficence and beneficence are similar and are often treated in moral philosophy as not

sharply distinguishable, conflating them into one principle obscures relevant distinctions."[24]

(2) According to the CONTEMPORARY ISSUES IN BIOETHICS, "the range of duties requiring abstention from harm and positive assistance may be conveniently clustered under the single heading of beneficence."[25]

This term has a broad set of meanings, including the doing of good and the active promotion of good, kindness and charity. But in the present context, the principle of beneficence has a narrower meaning: it requires us to abstain from injuring others, and to help others to further their important and legitimate interests, largely by preventing or removing possible harms.

According to William Frankena, the principle of beneficence can be expressed as including the following four elements or obligations, "the first of which we will distinguish as the obligation of non-maleficence and the other three of which we will refer to as obligations of beneficence:

1. One ought not to inflict evil or harm (what is bad)
2. One ought to prevent evil or harm
3. One ought to remove evil or harm
4. One ought to do or promote good"[26]

Frankena contends that these elements appear in a hierarchical arrangement, so that the first takes precedence over the second, the second over the third and the third over the fourth.

There are philosophical reasons for separating passive non-maleficence (as expressed in element 1) and act beneficence (expressed in elements 2-4), which point out that ordinary moral thinking often suggests that duties not to injure others are more compelling than duties to benefit them. For example, we do not consider it justifiable to kill a dying patient in order to use the patient's organs to save two others. Similarly, the obligation not to injure a patient by abandonment seems intuitively stronger than the obligation to prevent injury to a patient who has been abandoned by another (under the assumption that both are moral duties). Each of these forms of beneficence requires taking action by helping – preventing harm, removing harm and promoting good,

whereas non-maleficence only requires intentionally refraining from actions that cause harm.

In medical ethics, the principle of non-maleficence as well as the principles of beneficence have been viewed as providing a basis for paternalistic treatment of patients. This informs the practice of physicians who hold the view that disclosing certain forms of information can cause harm to patients under their care and that medical ethics obligates them not to cause such harm.

Considering the case of a man who brings his father, who is in his late sixties, to his physician because he has a suspicion that his father's problems in interpreting and responding to daily events indicate Alzheimer's disease. The man also makes an impassioned plea" that the physician should not tell his father whether the tests suggest Alzheimer's or not. The physician also notes that disclosure of Alzheimer's disease adversely affects patients' coping mechanisms, and, thus, could harm the patient, particularly by causing further decline, depression, agitation and paranoia. Some patients, for example:

> those who are depressed or addicted to potentially harmful drugs, are unlikely to reach adequate reasoned decisions. Other patients who are competent and deliberative may make poor choices about courses of action recommended by their physicians. When patients of either type choose harmful courses of action, some health care professionals respect autonomy by not interfering beyond attempts at persuasion, whereas others act beneficently by protecting patients against the potentially harmful consequences of their own choices. Problems of how to specify the principles, which principles to follow, under which condition and how to intervene in the decisions and affairs of such patients, when intervention is warranted are all central to debate about medical paternalism.[27]

2.8 JUSTICE

Every civilized society is a cooperative venture, structured by moral, legal and cultural principles that define the terms of social cooperation. "The terms, fairness, desert (what is deserved) and entitlement (that to which one is entitled) have been used by various philosophers in attempt to explicate justice."[28]

Beneficence and respect for autonomy are principles in this fabric of social order, but justice has been the subject of more treatises on the terms of social cooperation than any other principle. A person has been treated justly if treated according to what is fair, due or owed. For example, if equal political rights are due to all citizens, then justice is done when those rights are accorded.

Theories of Justice

A theory attempts to connect the characteristics of persons with morally justifiable distribution of benefits and burdens. For example, a person's service, effort, or misfortune might be the basis of distribution. Several systematic theories have been proposed to determine how social burdens and goods and services, including health care goods and services, should be distributed or redistributed.

Some of these theories include:

(i) Utilitarianism theories: Utilitarianism theories emphasize a mixture of criteria for the purpose of maximizing public utility. They argue that the standard of justice is not independent of the principle of utility. Rather, justice is the name for the paramount and most stringent forms of obligation created by the principle of utility. Typically, "Utilitarian obligations of justice are correlative rights for individuals that should be enforced by law, if necessary. These rights are contingent upon social arrangements that maximize net social utility in the circumstances."[29]

(ii) Communitarian theories: Communitarians react negatively to liberal models of society (such as those of Mill, Rawls, and Nozick) that base human relationship on rights and contracts and that attempt to construct a single theory of justice by which to judge every society. Communitarians regard principles of justice as pluralistic, deriving from as many different conceptions of the good as there are

diverse moral communities. They regard what is due individuals and groups as depending on these community-derived standards"[30]

(i) Michael Walzers Communitarianism, by contrast, focuses on past and present socio-moral practices. According to Walzers, no single principle of distributive justice governs all social goods and their distribution. Rather, a series of principles constructed by human societies constitute distinct "spheres of justice". Notions of Justice are not derived from some "rational" or "natural" foundation external to the society, but rather from standards developed internally as a political community evolves. Walzer contends that this system would be unjust in the United States because the "Common appreciation of the importance of medical care" had already carried the American people beyond the arrangement: "So long as communal funds are spent, as they currently are, to finance research, build hospital, and pay the fees of doctors in private practice, the services that these expenditures underwrite must be equally available.[31]

(iii) Egalitarian theories: Egalitarian theories of Justice propose that persons be provided an equal distribution of certain goods such as health care, but all prominent egalitarian theories of justice are cautiously formulated to avoid making equal sharing of all possible social benefits a requirement of justice.

(iv) John Rawls theory of justice present an egalitarian challenge to libertarian and utilitarian theories. Rawls explicates justice as fairness, understood as norms of cooperation agreed to by free and equal persons who participate in social activities with mutual respect. Rawls argues that "what justifies a conception of justice is not its being true to an order antecedent and given to us, but its congruence with our deeper understanding of ourselves and our history and the traditions embedded in our public life, it is the most reasonable doctrine for us."[32]

(v) In an influential interpretation and extension of Rawls theory, Norman Daniels argues for a just health care system based centrally on Rawlsian principles of "fair equality of opportunity". He relies implicitly on the importance of health

care needs and on a considered judgment that fair opportunity is central to any acceptance theory of justice. Daniels's thesis is that "social institutions affecting health care distribution should be arranged as far as possible, to allow each person to achieve a fair share of the normal range of opportunities present in that society. The normal range of opportunity is determined by the range of life plan that a person could reasonable hope to pursue, given his or her talents and skills."[33] This theory, like Rawls', recognizes a positive social obligation to eliminate or reduce barriers that prevent fair equality of opportunity, an obligation that extends to programs that correct or compensate for various disadvantages. Disease is disabilities are viewed as undeserved restrictions on persons' opportunities to meet basic goals. "Health care needs are determined by whatever is necessary to achieve, maintain, or restore adequate or "species-typical" levels of functioning (or the equivalent of these levels). A health care system designed to meet these needs should attempt to prevent disease, illness, or injury from reducing the range of opportunity open to the individual. The allocation of health care resources, then, should ensure justice through fair equality of opportunity."[34]

The Principle of Formal Justice: Common to all theories of justice is a minimal requirement traditionally attributed to Aristotle: Equals must be treated equally, and unequals must be treated unequally. This principle of formal justice (sometimes called the principle of formal equality) is "formal" because "it states no particular respects in which equals ought to be treated equally and provides no criteria for determining whether two or more individuals are in fact equals. It asserts that whatever respects are under considerations as relevant, persons equal in those respects should be treated equally. That is, no person should be treated unequally, despite all differences with other persons, unless some difference between them is relevant to the treatment at stake."[35]

2.9 PRINCIPILISM AS A PRACTICAL APPROACH

The moral principles of autonomy, beneficenmmce, non-maleficence and justice are combined in the application of the approach known as "Principilism". Significantly, this approach does not, in any way, conflict with the ethical theological and social approaches in matters of decision-making. However, principilism and other approaches offer a pluralistic method, such that:

> This pluralistic approach is essential when making moral decisions institutionally, pedagogically, and in the community as pluralistic interdisciplinary groups by definition cannot agree on particular moral theories or their epistemic justifications. However, pluralistic interdisciplinary groups can and do agree on inter-subjective principles. In the development of a principilistic moral framework, it is not a necessary condition that the epistemic origins and justifications of these principles be established. Rather, the sufficient condition is that most individuals and societies would agree that both prescriptively and descriptively there is wide agreement with the existence and acceptance of the general values of autonomy, non-maleficence, beneficence, and justice.[36]

2.10 INCOMMENSURABLE BELIEFS

Even though pluralistic groups will in large part have shared universal values, it is still clearly recognized that there is and will be incommensurable beliefs as to how the specification and balancing procedures found in the principlistic approach ought to be implemented. However, principilism has the advantage over most other moral approaches in that it emphasizes the shared interdisciplinary universal values or principles and uses them in a systematic and transparent fashion, resulting in a greater shared understanding and/or compromise. Certainly, principilism does not claim to be able to solve all moral dilemmas, caused by conflicts of beliefs, yet principilism, without a doubt, has tremendous output power for practicing interdisciplinary moral decision-making.

2.11 UNIFIED APPROACH

Principilism is a unified approach in that each moral principle seems to converge into each of the other three principles. For example, it can be argued that

Principilism, as a comprehensive moral approach, is just another term for justice. To the extent that justice is socially valued because of how it effectively establishes autonomy, non-maleficence, and beneficence, both personally and socially, it can be argued that principilism only needs its fourth principle - justice - in order to fulfill its moral function. However, this argument can also be made with regards to each of the four principles as each principle seems to be able to include each of the other three principles. Personal autonomy results in the maximization of personal benefits (beneficence) and the minimization of personal burdens (non-maleficence) within a legitimate social structure justice. Likewise, non-maleficence is maximized, by maximizing autonomy, beneficence, and justice and beneficence is maximized, by maximizing autonomy, non-maleficence, and justice.

The fact that each of the four principles can be argued to be the supreme moral principle further validates the principlistic approach towards moral decision-making. In other words, Principilism is a unified moral approach in which the addition of each principle strengthens the legitimacy of each of the other principles to the extent that each principle is specified and balanced using independent criteria and yet each principle supports each of the other principles.[37]

2.12 GOAL OF MORAL DECISION-MAKING

The goal in moral decision-making is ultimately to specify and balance each of the four principles, recognizing that there is no set hierarchical order of principles in that one or more moral principle may override the others, depending on the circumstances. Specifying is the narrowing down or making broad moral principles relevant to a particular decision and balancing is the attempt to maximize, as much as possible, all of the contributing or competing moral principles.

Principilism, in relation to advance directives, in the view of the advocates of advance directives, these four principles: autonomy, beneficence, non-maleficence and justice enable one's wishes to be respected and be granted. However, Africans, with their communalistic way of life, would put much emphasizes on beneficence and non-maleficence. Africans believe that an absolute autonomy of freedom could be destructive and would prefer beneficence to autonomy.

END NOTES

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CHAPTER THREE

THE IGBO CONCEPT OF THE HUMAN PERSON

3.0 INTRODUCTION

A philosophy on the human person will certainly be a critical evaluation on the tenets that make up and give us a rational explanation on the mystery of the human person. The human person is a mystery, given the case that beside other creatures and existents in the world, the human person is the most rational and the most unpredictable. This point is buttressed by the fact that many human social sciences are yet to get to the level at which they will predict human attitude with the greatest certainty.

Man is a human person. It is when we wish to give a comprehensive name and meaning to man's being, a name expressing his entire reality in a precise and unequivocal way, we say that he is a person.[1] This term is used not for plants or animals but only for man. The concept "person" has been understood and explained by different people, both as individuals and as group. For the purpose of this work, we shall pay attention to the Igbo concept of person.

In an attempt to understand the Igbo concept of the human person, we must bear in mind that while this group of people may share similar explanations on the nature of the human person with other ethnic groups, especially in Africa, theirs is specifically unique and has been held since ages. But before we move into the discussion proper, we must try to understand this group of people.

3.1 WHO ARE THE IGBO PEOPLE?

The Igbo constitutes one of the largest ethnic nationalities in Nigeria. Their language is Igbo with many vocal dialects. Their territory cuts across the equatorial forest in the south and the savannah in the North. Igbo land includes areas both East and West of the River Niger. In the West, Igbo territory is found in today's Delta State of Nigeria. In the East, it embraces the whole of Abia, Anambra, Ebonyi, Enugu, and

Imo States of Nigeria and spreads to ports of Ogoja in Cross River state of Nigeria, Ikueme, Ahoada and Port Harcourt divisions of Rivers
State of Nigeria. The Igbo are surrounded on all sides by other ethnic groups, (the Bini, Warri, Ijaw, Ogoni, Igala, Tiv, Efik and Ibibio).[5] These people called the Igbo have their own worldview one of which is their view/idea of the human person.

3.2 "MMADU": THE IGBO NAME FOR THE HUMAN PERSON

The Igbo name for the human person is "Mmadu". This word is a combination of two Igbo words, namely, "mma" and "du".[3] "Mma" means "beauty" or "goodness" while "Idi" simply means "to exist" and "ndu" means "life". If we are to take "mma" and "idi", we shall arrive at this meaning: there is beauty of goodness. When we take both "mma" and "ndu", they mean: the beauty/goodness of life. Thus, we shall have a seeming two meanings of the name of the human person in Igbo namely: there is beauty/goodness and the beauty and goodness of life. These two definitions do not mean that there is an equivocal meaning of the Igbo name for the human person. Thus, the Igbo name for the human person actually means the beauty and goodness of life. This is so because the human person, and not God, or the Angels, is the perfect manifestation of the existence of beauty and goodness of life.

In the world of creation, only the human person has the greatest attributes that connote the concrete manifestation of the goodness of life. For, although creatures are wonderful in their own. ways, the human person enjoys the highest degree of this goodness. Chielona Eze shares this sentiment when he says that "mma du and mma di means the same thing: there is beauty or goodness. It is an assertion implying the absolute certainty of the existence of beauty and goodness in the world."[4] Perhaps another reason the Igbo has this name for the human person is the role and place of the human person in the world; the place of the caretaker of the universe, possessing in greater degree more reason, ability and intelligence than even the cleverest of other creatures. In buttressing this fact, Nwala avers that, "man is not only regarded as the most important being in creation, he is also regarded as being superior in natural intelligence to other beings including spirits…"[5] One cannot doubt easily, given the fact that what the world will be like, when there are no human persons, is better unimagined.

One philosophical puzzle that may emerge here is the question of the genesis of the name the Igbo uses for the human person. Though a corresponding answer to this question will assist us a long way, we must admit that just like most ancient human terminologies for things in other cultures and places, the name the Igbo uses for the human person has been in existence from the very beginning. This could be a near valid point given the case that from the time the language came into existence, which may not be unconnected with the origin of the Igbo people, the Igbo name for the human person has been in vogue.

However, while many hold on to this solution, others believe that at the time of creation of the human person (in Igbo worldview of creation), God has given the name to the human person. In line with this, Emefe Ikenga Metuh has this to say:

> The Igbo word for man is "mmadu". Arazu claims that he learnt from an Igbo sage that the etymological meaning of the word is "mma" (goodness), "du" (exists). This word, says, the sage, was first pronounced by God when he looked at the world he had made and said "mmadu", "Let goodness exists". This may well be.[6]

A significant fact that needs to be learnt about this Igbo name of the human person is that this name "mmadu", meaning "the goodness of life", has an ethical dimension. This is because such a name already gives the human person the natural and ontological responsibility to radiate beauty and goodness in life. This is the issue of morality. "Mmadu" is called from creation to continue to expand the goodness of life. Even when other creatures manifest goodness, they are not charged with the task of increasing it. Such increase is for man who has been placed over them as a moral agent too. And it is for this very reason that man is solely responsible for his/her place in the interactions with the world. Chielona Eze agreed to this point when he asserts that:

> Goodness and beauty do not exist on their own. A thing has to pass an aesthetic test to be beautiful as much as an act would be subjected to more assessment to determine whether it is good or bad. To say that *mma du (di)* would

> imply that the Igbos have a sense of taste and moral probity…to prove their seriousness about the being of goodness and beauty, the Igbos have no less a being to present than the species of man.[7]

Moreover, the name *mmadu* refers to the human person, irrespective of age/stage, from conception to death. It also distinguishes human beings from other creatures in the world.

3.3 THE IGBO INDIVIDUAL NAMES OF HUMAN PERSON

"A name could be a word or a set of words by which someone or something is usually known, addressed or referred to."[8] The Igbo places so much dignity on the individual human person whom they believe is unique. This dignity, which starts from the time of conception, is rightly affirmed by distinguishing individuals through their names. To give names to the newly born may not be attended with much ceremony in other parts of the world. However, for the Igbo, the giving of names is often done with a big ceremony because there is always a huge regard placed on the name of each individual human person.

The Igbo believe that a person's destiny follows him or her from the moment of conception till birth and the whole life of the person. Hence, in the choice of name for the individual person, care is taken so much to include a consideration of the events surrounding the birth of the child within the family and, by extension, within the kindred. The wisdom there is that the name given to the child must be in line with the destiny desired in connection with the events and circumstances before the birth of the child. Paul Nnamdi Njoku captures this fact thus:

> Every Igbo name has deep-rooted meaning. This is why the naming ceremony is very important…For sure what makes a person an authentic Igbo is his local name. Without the Igbo name, the child has no cultural Identity…Before the Igbo give out a name, they often consider the circumstances of the birth of the child.[9]

More still, the Igbo believe that even in some cases where the circumstances surrounding the birth of a child appears tragic, the name of the child has a way of being a prayerful wish for the good of the child, the family and the society. Since they cannot predict the future perfectly, they turn to their Supreme Being, God, who is *Chukwu* in Igbo, for an improvement of the present in the future through the birth of the child. Here we have these names: *Ozoemena*: let it not happen again (probably after many tragic events of deaths in the family).*Onwubiko*: Death, please, (pleading after many deaths in the family, it is now enough). There are also names like *Ogueri*: spared by the War; *Onwumere*: caused by death (in circumstances where death ended marriage), and so on. There are other names indicating wealth or blessing like *Obiageli*: one who comes to enjoy (in a family where there is wealth); *Ngozichukwu*: blessing of God (in circumstances where God has blessed the parents with prosperity); *Ijeoma*: safe journey (in circumstances where one arrives safely in the midst of wealth). Most of these names also show different forms of supplication, expectations, wishes and affirmations, as seen in the following names *Chinyere*: God gives; *Chukwudi*: God exists; *Chidiebere*: God is merciful; *Chinedu*: God leads; *Chibuikem*: God is my strength; *Chikadibia*: God is greater and more powerful than the native doctors.

One thing that needs to be added in the understanding of the Igbo attitude to individual names is that the names are not gender-based, that is, there are no restricted names for any of the sexes. There is nothing like male names or female names in the individual names the Igbo give to the different persons.[10] The only thing is that the Igbo do not give names arbitrarily; there is always a consideration of many factors before a person is given a name in Igbo land.

Significant to note is that while a name solely belongs to the person named after, the traditional Igbo understanding is that one cannot easily change the name being given. This is consequent upon the fact that such name is a product of long reflection on the events surrounding the person's birth. Hence, in an attempt to understand a person in Igboland, an examination on the person's native/local name will go a very long way to determine the person's family background. This is particularly the case with those names that have connections with tragic occurrences during the birth of a person.

3.4 THE NATURE OF THE HUMAN PERSON

In discussing the nature of the human person, the driving question is: what makes the essential part or components of the human person? The human person, in the Igbo/African traditional thought, is a member of the universe. The human person is a major existent in the entire cosmos. He or she is the link between the spiritual and the material world. This human person is a complementary composite of diverse interacting parts of which immaterial substances (soul or spirit /mind) and a material substance (body) are the most outstanding units.[11]

The Igbo believe that the human personality is a very complex structure whose operation can be understood in terms of the powers as well as the interactions, of both the spiritual and the material substances. The powers of these two components of the human person give rise to the basic natural placement of the human person. With these the three aspects of the human person are realised: the transcendental, the communal and the individual.[15] These contribute to constitute personal identity, which is always in need of perfectibility.[13] For a better understanding of the essential parts of the human person, therefore, we shall discuss two levels namely: the internal zone, which has the features of the body, mind and soul, and the second, the external which is the socio-communal perspective that expresses the internal.

3.5 THE INTERNAL ZONE OF THE HUMAN PERSON

The internal zone of the human person consists of those essential parts that do not have or depend on explicit contact with the others before they are recognised. This means that these elements are essential to each individual person irrespective his or her relationship outside the self. These elements are: the body, the mind and the spirit or soul. While the first element consists of the material element of the components of the human person, the last two consist of the spiritual/immaterial components. These elements form the three essential parts of the life of the human person. It is worthy of note, therefore, that on these three elements lie the life of the human person, as understood by the Igbo. Without any of these, human life is not actually in existence.

The Igbo word for the body is *Ahu*. It is the visible part of the human person which perishes and becomes earth at death.[14] This body is not a pure spirit but a

corporeal being. The person, in this context, is embodied: he has a body. He is not a spirit or a disembodied invisible being. The body is composed of flesh, bones and blood. It can be perceived through the senses.[15] By not being a spirit, pure and simple, he is a human being. As *mmadu*, the human person is not an extraordinary being, with spectacular identity of supra natural constitution and powers.[16] Also, he is not an invisible element that can perform the supernatural actions that spirits perform. He is ordinary like all other beings that are sand and ashes.

By being a body, the human person is limited, fragile, contingent and merely human. Thus, the conclusion becomes that part of the essence of the human person is the human body. This material aspect of the human person is so important that it is valued and respected. Much care is taken to preserve it and promote its health, since death to it means an end to its existence in the present world.[17]

The conclusion from this is that part of the essence of *mmadu-ness* is body (*ahu*).[18] This corporeal aspect of *mmadu-ness* is such an essential part of the constitution of the human person, which at times, it is used to design the entirety of the body. Thus, we often hear *Ahu adighi m* meaning *my body is not with me* or *my body is missing.* This is often said when the person is sick. To say that one's body is not with him, or that it is missing as the Igbo expression of sickness, means that the body, which should be under the control of the whole human person such that he or she can use it to achieve some things, is no longer fit for such engagement. That is why the sick is usually relieved of some functions with someone playing the sick role. Hence, the sick can say that the body is not with him only in the sense that he/she cannot control and use it as desired.

Another component of the spiritual element of the human person is the mind. The Igbo word for the mind is *Uche.* The mind is the human person's faculty of intellection or rational operations around which such activities as thinking or thought (*echiche***)**, knowledge (*amamihe*), understanding (*nghota*), memory (*Ncheta*) and willing (*icho*) revolve.[19] It is the capacity possessed by individuals to think, or the outcome of the exercise of the capacity to think.[20] This brings about the idea of human freedom which the Igbo believe is intrinsic in the life of the human person. The human mind has a more superior position over the body even if it can be incorporated. It is the

very centre of the human person as in it is the flow of consciousness and actions of the person. These are processes arising from the dictates of the mind, in the form that the mind commands or directs the human person.[21] Here one is said to have done what his/her mind tells him/her under the dictates of the mind, which directs the human person.[25]

It is important that one is able to think throughly, to do things in a way different from other bodily beings like animals. It is worthy to note that reasoning (Uche, Ako na uche, Echiche**)** is a quality which, even though is present in all human persons, may be there either potentially (as in a child who has not reached the age of reason) or feebly (like in mad people, morons or other mentally sick persons).[23] These people are still human beings. They are not regarded as animals, even though they do not reason normally. This is because they are sick, not because they are subhuman.[24] And their *Uche* (mind) will function again when they recover.

Interestingly, the Igbo and other Africans believe that the mind is not a substance or an entity that constitutes part of the natural (physical) make-up of each human person.[25] But then, the accurate functioning of the mind gives the clear understanding that man is a rational being. This brings to the fore the question of the location of the mind in the body of the human person. For the Igbo, it is believed that the mind is located within the heart.[56] Emefie Ikenga Metuh avers that "the heart, *Obi,* is man's animation principle, and seat of affection and volition.[57]

The spirit (*mmuo*) is another essential element in the *madu-ness*. The spirit is another aspect of the human person which is the spiritual, the invisible and the determinant of the ontological-transcendental being and the functioning of the human person. The spirit is, thus, the indestructible immortal element that leaves the body at death. There is this belief that the spirit survives after the death of the human person and it is supra-empirical. Like other Africans, the Igbo believe that it is the spirit that has travelled at death to the land of the spirit to sojourn with the ancestors. The spirit is the life - giving force of the human person. That is why when it leaves the body, the death of the human person has occurred, leaving the body in lifelessness, corruption and disintegration of the human person. Without the spirit, the human person is a mere body, a non-living body. When the spirit it leaves the body, it results in death,

lifelessness, and disintegration of the person. This process is evidently an essential constituent of the human person. The spirit, at death, departs into a separate existence in the spiritual realm and at the same time may reincarnate and is born into life again.[58] This Igbo conception of the role and place of the spirit in the life of the human person is equally shared by the Akan people of Ghana. Oyeshile gives us a clue on this point when he notes that:

> The Akan *sunsum* means spirit which is responsible for one's personality, ego, looks, and individuality. It is an intangible element, which is believed to have the power to leave a person's body during sleep, and may or may not return to the owner. *Sunsum* also has an ambivalent nature like the *okra* and it can be compared with *emi*in Yoruba's and *Ndu* and *Nkpuruobi*in Igbo's because it accounts for the possibility of life. This is because if it does not return back to the body when it leaves, it means death for the body.[59]

Significant to mention here is that the soul (*nkpuru-obi*) is used interchangeably with "spirit" in today's Igbo's understanding of the human person. Arguably, this term may have come with Christianity, or may have incorporated the Christian meaning of the soul into its understanding in the life of the human person. There is no stated fact that the traditional sages in Igbo land gave an explanation of a traditional understanding of the soul as a component of the spirit or an element on its own. We could, thus, say that its present association with the human person in Igbo worldview is a product of recent Igbo philosophical tradition.

Given that this explanation may have some seeming diversity, they all agree as to its nature and place in the nature of the human person. In line with this, Oyeshile has this to say: "Among the Igbo, there is the *Mmuo*, the spirit of a person that is capable of reincarnation, the *Nkpuru-Obi* is the personality soul, it is said to be material and perishes with the body at death."[30] Elaborating further on this association of the soul (*Nkpuru-Obi*) with the spirit (*mmuo*), Nwala asserts that:

> *Nmuo*-this is the spirit of man and it incorporates attributes of spirituality, intelligence, feeling, emotion, and conscience, Mmuo is also associated with ***Nkpuru-Obi***- soul, which is located in the

> heart. The spirit of man has no particular shape or form and could be compared with breath or air…it is however the location of the life-giving force…[31]

With this elaboration, we come to realise why the soul is associated with the spirit simply because it is taken to be the seat of life-giving force or the life-giving force itself. This is simply the breath of life, which links man with other forces-both cosmic and non-cosmic. Agreeing with this position, Emefie Ikenga Metuah has this to say:

> Obi, 'Breath' is an immaterial spiritual substance which sometimes leaves the body…the breath is a life-force which links man with other cosmic forces. It may be attached through witchcraft or sorcery and may be weakened or die…at death, the heart leaves the body but it does not survive. Nowadays, one hears of *mkpuluobi*[35] as 'soul' and identify it with the Christian soul, but this is a concept completely alien to traditional Igbo beliefs. Traditionally, *mkpuruobi* is the same as Obi, breath…[33]

The conclusion here becomes that the spirit, soul, and breath are used interchangeably in defining the elements that make up the spiritual aspect of the human person. One thing that is clear is that it is the life-giving force of the human person: without it, the human body remains lifeless.

Despite the different substances that define the human person, the Igbo believe that he or she is one. The three elements body (*Ahu***)**, mind (*Uche***)** and spirit (*mmuo***)** do not mean that the person is three persons but one instead; he is seen in different perspectives *mmuo* (spirit), *ahu* (body) and *uche* (mind). The human person can never be conceptualised in a fragmented mode but is an embodiment of complementary unit that form a whole.[34] The three elements work interrelatedly. While the mind conceives of an action, the spirit encourages, or discourages as the case may be, and finally the body will execute it. Hence we can say that the totality of the human personality is involved in the execution of the basic human acts that emanate from these substances. Also the Igbo use the words *obi*, *uche*, *mmuo*, inter-changeably to designate the mind. This points to the close unity in the operation of these faculties under their relationship to the body, which is a visible element of the whole. It is under this condition of close

unity that the human person can be conceivable. For the human person to be normal, his spirit (*mmuo*), mind (*uche* or *obi*) and body (*ahu*) must work together, harmoniously and complementarily. The Igbo, therefore, do not have dualism of personality.

3.6 THE EXTERNAL ZONE OF THE HUMAN PERSON

Another composite of the human person, which is more of external than internal, is the social nature of the human person. Africans see the human person as a being with others. This external zone of the human person does not mean that it is the element that brings about the biological make-up of the person. Rather, it expresses the Igbo's understanding of the human person as a human being and a member of the human society or community, thereby complementing his or her biological composition. What is the community? Or who is the community? Is one basic question that will be asked here; the understanding of this question will solve the puzzle connected with the influence of the community on the person.

The Microsoft Encarta Encyclopedia defines "community" as a group of people in the same area, or the area in which they live; a group of people with a common background or with shared interests within society; a group of nations with a common history or common economic or political interests; or a public society in general.[35] Here we have some related definitions of community. But the Igbo understanding of the meaning of community seems to encapsulate all these dictionary definitions. Hence, the contemporary Igbo philosopher Agulanna affirms that:

> By 'community' on the other hand, we usually have in mind a sub-society whose members (1) are in personal contact, (2) are concerned for one another's welfare, (3) are committed to common purposes and procedures, (4) share responsibility for joint actions, and (5) value the membership in the community as an end worth pursuing.[36]

In this description of the community, it is observed that the human person's contact with the people may have been ontologically caused by their blood relationship even in different generations. This blood relationship also spurs them on to be concerned with the affairs of others in a positive direction; this inevitably warrants commitment to public services. The many positive implication of this relationship

makes them to appreciate the community life more than anything else. In a more lucid clarification, Nwala explains that:

> In Igbo traditional thought, a *community* is the same as *'people of one blood',* irrespective of their geographical location. Hence, members of a community are referred to as *'Umunna- Brethren* (*or Kinsmen*). The community itself has its being, identity or existence defined by this common blood.[37]

The community is made up of families, clans, and kindreds who are united by blood in the line of their ancestors. Beyond this blood link, there is also a spiritual bond that links the family and the community. For this, Emefie Metuah explicates that:

> The bond which links the family community is not only a sociological bond but also ontologico-spiritual. The Eke, ancestral guardian, assigned by God, is usually, though not exclusively, a member of the family or a spirit related to the family. The Eke is said to be reborn in the new member of the family to whom is assigned, and thus gives him his form, character or personality. The Eke thus maintains the unbroken ontological bond between a person, his family, lineage, clan, tribe.[38]

The first contact one has with reality is human contact. This is expressed in the family and soon in the community. The community consciousness resounded to constitute the backdrop of a person's realization of his consciousness as a person, distinct but already immersed in one's community. Hence, the identity of a person is constituted by the community.[39] The human person does not have the definition of self-outside the community. To be a person is to be a being with others. Thus, though a person is a distinct individual, he/she is a member of the society.

As the human person is a member of a family, a clan or kindred, so also does he/she automatically become a member of the human community. This ontological membership and the subsequent fulfilment of the stipulations of the community is what qualifies one to be a human person. This is true because the idea of "personhood" invokes a set of rights and responsibilities that is acquired developmentally by participating in communal life and social recognition.[40] From this we learn that for the

Igbo, the human person must belong to a family which links him/her to the community. As a member of the community, the individual is defined in the context of his/her community. Hence, personal identity of the human person is inseparable from the social and cultural environment which is the community.

In similarity with the Igbo concept of the human person, other African societies believe that personhood is attained in communal life. This is contrary to the western understanding of the individual believed to have first existed before the community. Polycarp Ikuenobe, making reference to Gail Presbey, says that African conception of personhood is based on an intragroup moral and social recognition.[41] Ifeanyi A. Menkiti summarises it thus when he says that:

> …in the African view, it is the community which defines the person as person, not some isolated static equality of rationality, will, or memory… the fact that persons become persons only after a process of incorporation. Without incorporation into this or that community, individuals are considered to be mere danglers to whom the description 'person' does not fully apply.[42]

It is this incorporation into the human community that the Igbo do when they celebrate the birth of a new child according to the rites of circumcision, naming ceremony and other early incorporation stipulations, as the community has stipulated. This is true given the case that the issue of circumcision is cultural to the Igbo, though not exclusive, and the names to be given to the child must not be alien to the community even at the broader level.

It is in line with this understanding of the nature of the community within the African context, of which the Igbo people are a part, that Ifeanyi Menkiti describes the community as a *collectivity* of persons, principles, processes, and structures that defines social norms, moral expectations, responsibilities, on the basis of which one is recognised as a person.[43]

The community functions in not only identifying the personhood of the human person but in guiding the freedom of the person towards responsibility. Hence, the community is provider of morality and rationality for the human person. These emerge

from the cultural values, beliefs and ideas about the world. From these sources, the community fashions out moral codes and values and, thus, expects that the individual members will abide by them. This very Igbo view is shared by the African society. Polycarp Ikuenobe agrees that:

> The community is at the centre of every thought, activity, or practice; it shapes one's ways of life, attitudes, ways of seeing things, and methods of doing things. Many African ideas and beliefs, and values are grounded and made meaningful only in the context of their communalistic conceptual and normative schemes. Traditional African societies are founded on, and sustained by, the idea of communally shared beliefs, practices and values.[44]

For the Igbo then, to go against the morality of the community is taken to be an offence against the land: *Iru Ala.* It literally means to desecrate the land. Anyone who does this is always frowned at; and because the moral norms are aged-long, the forgiveness of such an offence involves a purification by the elders after making supplication to the gods of the land and the ancestors, through whom these moral norms have emerged.

Consequently, a moral person is one who appreciates the communal values and attitudes, and refrains from actions that threaten the general welfare. The faithful adherence to these values and moral norms is what makes one a true human person; for as a member of the community, he acts in the welfare of the community. Hence, the recognition of the human person also includes the moral character and even mere achievements. The Yoruba people share this line of thought with the Igbo. The Yoruba people of the Western part of Nigeria have the word for the human person: *eniyan*. But, *eniyan* has both a normative dimension and an ordinary meaning. Accordingly:

> …It is not unusual, referring to a human being, for an observer to say *Ki I seeniyan*(he/she is not an *eniyan*). Such a comment is a judgment of the moral standing of the human being who is thus determined to fall short of what it takes to be recognised as such. In the language, greater emphasis is placed on this normative dimension of *eniyan*, perhaps more than is placed on the concept of person in English Language.[45]

The morality of the human person does not only end in the concrete good moral actions as stipulated by the society. More than that, the morality of the human person begins from the framework of the mind where these actions are judged before action. Such psychology is coloured by the community's way of life. Thus, Polycarp Ikuenobe explains this with the Character of Okonkwo in Chinua Achebe's *Things Fall Apart* when he asserts that:

> Complex communal relationships, which involve the moral and psychological integration of a person into the community, also provides the foundation for people's rational and emotional character and identity. Such relationships indicate that a robust sense of personhood goes beyond mere achievements. Achebe indicates in the character of Okonkwo how, in spite of one's achievements, one may fail to achieve personhood, and subsequently ancerstorhood, simply because one lacks some necessary psychological elements. In order to achieve personhood, an individual must be "psychologically wholesome", emotionally and rationally stable, communally well adjusted, and must consistently show excellent judgment.[46]

Furthermore, the community spirit exists in shared beliefs and practices. Through this sharing, the human persons grow better and the society in turn grows. This brings out the Igbo belief that no one can live alone; for there is always the need to share with others either by necessity or by convenience. For the Igbo, no one can make a family not to talk of the community. Everybody is needed to establish a successful family and community at large. Agulanna is emphatic about this; for he says that among the Igbo, one shared attitudinal inclination is the belief that human existence only makes meaning within social setting…. With particular reference to the Igbo way of viewing things, scholars are agreed that "community spirit" is very strong among the people.[47]

The Igbo believes that the communal life, apart from its natural demand, is of many benefits to the individual person. The community guarantees the security of life and property of the individual person. At the various stages of growth and development, the human person is not only provided security but also contributes

his/her quota in the security of the entire community members whether far or near. For this reason, the Igbo do not fail to reach out to their people and warn them of any eminent danger. In the exact words of Agulanna:

> Among the traditional Igbo, a person was only assured of security by being attached to his or her community. From the time an individual is born, until the time he dies, he is made aware of his dependence on his kin group and his community. From his earliest age, the individual is made aware not only of his reliance on his community but also of the need to make his own contribution to the group to which he owe much.[48]

In further stressing the fact that geography does not place a barrier to the Igbo community spirit, Agulanna adds that:

> …those in Diaspora still experience this sense of being bonded or yoked to their land of nativity or home community. The dispersed Igbo, or those scattered in other parts of the globe do not by the very fact of living outside their home communities detach themselves from their kin back home. Rather, they are expected, as a social demand, not only to contribute to the development of their native communities but also to be active members of their various places of sojourning.[49]

The individual cannot do without the community. In fact, it is always the case that the community cannot do without the individual but the reverse cannot be the case. Hence, the Igbo person is always seen making use of the expression *Ikwu and Ibe* which refers to the entire community of kinsmen, children, women and all other relations. Thus, the individual person in Igbo land does not ignore nor abandon the social life. Hence, it is taken as the worst of punishment for a person to be banished from the community due to a grave sin committed. In the Igbo people's understanding, the person has lost a value to his life.

The Igbo understanding of the human person in the external zone: the social/communal life is fitting for several purposes. This insistence on the communal life ensures the full development of the human person in terms of providing the persons economic needs, security, peace and unity among other persons in the society; it also

promotes equality in the society, thereby manifesting the dignity the Igbo places on the human person. Agulanna further explains thus:

> Usually, in Igbo world, in carrying out his obligations, the individual expects his community to reciprocate by providing him with the needed security and protective shield. Social anthropologists and other scholars who have studied the patterns of life among the pre-colonial Igbo society recount that it was rare to find cases of individuals who starved in the society simply because they lacked food or personal weal. Recollecting the faint idea he had about the traditional Igbo life before he was sold into slavery around 1756, the popular Igbo slave, Olaudah Equiano speaks of the Igbo social life this way: "everyone contributes something to the common stock, and as we are unacquainted with idleness, we had no beggars."[50]

The importance attached to the communal life among the Igbo is equally revealed in the fact that between the interest of the community and that of the individual person, that of the community takes precedence. What this means is that one can do his will but must not be done at the expense of the good of the community. For Agulanna, "among the Igbo people of Nigeria, as among other African peoples generally, the obvious curtailment of a person's power to do as he wills is provided by the potent force of what is known as "the will of the community". [51] Polycarp Ikuenobe agrees with this when he says that:

> in African conception, the interests of the community are *logically prior* to the interests of the individual; individual interests are shaped by those of the community. Logically this does not imply the *moral* priority of the community over the individual, it simply means that the attitudes, sentiments, and moral dispositions of individuals are formed by virtue of belonging to a community with requisite norms.[52]

Uzodinma Nwala gives us the reason behind this hierarchy of interests between the community and the person when he posits that:

> The community itself has its being, identity or existence defined by this common blood. The life of a member of the community is interwoven with the others through the common blood which they share and through the web of economic and social interdependence which practically exists in the community. Consequently, the being of the community is larger than prior to that of any of its individual members, since the being of the community as a whole is identical with the being of the total personality of the ancestors.[53]

However, one may think that the Igbo have no place for the individual persons, in terms of allowing for self-actualisation and self-realisation. This is not the case. The fact remains that the Igbo, like most Africans, recognise the individual persons and even promotes their interest; but this pursuance of self-realisation cannot be hinged on individualism or autonomy which neglects the society. In this line of thought, Anthony Chukwuemeka Okonkwo succinctly says:

> Individuality or autonomous definitions of the human person are not for the Africans. Africans see the human person as a social, communal and rational self. John S. Mbiti made it clear in his self-other relationship; he says: "I am because we are; and since we are therefore I am." The African Phenomenon starts from the opposite end: the external, the other persons, existence felt, lived, and communicated. Because they are, because I live and work, and commune with them, I discover my own presence, I exist because they exist. If they did not exist I could not act, love, and live (with them), I could not know that I exist.[54]

In essence, the definition of personality, from the external zone, is represented in this phrases *Mụ na ndị ọzọ,* meaning *I with others*. Thus, for the Igbo, though a person is a distinct individual he/she is a member of the society. The Igbo does this through the community. Human liberty cannot be sought and expressed outside the community as understood with the Igbo and the African peoples. Individual persons are respected and valued too within the framework of the community. Panteleon Iroegbu continues when he says: "the life of the community that defines a person's personality does not destroy his/her liberty. Rather, the person's liberty, a limited one, is reaslised

in, and authenticated in the insertional participation (contribution and distribution) in all the aspects of the life of the community."[55]

Within the community's wide range of options for human development, at the personal and collective level, the individual is allowed and even encouraged to build on his/her potentials but not at the expense of the community. Paul Nnamdi Njoku stresses that:

> The Igboman is strongly attached to his community, no matter how remote it is. If his community is too backward, he goes out, makes wealth and comes back to his community to help build and develop it. His motto always is "No place like home". The peak of his attachment is his family, clan, village or kindred…A successful man is never acknowledged if he fails to help the members of his family or community, especially the young, to register their own success.[56]

The foregoing discussion expresses the importance the Igbo people places on the human person's interaction outside himself as regards his fellow humans. For them, this communal life does not only concern those living but also the ancestors who are believed to be present in the affairs of the community. That is why V. C Uchendu holds strongly the belief that, among the Igbo, an individual who is not attached to the patrilineage (called *Umunna*) is said to be an Igbo without citizenship both in the world of the living and in the "world" of the ancestors.[57] *Umunna* is a group of people of the same blood that may be traceable to common origin. This goes beyond the family stratum and involves all family relations that have a tie by blood or by some other social relationships.

This relational nature of the life of the human person, as understood by the Igbo, is not just horizontal (existing between human persons) but also vertical, that is, the relationship the human person has with the spiritual entities, namely: God (*Chukwu),* the spirits and the ancestors. All these species of spiritual relationship are derived from the destiny the human person is believed to have received collectively or individually.

3.7 THE HUMAN DESTINY

The Microsoft Encarta Encyclopedia defines destiny as an individual's preordained future: the apparently predetermined and inevitable series of events that happen to somebody or something; or, an inner realizable purpose of life: the inner purpose of a life that can be discovered and realised.[58]

The Igbo understanding of human destiny encompasses the two dictionary definitions of destiny. The first notion of destiny as a predetermined and inevitable series of life events strictly pertains to individual destiny. But the second understanding, though having individual dimension, is mainly concerned with the collective human destiny.

The Igbo believe that every individual person in the world has a role to play towards the growth and development of the world. But this role is bounded by the term destiny. This destiny, which seems to be imposed because of its predetermined nature, guides one's course in life increasing and decreasing the one's freedom. Thus, out of its guidance comes either success or failure, as the case may be. Whichever, one's destiny determines the one's personality, which is mostly and fully known at the end or near the end of one's life. In the thoughts of Olatunji Oyeshile; "Destiny is a common feature in the conception of a person in most African cultures. It is believed that a person's destiny, whether by choice or imposition, predetermines for that person what he or she will be in life. It further determines a person's success, failure, personality, luck and ill luck."[59]

The human destiny is believed to be unchangeable: no matter what happens, every bit of the destiny will be realised. The Igbo believe that one is not allowed to know one's destined before hand; that is, before coming into the world. However, in the course of the events of one's life, one begins to have a clue of one's destiny is really all about.

But what is the origin of this human destiny and how is it guided towards its realisation? This question brings to the fore the Igbo belief in the reality of Spiritual beings whose existence is not unconnected with the good of human existence. There are mainly three groups of spirits, namely: the Supreme Being (God), the lesser spirits (small gods) and the spirit of the ancestors. The Supreme Being is called *chukwu* which

means the *Greatest God*. Within the lesser gods is the *personal Chi* which the Igbo believe is attached to every human person. The ancestors as well have a role to play in the affairs of human destiny, in terms of origin, guidance and direction.

The Igbo believe that the origin of the human person is not accidental. Hence, and as created by God, the destiny of each individual is created and fashioned by *Chukwu*, whose wisdom is taken to be the best. So, the Igbo believe that human destiny comes from him. The Supreme Being is seen as the all-powerful and the creator of the universe. He accounts for the origin and the end of all creatures. Hence, fervent worship is given to it for favours and in thanksgiving for favours received. Having fashioned the destiny of each person, he, therefore, entrusts this destiny in the care of a small god (*Chi*) who is very personal to each person. It is this personal god that bears the burden of the questions being raised about the person in the course of his/her life.

Africans recognise a Supreme Being/deity (*Chukwu* in Igbo, *Olodumare* in Yoruba), which can be approached personally and through innumerable lesser deities and through the instrumentality of numerous sacred objects.[60] This Supreme Being is taken as the Greatest Spirit who manifests his power through a pantheon of gods: below these are lesser spirits with animate trees, animals or charms.[61] The practical and concrete preoccupation with the activities of the life of human beings is the concern of the gods. In fact, the gods constitute the font of the resolution of problems, conflicts and the continued administration of communal life.[62] More so, there is this belief that these gods carry the face of persons in the sense of being the expressions of the human desires: peace and security, family, fertility, wealth and long life, strength and progeny.

The personal god (*Chi*) is made to be in-charge of a person's destiny. And it is left for this personal god to decide the overall realisation of the destiny. For Emefie I. Metuh:

> Chi is associated with a child from the moment of its conception. Igbo beliefs say that at conception, God assigns a Chi to each person, and places before the Chi several parcels of fortunes. Whichever the Chi chooses becomes the destiny of the child entrusted to his care. This parcel of destiny which is also referred

> to as Chi has, contains the total luck or misfortunes the child will have in life.[63]

However, this understanding of the destiny as something already predetermined is close to fatalism. The Igbo does not have any room for this idea. When they say that the personal Chi is responsible for the person's luck or misfortune, they simply mean that first, there some things one cannot change in his/her life. These experiences could be of success or misfortune. This is mainly used to explain situations whereby human causes are little or lacking in the result. But second, there is the belief that there are cases in which the person is ontologically capable to reach a sort of agreement with the personal. This is strictly connected to those experiences and situations where one contributes larger percentage to the outcome. T. Uzodinma Nwala helped us this matter when he says that:

> Whatever befalls a man is *ihe ya na Chi ya kpara*- what he settled with his chi. However, *onye kwe Chi ya ekwe*, whatever a man wills, becomes the will of his personal chi. Thus, the element of fatalism (which leaves a man to the mercy of destiny) is mitigated by ascribing a measure of will power and initiative to man. One can influence one's chi through 'brave' or 'good conduct' and this 'knocks the horn of will power and initiative to man.[64]

This great role the personal chi has in the life of the persons, make the Igbo man have what we know as the "Chi Cult". Although each person participates in this cult from adulthood, every person is expected to make sacrifices to his/her personal chi, asking for favours and blessings.

Significantly, just as there is personal chi, there is also a communal chi. Although this may be likened to the Ancestors, they are not the same. The same role the personal *chi* plays for the individual person is what the community chi does for the community. This communal chi is responsible for the success and failure of the community. The community establishes a cult/shrine for the community's chi where the community gather together to call upon him. Flowing from the horizontal relationship of the human person, that is, the external zone of the human life, the community's *chi* is

higher than the person's *chi*. This community chi is taken to be the controller of the personal chi of all the members of the community and as such, it supersedes the personal chi.[65]

Furthermore, the destiny of the human person is influenced by the ancestors who the Igbo believe are part of the community though dead. The Igbo like other Africans value them. Ancestors are the living dead. The life of the ancestors is the continuation of life after death, and it succinctly explains the African belief in the idea of immortality. One becomes an ancestor immediately after death if and only if he lived a very good life on earth. The ancestors live in the land of the spirits or the ancestral world. From here they care for their families still living here on earth. And from here too they reincarnate.[66] Ancestral spirits exist in big numbers and play important roles of protecting and caring for their kith and kin. The idea of an eternal transcendent space is co-joined with the idea of corporeality to arrive at an idea of the living dead, land of the spirits or the ancestors.[67] The respect and value given to the ancestors gave rise to ancestral worship.

Ancestor Worship which is the reverence granted to deceased relatives who are believed to have become powerful spiritual beings or, less frequently, to have attained the status of gods. It is based on the belief that ancestors are active members of society and are still interested in the affairs of their living relatives.[68] Hence, the Igbo man pours wine of oblation to the ancestral spirits every morning; in thanksgiving for the life and in petition for more favours.

The cult of ancestors is common among Africans. Ancestors are believed to wield great authority, having special powers to influence the course of events or to control the well-being of their living relatives. They are considered intermediaries between the supreme god, or the gods, and the people, and can communicate with the living through dreams and by possession. The attitude toward them is one of mixed fear and reverence. If neglected, the ancestors may cause disease and other misfortunes. Propitiation, supplication, prayer, and sacrifice are various ways in which the living can communicate with their ancestors. Ancestor worship is a strong indication of the value placed on the household and of the strong ties that exist between the past and the

present. With this value of the Ancestors, the African is specially trilled to become an ancestor. Hence, every normal Igbo longs to join the ancestral world after his life to commune with his forbears in a happy continued existence.[69]

The Igbo understanding of human destiny as the inner purpose of a life that can be discovered and realised concerns the totality of all human persons which is humanity. This brings to fore the place of man in the universe. The Igbo believe that the human person has been made very beautiful and full of goodness. And this quality confirms on the human person the responsibility to radiate and increase this goodness in the affairs of the world. This is the inner purpose of life, the universal human destiny which everyone is called to.

3.8 THE HUMAN LIFE AND THE DIGNITY OF THE HUMAN PERSON

The Igbo has it that the human person is very valuable and the most valuable creation in the world. This is because he has been made the perfection of all creation, and he is the most rational and intelligent being in the world. To this, care and concern is given to the human person from birth to death.

The human life begins from conception, and goes through childhood, puberty, adulthood, aged, (death) and Ancestorship. The value of the human life makes the Igbo appreciate pregnancies and celebrate it. The Igbo actually celebrate pregnancy because of some reasons. First, it is a sign that the gods are still working for the people earth and thus furthering the human generations.[70] This value placed on pregnancy makes the Igbo man decry anything that will truncate it. Hence, the traditional Igbo society never allowed for abortion irrespective of the reason. This same value is placed on the life of the human person in all its stages.

The value of the life of the human person in Igbo land is also felt in their upholding the sacredness of human blood. To spill a human blood is one of the greatest violence and the punishment is murder or total banishment from the community. The human blood is seen as the preservation of hereditary traits. It is that which sustains life and transmits the same life to offspring. And so, the human blood is valued because it sustains life. In the words of Uzodinma Nwala: *Blood* in Igbo ontology is that which

sustains life by nourishing it; *the spilling of which not only causes dissolution to the flesh but deprives it of the ancestral life line*, and is also seen as defilement of the land and the Earth goddess (Ala). It is, thus, held very sacred. The unlawful shedding of blood is defilement to the sacred earth…[71] The lawful shedding of blood may be as punishment for murder and other grave crimes.

One thing about the understanding of life among the Igbo is that life is a continuous process. It ends temporarily in death and may begin in reincarnation or ancestor ship. Africans believe and affirm that the end of death is life.[72] Two facts are very central to the philosophy of death and after-life in Africa namely: death and reincarnation. While death is the end of the life on earth and a beginning of another life in the land of the spirits, reincarnation is a passage from the spirit-world to this present world.[73] With regard to the survival of the human person after death, Africans maintain that this continued existence is imaginable only as a totality. For them, the soul or spirit is not only immaterial but a reflection of the totality of the human person as it survives after death, such that this spiritualised body must have its faculties and the capacity to perform its operation freely intact. This is why the spirit goes to the land of the living dead or land of the spirits and can be omnipresent, at the same time, as situations require.[74]

Africans firmly believe in the notion of the sacredness of the human person; for the human body is capable of continued existence after death in the land of the living dead or land of the spirits. The physical decay of the body is a consequence of the corporeality of the human body but the real body which is the spirit continues its existence after death and constitutes an integral part of the totality that is evident in its reappearance as corporeal spirits, as re-personated or re-incarnated bodies.[75]

The idea of reincarnation offers us more understanding of the African conceptualisation of death and afterlife. Reincarnation involves a return, after death, of a human person to continue his or her earthly existence. The belief is that this reincarnated person is coming back to complete the mission he or she was assigned by the Supreme Being. In most cases, the reincarnated person shows concrete signs of his or her former person. This is significant in the bodily marks, discernable character and personality traits and the ability even to remember events in previous life.

The question of death and afterlife concerns the idea of immortality of the human person. To arrive at an explanation of this idea, Africans strongly believe that the earthly existence is not the only existence. They believe that after the life on earth through the occurrence of death, another life begins in the land of the spirits. Interestingly, African metaphysics maintains that the life after death is of two folds namely: the life of the ancestors and the life of the reincarnated human person into lower animals. While the life of the ancestors is a reward for the goodness of one's life on earth, the other is a punishment for the evil life lived on earth. Hence, although death is a painful realty, it is a link for the life on earth and life beyond: the afterlife.

CONCLUSION

The Igbo understanding of the human person is holistic. It goes beyond the ordinary biological formulation (the material element and the spiritual elements) and delves into the social nature of the human person. This social character, naturally derived by being a member of the community, impels one to surrender himself to the community who will in turn respect the person. Beyond this, the Igbo name for the human person *mmadu* showcases the fact that the human person is to radiate beauty and goodness in the world, since he is intrinsically the perfection of the beauty of all creation.

The fulfilment of this natural responsibility is realised through the social norms and mores which the community's interest has taken charge of with the personal/individual interests subordinate to it. The human person enjoys his liberty as a human being, but in conflict situations, the community enjoys primacy over the individual. This buttresses the fact that the human person's horizontal relationship is one that shapes his personality.

Moreover, the vertical dimension of the human person's relationship brings about the role and place of the spiritual realities in the life of the human person. *Chukwu*, *personal Chi* and the Ancestors have roles to play especially in shaping and realising one's destiny in the world. In the final analysis, we come to understand it that the Igbo have dignity for the human person. The life of the human person is treasured even from conception till death. This protection and value underscores the Igbo belief

that life is continuous: in the world as human beings and as ancestors in the afterlife. In a nutshell, human life is treasured by the Igbo people, hence, the need for the idea of advance directives, since it upholds the Igbo concept of the human person.

END NOTES

[1] Mondin, B. 1985. *Philosophical anthropology.* Rome: Urbaniana University Press. 243.

2Njoku, P.N, 2002. *The World without Ndi-Igbo.* Owerri: CelBez Printing and Publishing Company. 44.

[3] Although this is the literal division of the two words. The second word is meant to be "ndu" or "idi" which goes a long way to express the first word "mma". These two words that form the complete form of the second word have complementary meanings with "mma", thereby explaining the mystery behind the name of the human person in Igbo thought.

[4]Eze, C. 1998. Man as Mma-Du: Human Being and Being Human in Igbo Context *West African Journal of Philosophical Studies.* 1:1. 31.

[5] Nwala, T. U. 2010. Igbo *philosophy*. Second edition. New York: Triatlantic books Ltd. 58.

[6]Metuh, E.I. 1980. *African religions in western conceptual schemes: The problem of interpretation.* Jos: University of Jos Press. 109.

[7]Eze, C. 1998. Man as Mma-Du: Human being and being human in Igbo Context. Op. Cit.

[8] Available at www.thefreedictionary.com. Accessed on 12th June 2015

[9] Njoku, P .N. 44

[10]Although this is indeed the case, recently, some Igbo names are predominantly attached to a particular gender.

[11] Asouzu, I.I. 2004. *The method and principles of complementary reflection: beyond African Philosophy.* Calabar: University of Calabar Press. 148.

[12] Okonkwo, A.C. 2010. *Destined beyond* Nigeria: Don Bosco Publications. 66.

[13]Iroegbu, P. 1995. *Metaphysics: The kpim of philosophy.* Owerri, International Universities Press. 80.

[14]Nwala, T. U. 58.

[15] Asouzu, I.I. 211.

[16]Iroegbu, P. 352.

[17] Iroegbu, P.352

[18] Iroegbu, P.352.

[19] Asouzu, I.I. 150.

[20] Wiredu, K. 1983. The Akan concept of mind. *Ibadan Journal of Humanistic Studies*. 3.120.

[21] Wiredu, K. 120.

[22] Wiredu, K.153

[23] Wiredu, K. 153.

[24] Wiredu,K . 353

[25] Ekanola, A.B. 2006. Metaphysical Issues in African philosophy. *Core Issues in African Philosophy.* Oladipo, O. Ed. Ibadan: Hope Publications. 80.

[26] The location of the mind in the heart means that the functions of the mind are sometimes said to be coming from the heart. It is from the heart that the person's will to carry out some actions emerges. It is also from the heart that affection and volition emanate.

[27]Metuh, E.I. 111

[28] Nwala, T.U 58.

[29] Oyeshile, O.A. 2002. Towards an African concept of a person: Person in Yoruba, Akan, and Igbo Thoughts. *Orita* xxxiv.109-110.

[30] Oyeshile, O.A. 108

[31] Nwala, T.U.

[32] This term means the same thing with *nkpuruobi.* It is just a question of Igbo dialect

[33] Metuh, E.I. 111

[34] Asouzu, I.I. 150.

[35] Community *Microsoft® Encarta® 2009 [DVD]*.2008 Redmond, WA: Microsoft Corporation

[36] Agulanna, C. 2010 Community and Human Well-being in an African Culture. *Trames: Journal of the Humanities and Social Sciences.* 14:3. 287.

[37] Nwala, T.U. 61

[38] Metuh, E.I. 114

[39] Iroegbu, P. 355.

[40] Ikuenobe, P. 2006. The idea of personhood in Chinua Achebe's *Things Fall Apart. Philosophia Africana. 9*: *2*. 121.

[41] Ikuenobe, P. 118

[42] Menkiti, I.A. 1979. Person and community in African traditional thought. Wright, R. Ed. *African philosophy: An introduction.* 2nd Edition. Washignton DC: University Press of America Inc.158.

[43] Menkiti, I.A. 179.

[44] Ikuenobe, 118

[45] Okonkwo, A.C. 66

[46] Ikuenobe, P. 125

[47] Agulanna, C. 290

[48] Agulanna, C. 290.

[49] Agulanna, C. 291

[50] Agulanna, C. 293

[51] Agulanna, C. 288

[52] Ikuenobe, P. 125

[53] Nwala, T.U. 61

[54] Okonkwo, A.C. 65

[55] Iroegbu, P. 79

[56] Njoku, P.N 83

[57] Agulanna, C. 291

[58] Destiny in *Microsoft® Encarta® 2009 [DVD]*. 2008. Redmond, WA: Microsoft Corporation.

[59] Oyeshile, O.A. 105

[60] Asouzu, I.I. 177.

[61] Yekini, A.S. 212.

[62] Iroegbu, P. 296.

[63] Metuh, E.I. 111

[64] Nwala, T.N 62

[65] Eze, C. 42

[66] Iroegbu, P. 341

[67] Asouzu, I.I. 168.

[68] Saliba, J. A. 2008. Ancestor Worship. *Microsoft® Encarta® 2009 [DVD]*. Redmond, WA: Microsoft Corporation.

[69] Iroegbu, P. 341

[70] This is mainly from the communal aspect. On the individual level, it is most celebrated; for through it the family believes that the gods have favoured their lineage.

[71] Nwala, T.U. 60-61

[72] Yekini, A.S. 2002. African metaphysics. P*hilosophy and logic today*, Asouzu, I.I. Ed. Calabar: University of Calabar Press. 215.

[73] Iroegbu, P. 312.

[74] Asouzu, I.I 168.

[75] Asouzu, I.I

CHAPTER FOUR

THE IGBO PERSPECTIVE ON ADVANCE DIRECTIVES

4.0 INTRODUCTION

As already noted in the previous chapters, an advance directive is a medical but equally a legal document or an instruction by which a person makes provision for health care decisions in the event that, in the future he or she is no longer competent to make such decisions for himself or herself. The primary purpose of advance directive is to provide a means by which a patient is able to determine through the written directives, how he or she wants to be treated when incapable of making decisions regarding preferred treatment. While this document is drawn up by the patient with the awareness of the medical practioners and the relations, no one except the patient or the person he has charged with such responsibility can alter the provisions there in.

Some salient issues are central in this understanding of advance directives namely: first, there is/there will be the presence of sickness (terminal ones in most cases); second, there is a possibility that the sickness will not be cured as one will die from it; third, is that the patient like each rational and mature person can decide what to do with his life irrespective of the time and circumstance; fourth is that the patient does not want to bother those living in taking decisions about his sickness and more still in spending time, energy and resources caring for the patient when there is a great doubt of survival. These basic ideas inform the choice and option of advance directives for the Westerners. On the contrary, the African perspective especially the Igbo perspective of advance directives does not hold these ideas, and this serves as the major factor behind their poor attitude to advance directives.

Nevertheless, it is good to add here that some Igbo persons especially those of them who have better experience of this medical practice perhaps either by the testimony of those who subscribed to it or their knowledge of these persons will go for

it. Despite these two contradictory positions on the Igbo perspective of advance directives, we cannot remove the presence of ambivalent attitude to the whole issue.

These issues shall form the crux of this chapter. However, before these issues are discussed, we must look at the interview responses gathered on this issue, offer our analyses and then further our discussions on this issue. In line with the nature of this work, some discussions were had with some of the Igbo people of Nigeria from various parts of the Igboland though having their residences in and beyond the South-East geo-political zone of the country. Four non-Igbo but within Nigerian tribes namely from Kaduna, Adamawa, Kogi and Akwa Ibom states were included. Below therefore is an analysis of the different interview reports gathered.

Forty-five (45) persons were interviewed. Twenty-two (22) persons/interviewees rejected the practice of Advance Directives among the Igbo. Fourteen (14) persons/interviewees were undecided on the issue, though with their reasons. Lastly, eleven (11) persons/interviewees accepted the practice of Advance Directives among the Igbo. For the group of people that rejected the practice of advance directives among the Igbos their ages range from 30 and 60 years of age. They are all post graduates and while some are single, most of them are married. They are all Igbo from different parts of Igboland.

To the question of whether it is a practice among the Igbo for a person to leave instructions in advance of certain ailments, the type and extent of treatment he/she may receive, they all answered in the negative. Subsequently, they all affirmed that in Igbo, a person cannot make a will detailing the type of treatment he/she can allow should he/she suffer from certain types of medical conditions. Also, they all affirmed that in Igbo, it is strange for one to determine while healthy, the medical treatment he will receive if he suffers a particular health problem in the future.

Interestingly and significantly too, they all affirmed that among the Igbo, the decision on the type and extent of health care given to a person under a particular health challenges are jointly decided by the relatives. Finally, to the question of whether anyone has subscribed to it in Igboland, some affirmed that they have not heard and do not know any Igbo person who left an instruction/directive as to the type and extent of

treatment he desires if he suffers stroke, brain damage, etc. However, eight (8) persons out of this group asserted that they have heard through testimony of an Igbo person who subscribed to Advance Directives but they do not know either these people who have done so or any other Igbo who subscribed to it. This claim becomes suspicious given the fact that they only rely on the testimony of others which may not be the case since incidentally, they do not know such persons neither do they know any Igbo who has done so. Expediency will warrant our negligence of such claims since it runs contrary to their foregoing claims.

Furthermore, as to the question whether a person should leave an instruction on the type and extent of treatment he or she will receive on certain illness, such as stroke, brain damage, and it is binding on the relatives in Igbo land, irrespective of consequences, they all disagreed strongly. On the question that inquires their response as Igbo whether they will implement the directives of a relative even if there is the danger of death, while most of them disagree strongly, few were undecided on the matter and few agree to it perhaps based on their respect for the person. Interestingly, for the last question as to whether they can give advance directives to their families under critical health conditions in future, most of them strongly disagreed on this, while few were undecided in their responses.

In their final comments, we received their unique attitudes to the whole issue. One of them has this to say: "a typical Igbo man or woman does not anticipate ill-health. It is not and will never be his or her portion. Consequently, it is strange to our culture as Igbo for one to determine or give advance directive on how to handle one's sick condition." For the second person, "I know that generally, men in particular, leave instructions regarding how but particularly where they want to be buried but not how they should be treated when they fall sick. There could have been some exceptions unknown to me." The third person who was taking the middle position on the matter reserved the practice to the individual even though he had earlier in his submission noted that he disagrees suggesting such, adhering to it or even subscribing to it. In third person's exact words, "it all depends on the individual in question; how much knowledge he/she has on the medication and how balanced is his or her judgment."

Implicitly given here is that the knowledge of the practice and all the medical involvement is a deciding factor.

The fourth person who is above 60 years of age avers in the submission that advance directives is not a practicable directive in Igboland.[1]

The fifth person was more concerned with the feelings attached to the practice of advance directives. For this person, advance directives are of an unpleasant nature perhaps for the Igbo. For in the direct words of this respondent "it is unpleasant for one to leave a directive or give an instruction on the type and extent of treatment he or she will receive if he/she suffers a particular ailment while healthy. In other words, one should not wish to be sick." The sixth person asserted that though life is sacred in Igbo tradition and should be protected; however, a man's wish may be honoured at times like an injunction not to be put in the mortuary at death. The seventh person in a vehement attitude commented that advance directive is strange to Igbo culture where life is sacred and everything possible is done to preserve it.

In the final analyses for the antagonists of advance directives, it is strange to the Igbo people, the individual is subject to the wishes of the community, irrational is the wish to be sick and even at that, all is possibly done to preserve life. While the final status of anyone in Igboland on this matter is seemingly in the negative, much knowledge on the matter may necessitate a change of mind.

Ambivalence towards the Practice of Advance Directives Among the Igbo

The interviewees under this group are all post-graduates and mostly above 50 years of age though few among them are between 30 and 40 years old. Their conclusions which are sequel to their individual submissions on diverse but related questions show that their preference of advance directives among the Igbo remains ambivalent.

To the questions which have to do with the practice of advance directives among the Igbo, they all answered in the negative. But on the questions about their knowledge of such medical practice being taken to by some people, only few of them attest that they have either heard or/and know someone who subscribed to it in the past.

But they all affirmed that among the Igbo, the decision on the type and extent of health care given to person under a particular health challenges are jointly decided by the relatives. However, further questions and their responses created the awareness of their individual preferences on the issue of advance directives based on their reasons.

On the issue of whether a person should leave an instruction on the type and extent of treatment he or she will receive on certain illness, such as stroke, brain damage, and that it is binding on the relatives in Igbo land, irrespective of consequences, only eight (8) persons out of fourteen (14) of them agreed on this matter even strongly, while the remaining disagreed even very strongly on this first case.

On the question that seeks their opinion as a typical Igbo if when a relative gives a directive how he should or should not be treated under certain medical conditions, even if it will cost his/her life, whether they will implement it, three (3) persons were undecided on this, nine (9) persons were purely negative to this and only two (2) of them answered in the affirmative. Finally, on the inquiry whether they can give an advance directive to their family under the same medical condition, nine (9) persons were buying the idea even strongly, four (4) persons gave their refusal, while just one (1) person was undecided on this particular issue.

The ambivalent attitude to advance directives is not without reasons. However, out of the fourteen (14) persons under this group, only five (5) of them made some further comments which may not be untraceable to their ambivalences. The first person who actually was undecided when it comes to obeying the advance directive of a relative has this to say: "while it is binding on relatives to implement advance directives, caution should be applied especially in cases that require pulling the plug in order not to encourage despondency in matters of terminal illnesses". For this kind of person, though there may be the possibility of death in such a situation, attempts should seriously be made to avoid death occurrence otherwise the advance directive is seemingly suspended. The second person who commented further avers that in some cases, the advance directives of a relative may only be implemented on the basis of respect and not necessarily on the acceptance of the practice. Interestingly, the third person as one of the interviewees here is from Akwa Ibom state, a non-Igbo person. In his submission and following from his doubt in implementing the advance directive of

a relative, he says: "if I were an Igbo, I would know the Igbo concept. It is good to leave advance directive but always a prolife directive." This person almost shares the same sentiment with the first respondent in this group; for they are likely to go for advance directives only when there is a pro-life or non-death effect.

The fourth person expressed different but related issues involved in the choice and practice of advance directive among the Igbo. Under the questions concerning advance directives either by respecting it or applying for it, he remained negative to the issues of encouraging advance directive for others, implementing it by the relatives of anyone who settles for it and finally on his personal choice of it. Although this person seems to be totally negative about this medical practice perhaps based on the age which is between 61 and 70 years, there is an indication that based on the present, advance directive may not be practiced among the Igbo but the future presents likelihood that advance directives may be practiced by the Igbo. Significantly too, he added that the issue of the occurrence of death in the practice may hamper people's choice of it since life is greatly treasured by the Igbo who even express this in their native names.[2]

The fifth person (between 61 and 70 years of age) who commented after expressing the ambivalence of the practice of advance directive among the Igbo asserted that the role of the specialists in the medical practice of advance directive is paramount.

One thing to note from this submission is that advance directives could only be taken when it involves taking the sick to a specialist hospital. Implicitly, advance directive for this person and all those who will share this view will only be encouraged when there is that sole desire to save life as against the other side of advance directives that involves the possibility of death.

In the final analyses, for the interviewee under the ambivalent attitude to advance directives, although it runs contrary to the present culture and tradition of the people, it could be allowed even in future only on the basis of the possibility and sole intention of saving life. Again, the decision to go for advance directives must involve the advice of the medical practitioner who alone *citeris paribus* knows the medical

condition of the patient and illness more than the patient and relatives who may have little or no knowledge about the problem at hand.

Proponents of Advance Directives Among the Igbo

As we noted earlier, about eleven (11) persons out of forty-five (45) persons were proponents of advance directives. It is worthwhile to mention here that three (3) persons out of these eleven (11) persons are non-Igbo from Adamawa, Kaduna and Kogi states. Though they asserted that advance directive is new among the Igbo with very few buying the idea, in their tribes, the issue of advance directive is not commonly discussed. And from their individual perspectives, they acknowledge the fact that advance directive could be subscribed to in certain health conditions.

On the questions that have to do with the possibility of Advance directive in Igbo culture, they all attested to the fact that even though it is not permissible by the culture and tradition, it could still be subscribed to as some persons they know and have heard of are taking to it. On the questions that concern the friendly attitude to advance directives, ten (10) persons among this group agreed to the propositions. However, only one (1) person answered negatively to questions while one person remained undecided when it comes to implementing the advance directive of a relative.

Furthermore, just like some persons under the two other attitudes to advance directives, five persons made more comments. The first of them who has agreed to advance directives either in encouraging people to subscribe to it and going for it but with undecided attitude to implementing it for the relative, notes that generally, issues of this nature are on the grey zone; and while some will propose it, others will oppose it. In the person's own words: "Some of these issues stand on the grey zone. Some well educated Igbo can make some of these decisions in advance, some may not." From here, we arrive at the place of adequate education and exposure in the acceptance of advance directives.

For the second person, who has heard of an Igbo who took to the medical practice and coincidentally agrees to advance directive either in suggesting it for others, implementing it for relatives or even in personally subscribing to it concludes by saying that the importance of advance directives includes saving the relatives from being

plunged into difficult decision-making over one's health issue. From this response, we realize that advance directives could be encouraged so that relatives will not have to struggle over deciding the right medical attention to give to a person when he/she is sick. The third person slightly commented that implementing the advance directive of a relative is a matter of tradition that demands the respect of the wish of the deceased relative. The fourth person who was negative to these issues of suggesting, implementing and subscribing to advance directive averred that while the question of advance directives should not emanate, the nature of the illness as at the time of its presence should be the click for the relatives to decide in conscience the medical practice for the interest of the patient. From this submission, the issue of conscience in the practice of medicine have arisen coupled with its near contradicting and equivocal idea of the interest of the patient. It remains equivocal since there will be a problem on who decides what is best for an individual: the individual or the relatives.

The fifth respondent who was greatly positive on the issue of advance directives and who is above 61 years of age is of interest to this issue of the Igbo perspective to advance directive. Although the person's age seems to betray his position as it runs contrary to ordinary expectation given the age and opinion, this person seems to be of the Modern Igbo who has equally be nourished in traditional way of life. The person gives a detailed comment on the several issues he was positively critical about.

To the questions: is it a practice among the Igbo's for a person to leave instructions in advance of certain ailments, the type and extent of treatment he/she may receive; and in Igbo land, a person cannot make a will detailing the type of treatment he/she can allow should he/she suffers from certain types of medical conditions, this person responds thus: "Formal will is not common among traditional Igbo. But there is no law I know that forbids making such a will". More so, to the question: in Igbo Culture, it is strange for one to determine while healthy, the medical treatment he will receive if he suffers a particular health problem in the future? The response was: "yes, if the person or the relatives have the means. More still, on the question: among the Igbo's, the decision on the type and extent of health care to a person under a particular health challenges are jointly decided by the relatives?, the answer given was: " yes, if the person did not leave any instruction before he/she became incapacitated.

Furthermore, on the question that demands the knowledge of anyone who has taken to advance directives, the answer is in the affirmative with this statement: "My mother who died in 1999 told us long before she dies not to take extra-ordinary measures if she is no longer able to get up and go or do whatever she wants to do but to allow her to die".

Under the second question concerning the implementation of the advance directive of a relative, here is the exact response: "I do not know whether I will be classified as a typical Igbo but, I will respect a relative's wishes in this matter. On the final statement which has to do with one's likelihood to subscribe to advance directives, the statement is: "Although I have not prepared a written advanced directive, I have told some close friends that nobody should subject me to extra-ordinary medical measures if I become incapacitated".

From this last person's submission, we arrive at some conditions which will warrant advance directives especially one that is of an extra-ordinary medical measure. This issue of extra-ordinary medical measures can be controversial if it is understood literally. But an in depth interpretation will see in this submission nothing against advance directives at the long run. We may infer that extra-ordinary is similar to further medical actions that are more critical and burdensome. This is simply in line with advance directives.

In the final analyses for the proponents of advance directives, the medical practice could be subscribed based on better awareness of the sickness, financial strength, a judgment of conscience for the interest of the patient and better awareness of advance directives.

Therefore, in concluding the analyses of the interviews and responses, ranging from the attitude of opposition, ambivalence to that of approval of advance directives, we come to have certain factors that determine the Igbo perspective on advance directives. These include, Cultural factor, interest of the patient, peace of the relatives, the input of the Medical personnel, awareness of advance directives, financial issue, and the question of death. These issues are factors that will affect the practice of advance directives among the Igbo.

4.2 FACTORS AFFECTING THE ADVANCE DIRECTIVE FROM IGBO PERSPECTIVE

As we noted just above, from the analyses of the interview responses, certain factors are inherently affecting the choice and practice of advance directives among the Igbo. These factors include: Cultural factor, interest of the patient, peace of the relatives, the Input of the Medical personnel, awareness of advance directives, financial issue, and the question of death. But before we begin our discussions on them, it is worthy to recall at this point the meaning and nature of advance directive. This will help us to situate these factors in line with the nature of advance directives and how they hold important place in the acceptance or non-acceptance of the medical practice from the Igbo perspective.

According to Alexander Morgan Capron in his article "Advance directive" advance directives provide a means to express wishes of any sort (for example, that particular treatments be used or not used, or that all possible treatments are to be provided) but they are usually thought of as a means to limit life-prolonging treatment, especially in the United States, where interest in advance directives originated and has been most intense."[4]

William May defines advance directives as "a document by which a person makes provision for health care decisions in the event that, in the future he or she is no longer competent to make such decisions for himself or herself."[5] Advance directives are oral or written statements in which people declare their treatment preferences in the event that they lose decision-making capacity.[6] Thus, advance directives may allow patients to prevent unwanted and burdensome treatments when struck by terminal illness, as well as permanent or profound mental disability.

From the understanding of advance directives above, it is clear that advance directives is seen to promote the fair treatment of incompetent individuals by providing a mechanism through which prior wishes regarding life sustaining treatment can be communicated. By providing guidance that is in keeping with the wishes of an individual, advance directives also reduces the difficulties faced by the loved ones of

patients in life-threatening situations. Such directives help to reduce or resolve disagreements between clients and their families.

Also, the expectation is that advance directives will increase the probability that loved ones and healthcare providers will make decisions in accordance with patients' value and goals. Whether or not this expectation is always met is another matter altogether. Although advance directives often focus on situations in which the patient would want to forgo treatment which may lead to death finally, they sometimes state circumstances under which a patient would want treatment.

In brief, advance directives gives the patient the opportunity to decide in advance what medical treatment that should be given to him when he/she can no longer make such decisions; the nature of the treatment could either be that of withdrawal of further treatment in serious terminal illness or that of further and possible treatment for the sustenance of the person's life at to a longer period. It is against this backdrop that these factors condition the practice of advance directives among the Igbo.

Cultural Factors

The Igbo society from its earliest times has always human life even from the individual level. Such practices of communalism and respect for elders and relatives are expressed in every aspect of the life of the Igbo person. The communalism of the Igbo society is so strong that the interest of the community/relatives supersedes that of the individual especially when the two clashes. This accounts for the great respect and value given to the kinsmen (*Umunna)* among the Igbo; for this group of people usually made up of elders almost has the final say in all matters that affect their relatives. And so considering the choice of advance directives as a personal decision made without consultation and approval of the relatives, the traditional Igbo is not likely to be in the affirmative position. The community's spirit will play a role in the issue of advance directives.

However, irrespective of the nature of such wishes, (of course in as much as it is moral), the wish of the elders are always adhered to. This is mostly seen at the time of their death or old age when they express certain wishes as to what will happen when they are very old and cannot decide rationally or even when they die. These wishes are

honoured by the relatives. And so any Igbo who goes for advance directives is most likely going to have it carried out by the relatives based on the cultural factor of respect for the wish of elders. Even though in some instances, the relatives are divided on the issue of implementation of such a wish especially when it will be tedious to execute, one major voice will be that of obeying what has been commanded.

The Interest of the Patient

From one of the interviews analyzed, we found out that advance directive could be implemented only when it is for the interest of the patient. And this judgment must be of the conscience. Two issues are present here namely: interest of the patient and the judgment of the conscience. On the interest of the patient, one is likely to question the right of the relatives or anyone to judge for the patient what is best for him/her after such a person has made advance directives with much medical consultations. This is not to remove the possibility of the patient to change his/her mind should the opportunity be given at that critical situation. To increase the conflict, the issue of conscience is brought up. With this, the implementation of advance directives is now subject to morality; a situation whereby the relatives are not likely to carry out an advance directive that is most likely to lead to death since such is indirect euthanasia/mercy killing. On the other hand, some relatives are likely to judge from the conscience that going on with the advance directive that may lead to death is better so that the patient is not allowed to suffer unnecessarily. On this issue of the interest of the patient, the choice and implementation of advance directive is conditioned to the judgment of the conscience by the relatives or the persons responsible to execute it which may either be executed or abandoned based on the conclusion reached.

The Peace of the Relatives

Some persons among the Igbo who do not like to disturb those around on what they consider to be infinitesimal will subscribe to advance directives. This is because should the directive be lacking, at critical moments, the difficulties of making an acceptable decision for/over the patient condition can be very tasking and dicey. This is because of the possibility of conflicts among the ideas of the deliberative relatives on the issue. For the typical Igbo, in such a situation any decision finally taken that may

become problematic afterwards is often avoided, yet there are no better options. This risky condition can either tear the family apart of unite them based on the resolution of their conflict. Again the pains of taking care and spending resources which most often may not be available will be great burden to the relatives.

Given these scenarios, an Igbo person may decide in advance what type of treatment is to be given to him in time of critical health conditions. This will save the family many troubles and keep them united too. Again, it will save them the burden of caring and spending for one who seems to waste time to die a determined death. Although this may be the case for some Igbo persons especially the highly-exposed ones, some Igbo persons who by culture is entitled to the care of relatives even at the time of sickness and those who do not want to commit indirect suicide, may not go for advance directives. Nevertheless, most persons may prefer advance directives to save the family the great risk of allowing them to decide for him/her at such critical condition.

The Input of the Medical Personnel,

Some persons have argued that the role of medical personnel in the choice of advance directives is paramount. This is because the doctor is in a better position to know the nature of sicknesses especially a specialist and their effects at the long and short runs both on the patient and the relatives. And so, being both pragmatic and traditional, the doctor has to analyze such sickness, the nature of the treatment available and its demands and perhaps available better options to be taken. Such a doctor too has to be a psychologist or needs to invite one in aiding the patient and the relatives to decide the nature of the advance directive to go for. This role when played will help the patient and the people to make better choices. This can equally work for the Igbo.

Better Knowledge of Advance Directives

The medical practice of advance directives is recent. Developing in the 1960's in Europe and America; and still not common in these places of origin cannot be bought easily by the Igbo person especially one who has been within the local society for almost all his/her life. Even those in the cities and in foreign societies where advance directives are taken to cannot buy the idea easily because they have to consider

some factors like their cultural backgrounds and perhaps what the relations will say about it. However, when this medical practice is widespread even in Nigeria, the Igbo person may not have strong reasons to shun it or discourage it. Therefore, a better knowledge of advance directives and the effect on those who have used it will go a long way to encourage many Igbo persons to go for it. While this better awareness is on a low level causing more rejection of it, the few persons who have known much about it will go for it. Thus, the practice and acceptance of advance directives into the Igbo modern culture is dependent on its prevalence among Nigerians and the world at large.

The issue of Finance

One of the respondents of the interviews expressed the idea that the issue of finance is important when deciding on advance directives. This is indeed an important factor. Though the nature of advance directive involves much fund especially when it requires a furtherance of all possible treatment or even the withdrawal of treatments, the issue is that both options involve much fund. But that of furtherance of medical treatment involves much fund. To this effect, an average Igbo person who does not have much fund and does not envisage its possibility *citeris paribus* may not subscribe to advance directives especially the type that will involve furthering treatment. Even the rich Igbo person is likely to suggest a withdrawal of treatment in future sick moment when there is no money or even when it seems to be a waste of money (perhaps useful for the burial) in furthering medical treatment at critical sick moments. Therefore, should advance directives be subscribed to, it will likely tend to a withdrawal of treatment when there is no fund or a furtherance of available treatments when the money is there. For instance, the rich can sponsor a kidney transplant or brain surgery in hospitals overseas, whereas the average or even the poor person will resort to fate which is death at the long run. And so the availability of fund affects the choice of advance directives.

The Question of Death

From the interviews, we arrive at assertions that some people will not implement advance directives especially when they involve death taking place. This is more detested when this death has been willed by the patient. This is consequent upon

the idea of death among the Igbo. The Igbo believe that human death is not the end of life but a passage to immortality either of a peaceful type or a restless condition. Two facts are very central to the philosophy of death and after-life in Igbo land namely: death and reincarnation. While death is the end of the life on earth and a beginning of another life in the land of the spirits, reincarnation is a passage from the spirit-world to this present world.[7]

With regard to the survival of the human person after death, Igbo maintain that this continued existence is imaginable only as a totality. For them, the soul or spirit is not only immaterial but a reflection of the totality of the human person as it survives after death, such that this spiritualised body must have its faculties and the capacity to perform its operation freely intact. This is why the spirit goes to the land of the living dead or land of the spirits and can be omnipresent, at the same time, as situations require.[8]

Igbo firmly believe in the notion of the sacredness of the human person; for the human body is capable of continued existence after death in the land of the living dead or land of the spirits. The physical decay of the body is a consequence of the corporeality of the human body but the real body which is the spirit continues its existence after death and constitutes an integral part of the totality that is evident in its reappearance as corporeal spirits, as re-personated or re-incarnated bodies.[9]

The idea of reincarnation offers us more understanding of the Igbo land conceptualisation of death and afterlife. Reincarnation involves a return, after death, of a human person to continue his or her earthly existence. The belief is that this reincarnated person is coming back to complete the mission he or she was assigned by the Supreme Being. In most cases, the reincarnated person shows concrete signs of his or her former person. This is significant in the bodily marks, discernable character and personality traits and the ability even to remember events in previous life.

The question of death and afterlife concerns the idea of immortality of the human person. To arrive at an explanation of this idea, Igbo strongly believe that the earthly existence is not the only existence. They believe that after the life on earth through the occurrence of death, another life begins in the land of the spirits.

Interestingly, Igbo metaphysics maintains that the life after death is of two folds namely: the life of the ancestors and the life of the reincarnated human person into lower animals. While the life of the ancestors is a reward for the goodness of one's life on earth, the other is a punishment for the evil life lived on earth. Hence, although death is a painful realty, it is a link for the life on earth and life beyond: the afterlife. Hence, one cannot will his death in such a defeating manner because such will not guarantee enjoying the afterlife as an ancestor. The Igbo person who is much aware of this, for traditional and cultural reasons may not indicate and resort to death in time of sickness; such will not appear in the advance directives.

From the explanations given from the interviews, we shall further in great details discuss issues inherent in the practice of advance directives from the Igbo perspective.

4.3 THE IGBO TRADITIONAL UNDERSTANDING OF ILLNESS

The oxford dictionary defines illness as the state of being physically or mentally ill. There could be many other definitions of ill health. But suffice it to be said here that illness is understood as the breakdown of the body system in varying degrees which could be cured or terminal as caused by diseases, infections and other causal factors of human illness.[10] One fact about human sickness is that it disrupts human comfort and happy living by preventing the victim of illness from fulfilling desired roles and goals. This unfulfilled engagements or a pending of these desires, warrants the victims to look for solutions to the problem of the health. Hence, the medical practioners and all those who can actually remove the sickness or reduce it to a manageable state are sought and consulted. This is consequent upon the belief that the sickness could be cured. This has being the natural attitude of man till the emergence of terminal sickness. To avoid problem connected to the death of sick especially as regards the management of the family left behind, wills are kept to provide for the decision of the dead over the living about the things he would have loved to happen were he to be alive. In the same way, advance directives have emerged to cater for those critical moments when one is not able to decide about the course of his/her medical treatment during the period of serious/terminal illness. The person thus, makes statements about the type of treatment he wants with the implicit belief that recovery from the sickness is not likely to happen.

For the Igbo, human sickness is part and parcel of human life and it can come through several means. However, the Igbo hold certain different ideas about human sickness. First, sickness is mainly caused from the gods as a punishment for an evil act done by the victim or a relation; and second, is that human sickness irrespective of the cause will be cured through the traditional medicine or through divination.[11]

In the traditional Igbo society and even at present, it is believed that human sickness is caused by the anger of the gods on the victim or on a relation whereby the victim's illness becomes a wrath or a punishment and at the same time an evidence that something evil has been done in one way or the other. This belief is actually held when the sickness is a serious type that makes the victim appear to be dying from it. To this effect, the medicine man is sought and consulted. This is the case with the Igbo because:

> The practical concern of the Igbo man is to protect life by warding off that which destroy it. One cannot deal with the threat to life in general terms, in each case one must identify the particular source of the evil. When disease or death strikes, it is assumed that there is an undying cause that must be brought to light.[12]

We have so many of these diviners whom the Igbo refer to as ***dibia.*** The medicine man is responsible for curing the sick and intervening for the sick to the gods over serious sicknesses. Although many others can cure through herbs, the medicine man is always recoursed to in time of great sickness. The "Dibia" or Medicine man is a key figure in Igbo traditional healing process; he is a mediator between God and man. The word "*dibia*" literally means healer or doctor.[13]

In describing further the medicine man's role and place in the community very well, T. Uzodinma Nwala has this to say:

> *Ndi Dibia Ogwu*-Medicine Men: These are the men who provide curative, protective and preventive medicines and charms. By means of these, the spirits can be manipulated and influenced. Such control can be exercised over diseases and disaster believed to be caused by the action of certain spirits.[14]

Supposing the medicine man is the last resort to the remedy of the sickness, he is invited over the sick person and he makes his divinations while consulting the gods about the cause of the sickness and the remedy. The Igbo believes that as the messenger of the gods, the medicine man will take the concerns of the people to the gods; for spiritual factors affect the cure of sickness. For C.P Ohia:

> The role of the *dibia* in Igbo traditional life is seen against the background of the close interaction between visible and spiritual world in their world view. Human conditions are not determined by physical and social factors only but also by the intervention of spirits. The *dibia* is not only a specialist in pharmaceutical medicine, but also an expert in spiritual healing methods.[15]

In most cases, the medicine man obtains positive answers from the gods and then, prescriptions of the items to bring to make sacrifices for the cure of the person to the gods are made. When all these have been fulfilled, the sick person gradually recovers. This is the belief and practice of the Igbo because they have numerous pieces of evidence to buttress the authenticity of this practice. And so with the medicine man's intervention, sickness is removed and health restored. This is the basic expectation of the ordinary traditional Igbo person because with the intervention of the medicine man, life is restored, happiness is increased and sadness thrown away. In rituals, life is continually made sacred, restored and multiplied. For the Africans, multiplying life is the greatest happiness, while weakening it – the greatest unhappiness.[16]

However, there are few cases in which the sick person dies afterwards; and it is taken to be just the wish of the gods who know the best.

Significant from this foregoing is that for the Igbo, one cannot assume the end of sickness to be death because human beings cannot say accurately the time of human death. And so, it is also believed that hope is never lost on any sickness except when the gods have spoken; and until the gods speak, the relations of the victim must run around looking for solutions because they believe they will find one. In most cases, these concerned relations seek many different medicine men as much as they can when the previous ones have answered in the negative on the remedy of the sickness.

Thus, the Igbo person believes that every sickness has a cure and could be cured according to the wish of the gods. The traditional Igbo believe that a fulfilled life ends at a ripe old age and not through death, except in few cases. And more importantly, hopes are high even during serious sickness until the gods have spoken otherwise through the *Dibias.*

4.4 THE DURATION AND SACREDNESS OF HUMAN LIFE

Perhaps like all human cultures, human life is sacred and must be respected. The sacredness of human life is a fundamental value of the Igbo people which they cannot treat with levity. Life is sacred primarily because it comes from the Supreme Being and he alone gives life of human beings. Every human life is seen as a gift from this greatest being and as such must be managed and handled properly. Life is sacred too because just as the greatest being gives life solely, so also does he take life when he deems fit. These qualities of the human life bring about another quality which is the fact that being a property of God and given out as a gift for his sole purposes, human beings irrespective of the circumstance do not have any right to either end any human life or harm any life.

Human life begins at birth and then continues to a happy old age and then one joins the cult of ancestors. At no stage of human development do human beings have the right to end life or harm. Thus suicide, abortion, euthanasia are prohibited in Igbo community. And so, advance directives which are nearly similar to euthanasia and for the very fact that it gives the human being the autonomy to decide to end his life during sickness, is not allowed. Should any of these be done, it is taken to be a sacrilege- what the Igbo call *Aru.* Hence, the Igbo believe that the duration of life normally starts from conception and ends at an old age. In any of these stages, even during sickness, no one has the right to end human life. This is mostly the case in most African traditional societies.

In summary therefore, we may say that:

> Life, which is considered sacred, is the fundamental value of the African peoples. Life is also the central notion in African cosmology. Each community is above all oriented at life and its maintenance. The

> birth of a child is a great event both for the parents and the community. This follows from the faith that life ultimately comes from God, who is its source and giver. Hence, it is the greatest gift and good that God can grant to man. The Africans enjoy life, respect it and consider long life to be a blessing of supernatural beings. Any kind of behaviour aimed against life is a sin in the social and moral sense.[17]

From the foregoing, we can say that for the Igbo, human life has natural beginning and natural end. If and since it has a natural beginning, no one and indeed none has the right to tamper it. Although, this is the traditional view about the Sacredness of human life, it is not the case that people do not go against this idea and belief. Many persons today commit suicide, abortion, euthanasia, etc. But that does not mean that the Igbo are changing this idea of the sacredness of human life. Human life begins at conception, develops through adulthood and ends in a happy old age. No matter the sickness, tradition demands that human life should not be taken by anyone irrespective of the challenges involved.

4.5 THE DIGNITY OF THE SICK HUMAN PERSON

The human person has dignity because he is free, intelligible and rational. Among all creations/creations, the human person is the most intelligent and the most rational. The Igbo believes that the human person is very valuable and the most valuable creation in the world. This is because he has been made the perfection of all creation, and he is the most rational and intelligent being in the world. To this, care and concern is given to the human person from birth to death. Above all existents in the world, man is the only being who is free and has the natural capacity to order the course of his actions in ways personally decided that will guarantee self-realisation, self-governance, self-control and self-fulfilment. Man unlike other living beings have the capacity of self-determination and self-consciousness, the ability that makes him a thinking being in total awareness of his environment while preferring ways to better the environment.

This dignity is accorded any human person irrespective of the condition whether sick or healthy; conscious or unconscious. Contrary to the view that consciousness and

the right use of reason makes a person, the Igbo believe that the state of any human life does not determine the personhood of any human being. For them, from conception, the human being is already a person and nothing changes such notion about the human being. Hence, no matter the state one finds himself, he is entitled to be accorded the dignity he deserves as a human person.

Consequently, the sick even in the vegetative state is still a human person and must be accorded respect. This respect entails treating the person not as a thing but as a fellow human being who should be valued. This means that the sick person must be cared for even till death as willed by the giver of life.

Proponents of advance directives will say agree with dignity to be accorded to the sick. But they will see it in the light of allowing the will/wish of the sick person about his sickness to be obeyed. But the Igbo will not see dignity to be accorded to the sick person as seeing the person as still part of the society, capable of helping the society if recovery occurs and thus should not be neglected.

Africans firmly believe in the notion of the sacredness of the human person; for the human body is capable of continued existence after death in the land of the living dead or land of the spirits. This existence beyond the worldly temporal order comes about when each person is dignified to the point of being allowed to live as willed by the Supreme Being without any human alteration in the process of living and fulfilling his life on earth.

4.6 THE SPIRIT OF AFRICAN/IGBO HOSPITALITY

One natural reason why the Igbo will not easily subscribe to advance directives is their natural life style of being hospital. The spirit of hospitality pervades everything action the traditional Igbo does in life. Hospitality takes the forms of assisting those in need as they approach one and finding people who are in need and then rendering some helps to them. As human beings cannot have it all most of the time, it follows that they will need the assistance of others. Like the Good Samaritan in the bible, an Igbo cannot see anybody in need and ignore the person. He/she must find possible means of helping anybody in need. Sometimes he/she takes full responsibility of the person in need as if the person is a relative or a close friend. The man or woman in Igbo cannot remove

his/her eyes from the sufferings/pleas of beggars; for he/she must in sympathy give out something to the needy. Hospitality is a valued way of life in Igbo. That is why the description of the Igbo culture will never be void of their Hospitality.

The spirit hospitality will naturally convince anyone that even in times of great suffering and sickness, people will be there for the person; and the challenges of taking care of the person at this time will never by a burden to those offering their help and neither will it be a deterrent to any probable assistance. And so even the sick person is already assured of being taken care of and will never be abandoned. In fact, he or she sees it as his/her right to be taken care of whenever sickness comes. Hence, why will advance directives be sought for especially when the propelling factor is the fear of being abandoned during the time of illness? Thus, whenever anyone falls sick in Igbo society, the healthy ones gather around the person and ensure that the best care is given to the sick. This concerns and mostly done by the relations of the sick beginning from the children and kinsmen. This care will be given to the sick amidst the pains and struggles until the sick person either recovers from the sickness of dies finally according to the wish of the gods. This is responsible for the relations' endless and hopeful search of the medicine man who will rescue their beloved from the sick that has befallen the person.

Therefore, the spirit of hospitality which permeates the spirit of the Igbo and the already imbibed disposition of respecting the dignity of every human person no matter the condition will never allow one to consider abandoning the sick at such a serious moment. Again, it will never allow planning ahead for such a period for fear of being abandoned. Although out of this same hospitality one can decide to avoid being a burden to others during his sickness in future and decide to go for an advance directives, the interpretation to be given will to a large extent mean that the person is avoiding the presence and participation of others in his/her life even at such a point where naturally such assistance is needed most. And so, the spirit of hospitality will never allow such a medical plan as advance directives.

4.7 POSSIBLE CONSENSUS ADVANCE DIRECTIVES

Culture is the patterns of behaviour and thinking that people living in social groups learn, create, and share. People in the same society share common behaviours

and ways of thinking through culture. Culture is also shared with other people of different cultures. Since no human society exists in complete isolation, different societies also exchange and share culture. In fact, all societies have some interactions with each other, both out of curiosity, and because, even highly self-sufficient societies sometimes need assistance from their neighbours. Again, people use culture to flexibly and quickly adjust to changes in the world around them. Culture helps human societies to survive in changing natural environments. This is even the principal reason responsible for the evolution of culture. These aspects of culture help people to address the problems reality confronts them with.

In their interactions with the outside world and in their knowledge of the practice of advance directives, the Igbo person may actually settle for it in future. The advantages of advance directives can actually spur on anyone within the Igbo society to go for it. Not just going for it, there is also the possibility of recommending it to the other persons within the Igbo society. The relevant question here becomes: given the fact that in the traditional societies, the idea and possibility of advance directives is relegated to the background, with today's cultural influence, how can advance directives be practice effectively within the Igbo society since the basic tenets of the medical practice runs in conflict with traditional ideas? To this pertinent question, a possible answer could be that instead of one's autonomy taking paramount place in advance directives, the Igbo involvement in it will affirm the centrality of the community in the decisions of the advance directive.

In the Igbo society, the community guides and directs the individual to the extent that the community takes the centre in the dialogue with the individual. The community is made up of families, clans, and kindred who are united by blood in the line of their ancestors. And so if the Igbo were to decide or contemplate the issue of advance directive, it could the form of community's advance directive for her member; this is what Dr. Lewis describes as "Consensus Advance Directives".

If the possible advance directives to be practiced by the Igbo or approved by them will take the shape of a consensus type, a vital question will be: where does the community come in alongside the individual's desires in the whole advance directives?

To what extent will both the influence of the community and the individual be felt in the decisions contained in the advance directives?

In the practice of advance directives, one basic fact about the Advance Directives is that before the document is drawn up, it is highly recommended that one's family of very close friends be made witnesses and judges over the document; for it is a valid legal document that cannot be overruled by family. In the Igbo consensus perspective, the relations and close friends will no longer be just witnesses and judges, but they will be deliberative voices before the wish is drawn. And so, before any proposition is made, the relations and friends will approve of it even though is about the life of just a member of the community/family. However, in the points of opposition between the individual's wish and the community's wish, given traditional practice, the community's wish will be taken. This may not be to relegate the importance and sense of individuality, but for the fact that two good heads are better than one, the community having more persons can know more than the individual and so are better to decide rather than the individual to decide with his/her limited knowledge.

More so, after the decision has been made, the document ends with the specifications of persons/offices where this document shall be filed after the signature of the patient. Also, there will be the signatories of the witnesses who testify that the document was effected in the patient's freewill and without duress. The community's signatory (especially the representatives) will be included and they will be given copies of the document to keep as being part of the decision made.

Moreover, another fact about the advance directives is that by its nature, only the patient who duly authorises it or the person charged with making decisions for the patient is the only person that can alter it and not by anyone else irrespective of the situation (and even when it is considered expedient to do otherwise). Under the consensus advance directives, the community can alter it when circumstances demand and they are not likely to face any legal action since they were part of the decision made. And so, in this type of advance directives, there will not be room for an individual to decide alone what he wants and the way he wants it; for the society will have a hand in the agreement since not only is one of them concerned but because what affects a member affects the general community.

4.8 THE COMMUNITY'S ROLE IN CONSENSUS ADVANCE DIRECTIVES

A genuine question that might be raised here is that of the role of the community in a personal/individual advance directives? One clear fact to be stated here is that whenever the community comes into the issue of advance directives and then is taken to be consensus advance directives, it is no longer seen as an individual/personal medical decision; rather, it becomes a community/individual decision made in unity over the health of a member of the community. And so, although it concerns the individual, it does not necessarily and it is not necessarily about the individual alone but it is about the individual in the community.

The community will come into this medical decision because she believes that she has a natural right to care for her members and ensure that the best is given and enjoyed by her members possibly all the time irrespective of the circumstance. And so, the traditional Igbo persons will definitely exercise this right even when the individual shuns them since they believe that they are doing the right thing. To abandon the individual to decide for himself especially about his health, is to let shame befall the community as she fails to perform her natural duty.

More still, the community is concerned about the individual's advance directives because she believes that each person is important to the community. In fact the life and death (but more importantly the life) of any person has a role to play in the make-up and development of the society. This stems from the fact that in the society, each human person regardless of the little or no recognition works in vary degrees towards the progress of the society and so to enhance and promote the good health of each person becomes a means to improve the resources of the community. And so, what happens at the moment of critical illness of any member becomes an urgent concern to the community. The recovery or non-recovery of the person will also affect the emotions of the people. And so, as a way of preparing for any aftermath of those critical health situations, the community comes around to deliberate on possible courses of actions depending on what happens with the intention of making the best out every situation.

Furthermore, the community comes into the advance directives of an individual who is her member because she wants to give a support, a kind of patronage to the decision. Not just as observer or witness but as solely a constituting figure in the establishment of such medical agreement. This already removes and prevents the possibility of anyone including the medical practioners to alter the decision made at any point in time and irrespective of the circumstance without the full consent of the community. By this involvement, the community gets involved to make sure that the good wish of her member is respected even in sickness.

The Notion of Consensus Advance Directives

There are two main types of advance directives namely: the living will and the durable power of the attorney. The living will is a signed, witnessed or notarized document that allows a person or patient to state that specific life-sustaining treatments be withheld or withdrawn if he or she is in a terminal condition and unable to make health care decisions. The durable power of the attorney is a situation where there is a signed document in which the patient or client designates another to make health care decisions for him or her in the event that he or she becomes incompetent.

While it is possible to uphold the living will in a consensus advance directives and perhaps even as the only type, the durable power of the attorney will be affected. This is because, the nature of this durable power of the attorney involves someone who has been trusted and thus designated by the patient to make decisions on his behalf should such critical condition arise. But then, since the community is now an active party in the whole agreement, she will definitely play the roles even a proxy will play. And so, at the end of the day, there will not be need for any person to be appointed to make decisions for the sick person since the community is already there. Hence, the idea of the durable power of the attorney will be relegated especially in this sense.

However, there could be the possibility of using the attorney. This comes in the form in which not just the patient appoints but he does that with the community as they agree among themselves the person or persons who can make decisions for their member in critical health conditions. While the non-consensus advance directives will use one person for the durable power of the attorney, the consensus advance directives

will to a large extent appoint persons who they trust especially based on their knowledge and prowess in such areas or other related areas to make decisions on their behalf over their member. And so, their idea of more persons playing roles in the process shows the presence of the community in the decision making.

The consensus advance directives ensure that the individual's life is treated with dignity and respect by the medical practitioners. The community is still interested in their member even at the vegetative state and so she should be allowed to care for her member the best possible way she deems fit. This is not to say that there may not be problems with this type of advance directives. But more than that, the interest of the community as larger than the individual's is shown even in the society's participation in the health decisions of her member to the extent that when they are not allowed to be actively involved, the community sees it that the individual has overrides the community.

4.9 Contradictions

The Igbo perspective of advance directives may be defeated in a situation a father for instance, gave a directive to be buried at a particular place within the compound (this is a normal phenomenon), but dies of ebola. Even the Umunna will not have the legal and spiritual power to keep to the directives. The government will surely ignore such order as it might, as a matter of health reasons, seize the body from the deceased family and Umunna.

In other words, reason, based on genuine medical implications can override a man's advanced directives. When this is the case, it is the duty of the Ummua to commune with the dead explaining why his or her wish could not be respected, that the authority over the Ummuna – being the government, for genuine reason deprived them, the Ummuna from keeping their promise. The dead is expected to understand so that his or her spirit could rest in peace.

4.10 CONCLUSION

An effort to examine and understand the choice and practice of advance directives from the Igbo perspective warranted a research in form of interviews conducted with forty-three (43) Igbo persons and four (4) non-Igbos. In the analyses of the reports derived from the interviews, we arrive at three attitudes to advance directives namely: that of opposition to it, acceptance of it and then the ambivalence in such a choice. But then, these attitudes are conditioned by some factors namely: Cultural factor, interest of the patient, peace of the relatives, the Input of the Medical personnel, awareness of advance directives, financial issue, and the question of death. These issues are factors that will affect the practice of advance directives among the Igbo.

In discussing these issues raised from the interviews, it become obvious that in Igbo, sickness is detested and everything humanly possible must be done with the hope that the sickness will go. The Igbo never lose hope of recovery until such a person dies. Thus, the Igbo person believes that every sickness has a cure and could be cured according to the wish of the gods. The traditional Igbo believe that a fulfilled life ends at a ripe old age and not through death, except in few cases. And more importantly, hopes are high even during serious sickness until the gods have spoken otherwise through the *Dibias.*

The rejection of advance directives among the Igbo is based on its seemingly indirect choice of death whereas traditionally, human life is sacred and cannot be violated by anyone irrespective of the situation. This is because human life has natural beginning and natural end. If and since it has a natural beginning, no one and indeed none has the right to tamper it. No matter the sickness, tradition demands that human life should not be taken by anyone irrespective of the challenges involved. This could be the problem in the choice of advance directives. Thus, the sick are respected and they are entitled to great care. However, some persons are likely to choose advance directives based on their desire to avoid troubling their relatives when they are critically ill.

Nevertheless, with better knowledge and financial strength, very few Igbo are going for it and in the future, most persons will go for it. And should this be possible, it must include one's relative and deliberation. This is the consensus advance directive which ensures that the relatives must participate in the decision and protect the interest of the patient. No doubt, the future can see the Igbo person taking a sort of consensus advance directives.

END NOTES

[1] For the Igbo, life is sacred, and everything is done to preserve it. Even if a person wants to cut it short for any reason, his relations would not allow it. A person may give directions on how his funeral would be if he dies, his living relatives can and would change the plan. Communal life is so strong as expressed thus " I am because we are".

[2] The Igbo people generally have high regard for the value and dignity of human life and human person. The truthfulness of the above statement can be seen in such Igbo names as: *Ndubuisi, Ndukaku, Ndukauba, Nduagwuike, Ndunagu,* etc. It is indeed presently against Igbo culture and tradition for an Igbo man or woman to give A PRE-DETERMINED MEDICAL DIRECTIVES TO PARENTS, SONS, DAUGHTERS, RELATIVES OR FRIENDS especially when such directives may run contrary to life or tamper with human life either because of too much sufferings in sickness or otherwise. At present ADVANCE DIRECTIVE is out of Igbo dictionary of culture and tradition unless things change in the future since culture is dynamic.

[3] The only condition to accept an advance directive on the medical treatment the individual requires is if the directive requires sending the sick to specialist hospital or teaching hospital for consultant's treatment. It is not proper for a sick person to determine the type of treatment to receive. Decision on medical treatment should be left to medical professionals, consultants in specialized fields.

[4] Capron, A.M. 2011. Advance directives. *A companion to bioethics.* Kuhse, H. and Singer, P. Eds. United Kingdom: Blackwell Publishing. 261.

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[6] Fischer, G.S., Tulsky, J.A., and Arnold, R.M 2004. Advance directives and advance care planning. *Encyclopaedia of bioethics,* 3rd ed. Post, S.G. Ed. I. USA: Macmillan Press. 74

[7] Iroegbu, P. 1995. *Metaphysics: The Kpim of philosophy.* Owerri, International Universities Press Ltd. 312.

[8] Asouzu, I.I. 2004. *The method and principles of complementary reflection in and beyond African Philosophy.* Calabar: University of Calabar Press. 168.

[9] Asouzu, I.I. 2004.

[10] Here too, we shall use the words illness and sickness interchangeably.

[11] Although, there are cases whereby people die out of their sickness, the traditional Igbo believe that such a death has been predestined by the gods or that it is the sole wish of the gods to allow such a person die from the sickness.

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[13]Ohia,169.

[14] Nwala, T.U. 2010. Igbo *Philosophy*. Second edition. New York, Triatlantic books Ltd. 64

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CHAPTER FIVE

ADVANCE DIRECTIVES AND THE VALUE OF HUMAN LIFE

5.0 INTRODUCTION

A critical examination of advance directives as well as its role and place in the value of human life underscores the prevalence of some inherent problems associated with it especially when it, becomes a medical tool for the advancement of human life, in all its respects. These include its competence to promote human life since legally and ethically, it may not truly realize the respect placed on the value of human life. Again, its seeming closeness with suicide and euthanasia on some grounds reveals its absolute ambivalence in its choice and exercise by people.

Placed alongside the value of human life, advance directives raises the question of the right to life and its implication; that notwithstanding, finance and desire for comfort measures are factors that will condition either the negative and positive status of advance directives to human life. If presumably advance directives is said to be promoting the value of human life, the implication becomes that it promotes and sustains human dignity. However, advance directives will definitely pose a challenge to human dignity especially when the issue of rights: to life and autonomy clashes on the long run. This problem couched in the depreciation of human dignity is equally expressed in the inherent diverse interpretations of human hospitality.

Finally, human life cannot be complete without the function of death in contributing to human dignity. Hence, the reality of death, its expectation and preparation has some quotas to contribute to the value of human life. As a possible and major reality in advance directives, death with its widespread interpretations can help humanity to continually examine the means through which human life is protected.

Forming the evaluation of Advance directives from the African/Igbo perspectives, the elaboration of these issues shall preoccupy this chapter with the view

of showing the current ambivalent role and place of advance directives in the promotion of the value of human life in general with specific cultural and classical interpretations.

5.1 THE LEGAL AND ETHICAL PROBLEMS OF ADVANCE DIRECTIVES

The origin and the necessitating factors that warranted the introduction of advance directive into the modern-day medicine conveys to the ordinary eye the great benefits associated with it and, thus, its great importance in the promotion of good and happy human life. The possibility of advance directives to enable individuals to freely decided for themselves for what happens with and through their lives even to the point of projecting into the future and deciding for the future too injects its attraction to so many minds especially those who have large penchant for the advancement of human freedom which can and should be expressed in every aspect of human life.

More attractive is advance directives when it has as one of its fundamental elements the absolute obedience to the stipulations contained starting from the medical personnel to all those who are interested in the health status of the patient. Also, with its reduction and total removal of the problems associated with making decisions over a sick patent by the relatives, many have come to subscribe to it. In this direction therefore, it is taken by its sympathizers as appreciative of the dignity of the human person. However, the possible challenges of this medical practice confirm to a large extent the possibility of advance directive to be a threat to human life; a depreciation of human dignity and a medical practice that have provoked bioethical reactions. It is in this light therefore that the manifest apparent disadvantages of advance directives give us a conclusion that legally and ethically, advance directives may not have answered its propelling objective: to make human life lived comfortably and experienced better.

On the legal problem with advance directives, we see the possibility of the imposition of the will along the way of administering the patient from either the medical personnel (doctor) or the attorney under the type of durable power of the attorney. In this type of advance directives, there is assigned document in which the patient or client designates another to make health care decisions for him or her in the

event that he or she becomes incompetent. Proxy directives (the durable power of attorney type), however, do not indicate the patient's wishes, preferences, or the type of treatments he or she might have decided under the circumstances at hand. This becomes the exact place whereby there is likely to be an imposition of the will of the attorney on the patient and his/her health conditions.

Although, the attorney must have enjoyed some trust at the signing of the document, whereby the patient in an earlier rational and competent moment entrusts the task of medical decisions on his behalf through the attorney, there is no guarantee that this attorney will make decisions that would have been favoured by the patient where he/she to be competent. Very risky it is when this attorney will benefit from any decision he/she takes for the patient which will be seemingly at the expense of the patient. More risky will it become when the decision taken by the attorney is conflicting with the available decision preferred by the doctor and the relatives of the patient. At this point, it is either the attorney imposes his will or there will be a moral dilemma as to which decision to take: that of the designated attorney (which perhaps is not tenable, but must be adhered to) or that of the doctor and perhaps the relatives (which appears morally tenable given the situation). Should the attorney's will be respected according to the stipulations of the directives, the will and right of the patient has been abused which originally was meant to be secured.

Arguably, because of problems of this nature, many people prefer the living will which has instructional directives based on the values and desires of the patient. But given the fact that at present, and perhaps in future, people decide to go for the durable attorney based on their conditions and belief that the future presents greater alternatives, will some attorney's refrain from imposing their wills? At such a point, especially when the result of such decisions is detestable to all concerned with the treatment of the patient, will the attorney not face the risk of legal prosecution for acting on his own will as against the expected wish of the affected patient? These issues are more than we could imagine. In these two conflicting cases, the practice of advance directive becomes burdensome, given the possibility of imposition of the will and inherent moral dilemmas.

In living wills, advance directives have inherent problems. For example, an aged person may not fully understand treatment options or appreciate the consequences of certain choices in the future. Sometimes, people change their minds after expressing advance directives and forget to inform others. Many times, advance directives are too vague to guide clinical decisions. For example, general statements rejecting "heroic treatments" are vague and do not indicate whether one want a particular treatment for a specific situation On the other hand, very specific directives for future care may not be useful when situations change in unexpected ways. New medical therapies may also have become available since an advance directive was given.

More so, advance directive has ethically been equivocal given the case that it appears to be an indirect suicide or an indirect euthanasia. Suicide is an intentional, self-inflicted death; a uniquely human act, suicide occurs in all cultures.[1] People who attempt or complete suicide usually suffer from extreme emotional pain and distress and feel unable to cope with their problems. They are likely to suffer from mental illness, particularly severe depression, and to feel hopeless about the future. Many persons have argued that advance directive is an indirect form of suicide; for both suicide and advance directives have certain essential conditions in common. First, in advance directives especially in the living will, some choices are made for the withdrawal of medical treatment which will lead to death. Although, in such a situation, the possibility of recovery is far-fetched given the terminal nature of the sickness, it is still explicit that the inherent choice of death through the application for withdrawal of treatment was personally made. In suicide, it is very clear that the victim having taught of the whole action, finally submits to it (death).

On another stand, this choice of death directly or indirectly was conditioned by the preceding events which ultimately is very painful and emotional distressful and is of such that one feels unable to cope with. For advance directives, one considers that in such period of terminal illness which will be very painful and emotionally distressful especially when there is consciousness on the part of the patient, the option of death is better so as to reduce and ultimately remove the burden of facing the challenging

situations. This is equally inherent in the option of suicide. Majority of the victims have judged themselves incapable of managing the situation and so desire to run away from the problem ultimately.

More still, one inherent fact about the withdrawal of treatment is the despair show over the recovery of the victim from the terminal illness. Scientifically and highly probable and based on recent cases in the past which remain similar with the present condition, the people involved already lose the hope of ending the challenging situation through recovery from the sickness even if it has to be miraculously possible through the actions of the medical personnel. The same thing applies to the suicidal actions. The victims have already lost hope for a better future given the past and the present.

With these and many arguments, critics of advance directives have argued that it is an indirect suicide and perhaps because of the assistance of the physician, advance directives is best seen as physician-assisted suicide.

Physician-assisted suicide simply means the assistance of the physician to the patient in ending the life of the latter. In medicine, physician-assisted suicide is explained as thus:

> The voluntary termination of one's own life by administration of a lethal substance with the direct or indirect assistance of a physician. Physician-assisted suicide is the practice of providing a competent patient with a prescription for medication for the patient to use with the primary intention of ending his or her own life. Physician-assisted suicide has its proponents and its opponents. Among the opponents are some physicians who believe it violates the fundamental tenet of medicine and believe that doctors should not assist in suicides because to do so is incompatible with the doctor's role as a healer.[5]

While it is possible to include the level of medical assistance in defining the nature of physician-assisted suicide, one obvious fact is that the physician assisted the patient to end his life as a demand made with full consent and in freedom. It is on this reason that the withdrawal type of advance directives is an exemplification of

physician-assisted suicide which even though accepted is rejected on some fundamental grounds. Opponents of physician-assisted suicide have raised a number of objections. First, it is often claimed that killing is intrinsically wrong. It is certainly true that in most cases killing is regarded—on both ethical and religious grounds—as intrinsically wrong. John Paul II adds that suicide is an act of cowardice and a rejection to brace up with the challenges of the time. For him:

> Suicide is always as morally objectionable as murder…it is a sign that one is not able to face the responsibility… it is a gravely immoral act. It contradicts the natural inclination of the human person to preserve and perpetuate his or her life. It offends love of neighbour because it breaks the ties of solidarity and participation with others.[3]

But it is also true that in certain very specific situations, killing is regarded as excusable, understandable, and sometimes obligatory: for example in war, in self-defence, and, some argue, in capital punishment. Even with these irregularities, advance directive is strongly opposed by many.

Second, opponents claim that permitting physician-assisted suicide would threaten the integrity of the medical profession. Rather, the integrity of the medical profession is presently jeopardized with this malady. Third, opponents claim that allowing physician-assisted suicide would lead to widespread abuse. This so-called slippery slope argument holds that allowing some physicians to assist in suicide will lead to the widespread killing of vulnerable patients. This could be said of advance directives since an uniformed patient could be subjected to death by the physician on the deceptive account that the patient has signed for such whereas the consent was based on misinformation.

Furthermore, another challenge that ethical faces advance directives is that it is been seen as euthanasia. The physician-assisted suicide is broadly seen as euthanasia. Euthanasia is a practice of mercifully ending a person's life in order to release the person from an incurable disease, intolerable suffering, or undignified death.[4] It is the wilful, direct or indirect killing of the incurably sick, be it at their request the request of

the parents, guardians or any other legal representative in the case of incurable who are incapable of deciding for themselves, such as infants, the irrevocable comatose and mental defectives.[5] Euthanasia could be voluntary or involuntary: passive or active. The term "involuntary euthanasia" is used to describe the killing of a person who has not explicitly requested aid in dying. This term is most often used with respect to patients who are in a persistent vegetative state and who probably will never recover consciousness. In voluntary euthanasia, a person asks to die (by either active or passive euthanasia). Non-voluntary euthanasia refers to ending the life of a person who is not mentally competent to make an informed request to die, such as a comatose patient.

Passive euthanasia involves not doing something to prevent death, as when doctors refrain from using an artificial respirator to keep alive a terminally ill patient. Hastening the death of a person by altering some form of support and letting nature take its course is known as passive euthanasia.[6] Examples include such things as turning off respirators, halting medications, discontinuing food and water so as to allowing a person to dehydrate or starve to death, or failure to resuscitate.

Passive euthanasia also includes giving patient large doses of morphine to control pain, in spite of the likelihood that the painkiller will suppress respiration and cause death earlier than it otherwise would have happened. Such doses of painkillers have a dual effect of relieving pain and hastening death. Administering such medication is regarded as ethical in most political jurisdictions and by most medical societies. These procedures are performed on terminally ill, suffering persons so that natural death will occur sooner. They are also commonly performed on persons in a persistent vegetative state; for example, individuals with massive brain damage or in a coma from which they are not likely to regain consciousness. Active euthanasia involves painlessly putting individuals to death for merciful reasons, as when a doctor administers a lethal dose of medication to a patient. Active euthanasia involves causing the death of a person through a direct action, in response to a request from that person.

Those who favour active euthanasia and a patient's right to die, do not acknowledge a distinction between active and passive euthanasia. They assert that the withdrawal of life-sustaining treatment cannot be distinguished in principle from

affirmative steps to hasten a patient's death. In both situations, they argue, a person intends to cause the patient's death, acts out of compassionate motives, and causes the same outcome. In their view, turning off a life-sustaining respirator switch and giving a lethal injection are morally equivalent actions.

Opponents of active euthanasia argue that it undermines the value of, and respect for, all human life; erodes trust in physicians; desensitizes society to killing; and contradicts many people's religious beliefs. Moreover, they maintain that the intentions and natures of active and passive euthanasia are not essentially the same. In active euthanasia, a person *directly intends* to cause death and uses available means to achieve this end. In passive euthanasia, a person decides against using a certain form of treatment and then directs that such treatment be withdrawn or withheld, *accepting but not intending* the patient's death, which is caused by the underlying illness.

While people cite differing reasons for choosing to end their own lives, those suffering from a terminal illness typically state that a serious disorder or disease has adversely affected their quality of life to the point where they no longer wish to continue living. Patients with terminal illnesses often fear, with good reason, a gradual loss of the quality of life in the future as the disease or disorder progresses, or they might already have lost a good deal of their independence and thus might require continuous care. Some feel that this loss of autonomy causes an unacceptable loss of personal dignity. Others realize that they will be dying in the near future and simply want to have total control over the process.

The controversy over the moral implications of euthanasia continues. And people continue to link advance directives with it. The inherent patient’s death chosen either by the patient or the relatives, whether it is before hand or timely, has provoked more critics than sympathizers of advance directives. This is because a critical look at the practice, its implications at the short and long runs will express the fact that either advance directives is a form of suicide and euthanasia. A better way of saying this will be to say that the three medical processes are similar. Whatever and however it is being said, advance directives is taken to be a threat to the value of human life.

5.2 THE VALUE AND DIGNITY OF HUMAN LIFE

What is human life and what value has it? The question of the value of human life becomes a paramount one in the face of much postulation, prescription and discussion on the positive attitude to human life. The value of human life thus concerns itself with the meaning of life in terms of its significance and existence. To this question, many areas of life have tried to give an understanding of the value of human life. We shall examine briefly the value of human life from the religious and cultural aspects, which will then give us a working framework for understanding the value of human life.

From the religious perspective and precisely from the Catholic Christian perspective, we get know that the value of human life is found in the fact that human life has a spiritual aspect which connects it with the Supreme Being. The Supreme Being is the creator and the maker of human life; and so no one has the right to violate it by demanding its termination. In the words of her doctrine:

> Human life is sacred because from its beginning it involves the creative action of God and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can under any circumstance claim for himself the right directly to destroy an innocent human being. In [God's] hand is the life of every living thing and the breath of all mankind" (Job 12:10). Every human life, from the moment of conception until death, is sacred because the human person has been willed for its own sake in the image and likeness of the living and holy God. The murder of a human being is gravely contrary to the dignity of the person and the holiness of the Creator.[7]

Suffering and death have a special place in God's plan. Human suffering is a share in Christ's Passion and a union with the redeeming sacrifice which Christ offered for us. Death is the door that ushers us into eternity. Because of the sacredness of human life, we have the grave responsibility to preserve and protect it with all reasonable means. At one end of the spectrum of life, we believe that it is wrong to kill an unborn child, even if the law allows such behaviour. At the other end of life, some in

our age have asserted a so-called "right to die," the right to cause death. No one has such a right, even if the purpose of causing death is to end suffering. This would be euthanasia, which is gravely wrong.

On the issue of human life, John Paul II says that human life is sacred and inviolable from conception down to death and in fact at every moment of existence including the initial phase which precedes birth. All human beings, from their mother's womb, belong to God. Human life can never be reduced to anything. It must be valued and respected and never violated. This is because the inviolability of the person, which is a reflection of God, finds its primary and fundamental expression in the inviolability of human life.[8] Finally, John Paul II adds that human life is a gift from God and for all. It follows that every human life has a specific function; for it was made for the good of all. And so the society must make sure that every life irrespective the stage must be respected if there is the desire for progress. He says:

> There is no true progress, no true civil society, no true human promotion without respect for human life, especially the life of those who have not voice of their own with which to defend themselves. The life of every person, whether of the child in the womb, or of someone who is sick, handicapped or elderly, is a gift for all.[9]

From the cultural understanding of the value of human life, the African perspective shows that human life is of a highest value. For the Igbo people in particular, human life is supreme and is very sacred. The human life begins from conception, and goes through childhood, puberty, adulthood, aged, (death) and Ancestorship. The value of the human life makes the Igbo appreciate pregnancies and celebrate it. The Igbo actually celebrate pregnancy because of some reasons. First, it is a sign that the gods are still working for the people earth and thus furthering the human generations.[10] This value placed on pregnancy makes the Igbo man decry anything that will truncate it. Hence, the traditional Igbo society never allowed for abortion irrespective of the reason. This same value is placed on the life of the human person in all its stages.

The value of the life of the human person in Igbo land is also felt in their upholding the sacredness of human blood. To spill a human blood is one of the greatest violence and the punishment is murder or total banishment from the community. The human blood is seen as the preservation of hereditary traits. It is that which sustains life and transmits the same life to offspring. And so, because the human blood is valued because it sustains life. In the words of Uzodinma Nwala: *Blood* in Igbo ontology is that which sustains life by nourishing it; *the spilling of which not only causes dissolution to the flesh but deprives it of the ancestral life line*, and is also seen as defilement of the land and the Earth goddess (Ala). It is thus held very sacred. The unlawful shedding of blood is defilement to the sacred earth.[11] The lawful shedding of blood may be as punishment for murder and other grave crimes. One thing about the understanding of life among the Igbo is that life is a continuous process. It ends temporarily in death and may be begin in reincarnation or ancestorship. Thus, because life itself comes from the Supreme Being it is given to the highest rational creatures and is naturally transitional from conception through death and ancestorship, human life is of great value.

From the above viewpoints, it becomes clear that human life is of great value because its ultimate source transcends the human environment and is given to highly rational beings for the edification of the universe. Human life is priceless. It has equal intrinsic value which cannot be compared to anything except other human lives. It has instrumental value. It is valuable as the happiness or good that life can create or experience. The ancient emphases on the value, respect and non-violation of human life gave rise to the awareness of the fundamental right to life and its establishment in all legal documents in the world.

The Right to Life

Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life. The right to life is the essential right that a human being has the right not to be killed by another human being. Life is a gift. To speak of life means to speak of existence in physical world. It means a living being or anything that lives. But fundamentally, every person has a right to life, and no one shall be deprived intentionally of his life."[12] This statement is an offshoot of the

Decalogue as it is in the fifth commandment of God. In that commandment, it is read: "You have heard how it was said to the men of old, "You shall not kill: and whoever kills shall be liable to judgment."[13] Thus, in the International Covenant on Civil and Political Rights, there is a precise understanding of the notion of the fundamental human rights which help to protect this life.

The role of this legal and ethical stipulations, that is, the right to life, is to add to our understanding of the value of human life and how it is been treasured by humanity. As the first fundamental human rights, it is equally valuable because it is the basis of other human rights; for when this right is respected, other rights are enjoyed and vice versa. From this value placed on human life, we can then talk about human dignity.

The dignity of the human person lies in the fact that the human person has been endowed with natural intelligence which allows him to create meaning in his existence in the exercise of his innate freedom through the courses of action ordered by the will. Above all existents in the world, man is the only being who is free and has the natural capacity to order the course of his actions in ways personally decided that will guarantee self-realisation, self-governance, self-control and self-fulfilment. Man unlike other living beings have the capacity of self-determination and self-consciousness, the ability that makes him a thinking being in total awareness of his environment while preferring ways to better the environment.

Having discussed what human life is: the value and its translation into the dignity of human life, and while advance directive has purported to advance human dignity, the veritable question to further ask at this point is: does advance directive really promote the dignity of human life?

5.3 ADVANCE DIRECTIVES AND THE DIGNITY OF HUMAN LIFE

In discussing the place of advance directives in the promotion of the dignity of human life, we must first of all consider the general role of medicine/medical science to human life and how advance directives, as one type of medical practice, fulfils the goal of science at the short run; thus, fulfilling the ultimate goal which is the promotion of the dignity of human life.

Medicine is the science or practice of the diagnosis, treatment, and prevention of disease; it encompasses a variety of health care practices evolved to maintain and restore health by the prevention and treatment of illness.[14] From the definition given, we realize that medicine is a specially created human activity that seeks to help human beings live happier, longer and comfortably, with little or no suffering. This very idea and aim has made medical science to constantly advance into providing ever better health practices, technologies that helps to promote human life. More than the patients for whom medicine is mainly provided for, the medical personnel are equally involved both in the prescription of treatment, giving the treatment proper and producing instruments and specific practices that will help to patients in attaining the best of human life lived with less suffering due to illness.

However, the dawn of 20th century medicine saw the birth of some medical practices that have seemed to relegate the sole aim of science. In describing this whole situation with medical science, Robert Sikorski and Richard Peters have this to say about medicine:

> Medicine (Latin *medicus*, "physician"), the science and art of diagnosing, treating, and preventing disease and injury. Its goals are to help people live longer, happier, more active lives with less suffering and disability. Medicine goes beyond the bedside of patients. Medical scientists engage in a constant search for new drugs, effective treatments, and more advanced technology. In addition, medicine is a business. New medical, reproductive, and genetic technology in the second half of the 20th century led to increased concern about moral issues in medical treatment and research. By the 1990s, medical ethics, or bioethics, emerged as a recognized discipline that involved physicians, nurses, attorneys, theologians, philosophers, and sociologists.[15]

It is, thus, the prevalence of some of medical practices like abortion, euthanasia, human cloning, and so on, came the controversial questions being raised on some of these new medical practices. While critics question the morality of such practices and its agreement with the primal function of medicine, sympathizers dismiss such oppositions on the grounds that these practices have reduced human problems and have made life better. This controversy is what has metamorphosed into medical ethics or

bioethics. Arthur L. Caplan, and Christopher King explains the current nature of bioethics as thus:

> Medical Ethics or Bioethics is study and application of moral values, rights, and duties in the fields of medical treatment and research. Medical decisions involving moral issues are made every day in diverse situations such as the relationship between patient and physician, the treatment of human and animal subjects in biomedical experimentation, the allocation of scarce medical resources, the complex questions that surround the beginning and the end of a human life, and the conduct of clinical medicine and life-sciences research. Many of the current issues in medical ethics are the product of advances in scientific knowledge and biomedical technology. These advances have presented humanity not only with great progress in treating and preventing disease but also with new questions and uncertainties about the basic nature of life and death.[16]

It is under this controversy that advance directives have been criticized as having moral problem, especially when there is an involvement of death (either willed or imposed) which is against the primal function of medicine. Initially, the art of medicine was meant to promote life by making it better and reducing human suffering through sickness. To have introduced the idea of death, as a means to end the complications and challenges of life, betrays the effectiveness of some medical practices of which advance directives is included. Advance directive faces this problem the most, since it has been described as an indirect suicide or indirect euthanasia. It is on this ground of introduction of death of the patient that most critics stand to say that advance directive is doing more harm than good and thus seems to either relegate the dignity of human life or at most less promotes it. This is also based on the different means employed in the medical practice of advance directives, especially as regards Ordinary and Extraordinary means of preserving life.

Ordinary and Extraordinary Means in Medicine

Ordinary means or measures are those that can be obtained or used without excessive expense, pain, or other inconvenience, or which, if used will offer reasonable

hope of benefit. Ordinary measures are those that are based on medication or treatment which is directly available and can be applied without incurring severe pain, costs or other inconveniences, but which give the patient in question justified hope for a commensurate improvement in his health.[17]

Extraordinary measures are those which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit. Extraordinary measures are those that are based on medication or treatment which cannot be applied without incurring severe pain, costs or other inconveniences.[18] Their application, however, would not give the patient any justified hope for a commensurate improvement in his health.

If assessed from an ethical point of view, it is possible to distinguish between on the one hand life-prolonging measures the application of which is morally obligatory (ordinary measures) - as they are likely to help the patient - and on the other hand those measures which can be applied optionally (extraordinary measures) as the benefit to the patient is not immediately obvious or subject to considerable debate. This is because as there is a difference between prolonging life and preserving life, and while the intention may be to preserve life in comfort, the eminent danger of death inherent in such a case (extraordinary means) poses a problem. Although, the intention is not death but to preserve the life of the patient and the possibility of death and the severe pain under which the patient will go through raises the questions of the possibility of such medical practice to promote the dignity of human life.

The issue of intentionality is highly questionable in ethics. The intention or the end in view for which an action is carried out justifies the action irrespective of the consequences of the action. In ethics, the issue of intentionality falls within teleological ethical judgment. Although, the intention of an action is the criterion for moral judgment in teleological ethics, it is highly questioned by the critics of consequentialism.[19] Some people object to consequentialism on the grounds that it does not provide guidance in what one ought to do because there is no distinction between consequences that are foreseen and those that are intended. In the cases of advance directives where extraordinary means are used to seemingly preserve life, the problem

of intentionality and reality becomes apparent, for the disregard of death in the process cannot be objectively proven. Even when the principle of double effect is used to justify intentionality in medical dilemmas,[50] it does not rule out the ethical controversy on the nature of intentionality in the judgment of moral actions. According to Mill, scrutiny of motives or intentions will show that almost all good behaviour proceeds from questionable intentions.[51] Therefore, Mill argues, our moral analysis should ignore matters of intention, and so we should reject DDE, which appeals to a distinction between intended and unintended consequences.

From the foregoing therefore, the possible use of extraordinary means in advance directives raises the challenge of the objectivity of the intentionality inherent in the possible result of death in the attempt to preserve life. For some others, going for extraordinary means, which impose severe pains on the patient, regardless of the end, is morally questionable. It is more questionable when there is no justified hope for a commensurate improvement in one's health despite the excessive pain melted out on the patient. Apart from these bioethical challenges of advance directives, another problem that determines the dignity it places on human life is its relationship with human hospitality.

5.4 ADVANCE DIRECTIVE AND THE ISSUE OF HUMAN HOSPITALITY

The pertinent question here is: does advance directive promote human hospitality? The fact that human hospitality adds value to life and, thus, promotes the dignity of human life, makes human hospitality a criterion for evaluating the practice of advance directive as a purported tool for adding value to human life. Hospitality takes the forms of assisting those in need as they approach one and finding people who are in need and then rendering some help to them. As human beings cannot have it all most of the time, it follows that they will need the assistance of others. In times of sickness, the spirit of hospitality demands that the sick person be cared for by relatives and friends even when such demands painful sacrifices. This is the ultimate demand of hospitality which every human being is naturally called to. To abandon the sick on account of the traumas of taking care of the person, and then suggesting ways of solving such problems, through withdrawal of treatment which will result into death, is against the spirit of human hospitality.

Sequel to this explanation, as to the question of whether advance directive promotes human hospitality or not, the answer is to a large extent in the negative. This is mostly the case from the African/Igbo understanding of human hospitality. The spirit of hospitality, which permeates the spirit of the Igbo and the already imbibed disposition of respecting the dignity of every human person no matter the condition, will never allow one to consider abandoning the sick at such a serious moment. Again, it will never allow planning ahead for such a period for fear of being abandoned. Although, out of this same hospitality, one can decide to avoid being a burden to others during one's sickness in future and decide to go for an advance directives, the interpretation to be given will to a large extent mean that the person is avoiding the presence and participation of others in his/her life even at such a point where, naturally, such assistance is needed most. And so, the spirit of hospitality will never allow such a medical plan as advance directives. Hospice as an element of hospitality is never allowed a chance with the prevalence of advance directives.[52] Hospice is service that provides patients in the last several months of a terminal illness with medical care and counselling to ensure the best possible quality of life. Hospice care seeks not to cure disease, but to relieve pain and symptoms, and provide psychological and emotional support to patients and their families during the last months of life and through the dying process. Hospice services also help families with their grief in the year following the death.

Hospice care is usually provided in the patient's home by a multidisciplinary team of health-care professionals and trained volunteers, including family members. When home care is not possible, hospice care may be provided in nursing homes, hospitals, and in homelike hospice centres. Hospice patients receive medication for pain and anxiety, and other medications to control various symptoms of their disease. Dietitians provide nutritional counselling to help ensure that patients who suffer from nausea or loss of appetite receive enough nutrients, and physical therapists help patients exercise to maintain strength and range of motion. When patients can no longer care for themselves, home health aides assist with daily activities. Trained volunteers may bring food, help with housework, or simply keep the patient company. Hospice patients may also receive counselling from social workers and clergy members if they so choose.

While professionals and trained volunteers are essential components of hospice care, family members provide much of the daily care that a patient receives at home. This practice helps relieve the distress of a dying patient by providing a familiar environment in which the patient is surrounded by loved ones, and helps both the patient and family prepare for death in a way that many find rewarding. Caring for an ailing loved one can take an enormous emotional and physical toll on the family, however. When they need a short break from providing care, families may get help from trained volunteers, or the patient may be able to spend a brief period in a homelike hospice centre. Hospice services also provide counselling and support to family members during the terminal illness and grieving process.

There is even the fear that the more advance directives is practiced, human life may be bereft of hospitality, especially in terms of the care shown to the sick. This is because people will presume and expect the existence of an advance directive to cater for the critical situations irrespective of the possible non-existence. At this point, even the minimal hospitality required to be shown to the sick is denied; for an advance directives should be in place to provide for such situations.

Thus, if advance directive to a very large extent is a threat to hospice, then it is threat to human hospitality. If human hospitality which promotes the dignity of human life (by showing the value of life even at sick moments) is threatened, then such a threat ultimately threatens the dignity of human life. In other words, advance directive does not promote the dignity of human life from the angle of withdrawing the required care given to the sick in their critical moments. Nevertheless, in another area of human life advance directives is seen as promoting the dignity of human life. This is precisely in the area of the dignity of human death.

5.5 ADVANCE DIRECTIVES AND THE DIGNITY OF HUMAN DEATH

Suffice it to be said that death is mainly seen as the irreversible cessation of life; the departure of the spirit/soul from the body, what concerns us here is the place of advance directives in promoting the dignity of human death. Human death can occur in several means. But our focus here is death as a result of critical/terminal illness. The occurrence of death in this situation should follow a steady care of the patient through

ordinary means of treatment (and possibly extraordinary means), with much care shown to the patient until the last breath of the patient.

Care of terminally ill patients may take place in the home but more commonly occurs in hospitals or more specialized institutions called hospices. Such care demands special qualities on the part of physicians and psychologists, who must deal with their own fear of death before they can adequately comfort the dying. Although physicians commonly disagree, the tenet that most patients should be told that they are dying is now widely accepted. This must, of course, be done with tact and caring. Many persons, even children, know they are dying anyway; helping them to bring it out into the open avoids pretence and encourages the expression of honest feelings. Given safety and security, the informed dying patient can achieve an appropriate death, one marked by dignity and serenity. Concerned therapists or clergy can assist in this achievement simply by allowing the patient to talk about feelings, thoughts, and memories, or by acting as a substitute for family and friends who may grow anxious when the dying patient speaks of death. It is this type of death that enjoys dignity. Taking this as the criteria for dignity of human death, advance directive will promote this on an ambivalent count. If the ordinary means and perhaps extraordinary means are subscribed to, we can say that the practice of advance directives promotes the dignity of human death.

However, when the withdraw type of advance directives is applied for with the sole decision give in to death at those moment, we can say that advance directives does not promote the dignity of human death. Although the patient who takes to advance directives especially the living will type may have got much psychological consolation over the reality of death, the reality of the unknown cause of events in the future and the comparison with the death that occurs in a process of love and care for the patient shows that such suggestion of death at the living will is not fruitful and productive. Hence, it does not promote the dignity of human death.

More so, it is worthy to note here that some people may not subscribe to the idea of a slow death with love and care shown to the patient. To this people, they belief that they have right to die added to their right to life. This makes them morally and

legally right to decide the nature of their death. For this people, that is where the dignity of human death lies.

The Right to Die

Right to die is right of an individual with a terminal injury or disease to refuse extraordinary medical efforts or life-sustaining equipment, such as the use of respirators and intravenous feeding, to continue his or her life. The catchphrase "right to die" represents an aspect of the right to privacy that is legally recognized in many states.[53] The dignity of pain (received and caused to others), control (being controlled perpetually by others, dependency (living perpetually by depending on others for everything in life) will make people project their right to death since they are autonomous and free beings. With their freedom, they can decide the cause of their lives until death. Hence, they can determine how to die and when to die since it is their lives.

This right to die thus makes people to apply for advance directives especially the withdrawal of treatment to facilitate their deaths. This right to die is equally present in the related issue of suicide. With the emancipation agenda of liberals can make them to choose advance directives even choosing the withdrawal of treatment type. However, the exercise of the right to life brings to the fore the ethical problem between the right to life and the right of autonomy.

The Right to Life and the Right of Autonomy

While it is crystal clear that the right to life is fundamental as well as the right of autonomy by the virtue of human freedom. However, while everyone is allowed to be autonomous in deciding the course of his/her life without infringing on the right of others, no one is allowed by the natural order to exercises his autonomy immorally. And so, the right to life has the corresponding duty to protect and preserve it without relegating the basic human freedom. It is the misunderstanding of this right of autonomy that warrants a blind choice of advance directives especially on the withdrawal of treatment type with the view that one is allowed to live freely and even decide his/her death.

Hence, while the insistence of freedom is recognized in advance directives and where as there is the danger of this freedom to be misinterpreted, except advance directives projects a better understanding of the limit of human freedom in advance directives, it will destroy human beings at the long run. It becomes a bit clear that advance directives is more of a pragmatic medical resort, of which pragmatism has not received wide acclamation when it judges actions especially on the level of expediency.

Nevertheless, the idea of death from the African/Igbo perspective may not guarantee the dignity of human death. This is because Africans/Igbo see death as a continuation of life in the world of the afterlife, where one becomes an ancestor after a fulfilled life in the world. To cause one's death by simple will or action is evil in the traditional society. On this note, the suggestion of the withdrawal of treatment type does not promote the dignity of human death. On the contrary, the suggestion of extraordinary means to preserve life in order to have a natural death is widely contestable. This goes to show that although many people are taking to advance directives, the question of its promotion of the dignity of human life from beginning to end is endless.

5.6 CONCLUSION

Just as every human endeavour, advance directive is set to make meaningful contribution to human existence in terms of promotion of good health care of the possible sick in the future. As a practice under medicine, it become obvious that it will inevitably share the goals of medicine/medical science which is the preservation and promotion of good and comfortable health. Given this goal as inherent in any medical practice, advance directive is thus examined to reveal its agreement with the general goals of science.

The attempt to address the question of the role and place of advance directives in promoting the value and dignity of human life, what comes to the fore is that the choice and practice of advance directives is problematic due to some legal and ethical problems. The legal problems among others reveal the possibility of denying the patient the right of being respected in his/her advance directive and similar to it is the

possibility of imposition of the will by the attorney. Some ethical problems associated with advance directives are revealed in linking it with suicide and euthanasia.

Understanding the value and dignity of human life as priceless, instrumental to an ordered end and a product of a supernatural reality, advance directive will only promote human value and dignity if all its processes do not violate the value of human life. However, the ordinary and extraordinary means used in medical science poses challenge of respect for human life with such uses. While the ordinary means used within the non-withdrawal of treatment type seems plausible to the promotion of the value of human life, the extraordinary means coupled with the withdrawal type of treatment manifest a betrayal of human dignity especially when it comes to the inherent choice/possibility of death of the patient.

Moreover, advance directives could have ultimately promoted human hospitality if it is void of withdrawal of treatment type and extraordinary means. This is because the African understanding of hospitality does not allow for such; for the practice of hospice is essential to African life, which expressed their respect for human dignity. The issue of death remains included in the criteria for determining the respect of human dignity through advance directive. But the ambivalent understanding in the meaning of death makes it obvious that those who will subscribe to advance directive the more are those who claim that they have absolute autonomy over their lives. However, those who eschew the idea of absolute autonomy such as Africans, will not support advance directives completely; only the aspect that preserves human life without much pain until the natural death of the patient will be promoted.

END NOTES

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[2] http://www.medicinenet.com/script/main/art.asp?articlekey=32841. Accessed 25th January 2015.

[3] Pope John Paul II, 1995. *The gospel of life. evangelum vitae*. Boston: Pauline Publication. 108.

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[6]http://legal-dictionary.thefreedictionary.com/physician-assisted+suicide. Accessed on 25th January 2015.

[7] Catechism of the Catholic Church, nos. 2258-2320. Nairobi: Paulines Publications Africa.

[8] Pope John Paul II. 1988. Post Synodal Apostolic Exhortation *Christi fideles Laici.* 38.

[9] Pope John Paul II. 1988. Post Synodal Apostolic Exhortation *Ecclesia in Asia.* n.35.

[10] This is mainly from the communal aspect. On the individual level, it is most celebrated; for through it the family believes that the gods have favoured their lineage.

[11] Nwala, T. U. 2010. Igbo *philosophy*. Second edition. New York: Triatlantic books Ltd. 60-61

[12] The 1999 Constitution of the Federal Republic of Nigeria, Chapter IV, sec. 33: 1

[13] The Bible, Revised Standard Version *Exodus* 20:13. *Deuteronomy* 5:17;.*Matthew* 5:21-22

[15] Sikorski, R. and Peters, R. 2008. Medicine *Microsoft® Encarta® 2009 [DVD]*. Redmond, WA: Microsoft Corporation.

[16] Caplan, A.L and King, C. 2008. Medical Ethics *Microsoft® Encarta® 2009 [DVD]*. Redmond, WA: Microsoft Corporation.

[17]http://www.drze.de/in-focus/euthanasia/modules/ordinary-and-extraordinary-treatment. Accessed 27th January 2015.

[18]http://www.drze.de/in-focus/euthanasia/modules/ordinary-and-extraordinary-treatment. Accessed 27th January 2015.

[19] Teleological ethics is an ethical theory that holds that the ends or consequences of an act determine whether an act is good or evil. Teleological theories are often discussed in opposition to deontological ethical theories, which hold that acts themselves are *inherently* good or evil, regardless of the consequences of acts. Teleological theories differ on the nature of the end that actions ought to promote. Cf. http://en.wikipedia.org/wiki/Consequentialism#Teleological_ethics. Accessed 27/01/2015. 10.57PM

[20] The principle of double effect — also known as the rule of double effect; the doctrine of double effect, often abbreviated as DDE or PDE, double-effect reasoning; or simply double effect — is a set of ethical criteria which Christian philosophers, and some others, have advocated for evaluating the permissibility of acting when one's otherwise legitimate act (for example, relieving a terminally ill patient's pain) may also cause an effect one would normally be obliged to avoid (sedation and a slightly shortened life). Cf. http://en.wikipedia.org/wiki/Principle_of_double_effect. Accessed on 27/01/2015. 11.53PM

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[22] Much of the discussion on hospice is culled from Storey, P. 2008 Hospice in *Microsoft® Encarta® 2009 [DVD]*. Redmond, WA: Microsoft Corporation.

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CONCLUSION

The study was devoted to the examination of an African perspective on Advance Directives using the Igbo Culture as a reference point. Chapter one of this work concerned itself with the idea of advance directives. Here, attempts were made to give a general view of advance directives connecting it with its history, types, nature and the controversies surrounding its nature. Hence, we showed that Advance directive is a medical document/instruction though with legal colouration by which a person makes provision for health care decisions in the event that, in the future he or she is no longer competent to make such decisions for himself or herself. The primal reason of advance directive is to provide a means by which a patient is able to determine through the written directives, how he or she wants to be treated when incapable of making decisions regarding preferred treatment. While this document is drawn up by the patient with the awareness of the medical practitioners and the relations, no one except the patient or the person he has charged with such responsibility can alter the provisions there in.

In Chapter two, some ethical theories were discussed in line with the essay with the view of showing how they affect the choice and practice of advance directives either negatively or positively. From the elucidation of the ethical theories, we arrived at the fact that the wide acceptance of advance directives especially in the Western world is based on the fact that advance directives helps the individual to assert himself by acting freely and taking responsibility for what happens in his or her life. For them, the autonomy of the individual which is respected in advance directive gives value of advance directives. Interestingly, the very reason behind the acceptance of advance directives becomes the reason for its rejection especially by Africans (in their contrary nature). This was clearly shown in chapter three which focused on the totality of the human person from the Igbo perspective. The rejection of the medical practice especially from the African perspective is based on their understanding of human life, human sickness and then the dignity of the human person.

Taking the Igbo society as a reference point, the human person is holistic. The human person is vertically and horizontally relational. Vertically, the human person's spiritual elements afford him the opportunity of relating with the spiritual entities of reality. With the material element, the human person interacts with the world as an individual and as community. One aspect of the life of the human person is that in the traditional Africa/Igbo society, the communal existence is rated higher than the individual, such that whatever happens and no matter the situation, the community takes precedence over the individual.

The communal living of the Africans/Igbo reveals that personal decisions most often are only approved by the community. This factor and other factors become responsible for the present negative attitude of the Igbo to the practice of advance directives. This was the conclusion of the fourth chapter. These factors were well represented in the research made on this issue through series of interviews conducted with some people. The result of this research has it that the communalistic traditional society will remain hostile to the practice of advance directives; for being contrary to local custom, advance directives asserts the autonomy of the people. Beyond this, there are some factors that are likely to affect the Igbo's perspective on advance directives. They include: interest of the patient, peace of the relatives, the Input of the Medical personnel, awareness of advance directives, financial issue, and the question of death. These issues are factors that will affect the practice of advance directives among the Igbo. Nevertheless, with better knowledge and financial strength, very few Igbo are going for it and in the future, most persons will go for it. When the Igbo person finally goes for advance directives, it may take the form of a consensus advance directives.

Chapter five went beyond the Igbo perspective on Advance directives to ascertain its moral and ethical condition in a universal worldview. More than the African/Igbo perspective on advance directives, the status of advance directives is highly questioned in the bioethics because of its inherent legal and ethical problems. The legal problems among others reveal the possibility of denying the patient the right of being respected in his/her advance directive and similar to it is the possibility of imposition of the will by the attorney. Some ethical problems associated with advance directives are revealed in linking it with suicide and euthanasia. Again, since many

emphases are placed on the avoidance of death of any human life as the value to life, some means used in advance directives puts to question the goodness of advance directives in according value to human life.

The ordinary and extraordinary means used in medical science poses challenge of respect for human life with such uses. While the ordinary means used within the non-withdrawal of treatment type seems plausible to the promotion of the value of human life, the extraordinary means coupled with the withdrawal type of treatment manifest a betrayal of human dignity especially when it comes to the inherent choice/possibility of death of the patient.

Again the controversies surrounding the dignity of human death, hospice and hospitality also makes the plausibility of advance directives equivocal. While the western understanding of human death, hospitality and the human person in general colours their acceptance and promotion of the medical practice, the African/Igbo understanding of all these from the angle of tradition will make the practice unpopular in Africa at present. However, with the growing globalisation, Africans may subscribe to it as "Consensus Advance directives" and will accommodate all the influences of the community in the life of the individual who is signing the advance directives.

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