This book discusses the role of the medical professionals who in the call of their duty have to occasionally clarify their values in as far as ethical dilemmas are concerned. It correlates the challenges of care giving with the christian world view concerning end-of- life issues. It attempts to reconcile and also draw parallels on the diverse views. The book presents some best case scenarios and dialogues on this subject from the local setting and elsewhere in a down to earth approach and will be invaluable to those in fields such as psychosocial, ethics, medical, nursing, religious studies and even law. Health personnel and especially those in critical care and hospice care should find the book useful. He has published several articles and a book: 'Inventory on Job Description of Nurse Managers in Developing Countries: Rising Above the Challenges in A Changing Work Environment'. ISBN 978-3-659-17612-8. His scholarly link is: https://www.researchgate.net/profile/Simon_Kamau/

Simon Macharia Kamau

Was an ICU nurse for over 20years, previously the Nurse Manager of Critical Care Unit/HDU at Moi Teaching & Referral Hospital, Eldoret Kenya. Holds BSc. Nursing(Moi),Higher Diploma in Critical Care Nursing(Nairobi). Is an MS iLEAD program candidate, University of Colorado, Denver, USA. Teaches in the BSN program at University of Kabianga, Kenya.

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ETHICAL DILEMMAS ON END-OF-LIFE ISSUES: TAXING VALUES AND FAITH OF HEALTH-CARE WORKERS IN KENYA

Epilogue

This book touches on ethics, law, social and public policy as they affect health care providers in Kenya, their values and faith. It borrows more from the Pentecostal Christian world view which happened to be the orientation of this author. Cognizant of the fact that moral and ethical issues on origin of life, death and destiny cut across different faiths with a common denominator: That life is sacred.

It is unfortunate that at times a patient in our care may die no matter what we do. Profound ethical questions on end of life issues confront the medical personnel as they watch and wait helplessly.

A conference to discuss on ethical dilemmas was thought to be a good way of airing out issues. Conference proceedings are a rich source of evidence based findings. The study thus is informed to some extent by deliberations on euthanasia and 'end-of-life issues' from a conference (The 26th General Assembly Federation of African Medical Students' Associations (FAMSA) Conference 17/2/2011 at Medical Education Complex, School of Medicine, Eldoret Kenya).

This compilation of the ideas, inspirations and reflections of the significant sessions and also fulfills some of the recommendations resulting from the distinguished panelists who included the clergy. A content analysis of the discussion was done. It also makes an attempt to dissect some ethical and legal issues that were presented.

All the cases, events and places are real some have been changed or withheld for ethical reasons. The setting hinges on a case study of Nelly (not her real name) from a local setting . A signed consent to highlight her case was sought from her relatives).

This is compared with three from elsewhere whose cases were heard and determined in courts of law there, thus are considered to be in the public domain. The last one was self-posted in an online essay exchange forum that this author participated in and by posting an excerpt of maiden materials included in this book.

Various authorities have written on this subject and this article wishes to add a voice on the Christian health care worker's perspectives on end of life issues. All materials used have been appropriately acknowledged or cited. One of the limitation experienced during this project as well as during the debate was lack of published cases or concluded court cases from within the country.

The objectives of this study were: to explore ethical dilemma issues on end of life which have a heavy bearing on health care providers. Also to explain euthanasia, withholding treatment and the law as it relates to Christianity.

In conclusion it acknowledges that ethical dilemmas on end of life issues were real challenges facing the health care providers on a day to day basis. More so it also challenging the values and faith of the Christian health workers. No pragmatic policy guidelines existed to safeguard the Kenyan health care providers on these issues. In the opinion of this author, not much else except that life is sacred did we get from biblical perspectives, therefore much more is needed to unearth the supportive resources available to the health care providers.

This author has published several articles locally and internationally. His first book: *Inventory on Job Description of Nurse Managers in Developing Countries: Rising Above the Challenges in A Changing Work Environment.* ISBN 978-3-659-17612-8. These plus his other scholarly interests can be accessed using this link: https://www.researchgate.net/profile/Simon_Kamau/

Key words: DNR, Ethics, End-of–life, Euthanasia, Dilemmas, Kenya law, christian

ACRONYMS

ACLS- Advanced Cardiac Life Support

BBC- British Broadcasting Corporation

CCU- Critical Care Unit

DNR- Do Not Resuscitate

FAMSA- Federation of African Medical Students Associations

GBS- Gullaine Barré Syndrome

ICU - Intensive care Unit

KMA-Kenya Medical Association

KMPDB -Kenya Medical Practitioners & Dentists Board

MEC-Medical Education Complex

MOH -Ministry of Health

MTRH-Moi Teaching & Referral Hospital

NNAK-National Nurses Association of Kenya

NCCU- Neurological Critical Care Unit

NHIF-National Hospital Insurance Fund

NTV - Nation Television

PAS- Physician Assisted Suicide

PVS- Persistent Vegetative State

TV –Television

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CHAPTER 1

INTRODUCTION

A conference to discuss on ethical dilemmas is thought to be a good way of airing out issues. This paper touches on ethics, law, social and public policy as they affect nursing practice. Unfortunately, a patient in our care may die no matter how much we try. Researchers and educators have stressed that education (*dialogue)* about ethics and attitude learning should be based on real situations and start from identifying problems.[1]

Profound ethical questions on end-of-life issues confront the health care personnel as they watch and wait helplessly. Hosmer points out that ethics… is not about clear cut choices, but more about multiple choices in complicated situations. [2]

He adds that it does not aim to change people's religion or customs, but instead to assist them with their decision making. Rev Dr Martha Jacobs[3] A Christian Guide to Confronting End of Life wrote some

[1] Beers GW. The effect of teaching method on objective test scores: problem-based learning versus lecture. J Nurs Educ 2005; 44: 305–9.
[2] Hosmer L. Adding ethics to the business curriculum. Business Horizon 1998; 31(4): 21–34.
[3] Jacobs Martha , 'A Clergy Guide to End of Life Issues' A Christian Guide to Confronting End of Life accessed online 17th Dec 2012, http://www.huffingtonpost.com/rev-martha-r-jacobs/a-clergy-guide-to-end-of-_b_836865.html

guidelines for the Christian, but which fall short of addressing the needs of the Christian health care provider in a country like Kenya.

Thompson and Harrow appreciate just like I do that many of the ethicists, Christian authorities and clergy who have written on the topic may never themselves have to make the decisions we as health care providers make, some on an every day basis. The reader will be directed to these resources for supplementary reading[4].

In certain circumstances, a patient in Critical Care Unit (CCU) will die imminently despite availability of the best possible care including life support. Others may have had a good chance of recovery if admitted to the Critical Care Unit, but then no bed is available for this new patient as limited resources impact on CCU admissions. Don chin's observed in 2004 (Bogner, 2004) that situations in the CCU are often fluid, the medical condition of each of the patients may be changed or perhaps hopeless.

The rapid pace of unchecked technological advances enables prolonging life by maintaining some patients on a ventilator even for years even where prognosis is poor or guarded, some even with 'silent' Do Not Resuscitate [DNR] orders. There may be no clear

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[4] Bert Thompson and Brad Harrub A Christian Response to "End-of-Life" Decisions, http://www.apologeticspress.org/apcontent.aspx?category=7&article=58

policy on DNR existing in any Kenyan hospital as yet. This dilemma often occurs in the Critical Care Unit.

Profound ethical questions confront the CCU personnel as they watch and wait helplessly. Bogner, 2004 also adds that apart from the relatives the critical care primary nurse bears the greatest psychological trauma.

Herbert (1981) in '*A Matter of Life and Death*', Radio Bible Class, radio interview described that it is depressing and stressful to see, manage or care for the brain dead patient. He regretted that the society has become less prepared for death and has come to rely on high tech medicine to work miracles…

Advanced Cardiac Life Support (ACLS) has become one of the techno age's primary end –of –life rituals, but it falls short of filing the gap left by the loss of life affirming community and family bonding ceremonies (Bogner, 2004). It was also observed elsewhere by (Borgatti, 1998) that family experience of death of a loved one ought to be more binding for their family than disintegrating.

This is a 'slippery slope' argument of all times, remarked a clinical psychologist in a recent discussion on Euthanasia. Nonetheless this forum drawn from a diverse audience including the clergy came together to discuss it in Eldoret, Kenya at the close of The 26th General Assembly Federation Of African Medical Students(FAMSA).

Professor Doucet, an ethicist, concluded in his article….when we have the technical means to prolong life, the real question is not "is it acceptable to stop treatment at the end of life?" but "At what point and how should we stop treatment in order to have a good death?" (Doucet, 1996). Even though the Professor wrote this over 20 years ago in Canada, the Kenyan situation has yet to appreciate or come to terms with dilemmas on end of life issues that face health care providers workers.

The following questions formed the basis of the conference debate on end-of-life issues (Lukoye, 2011).

1. Would it be wrong to shorten life intentionally or to prolong it unnecessarily when it is in the best interest of the patient to die?

2. A patient's choice to refuse treatment for any reason other than suicidal must always be respected. But how do we get the consent of a patient in coma, is it by advance directives (living wills), legal surrogates/proxy, or close relatives?

3. Should we continue insisting that he or she should receive all the necessary care until eventual natural death?

4. Is it like '…assuming that all will be well with the unwell?'

5. Should treatment continue at the risk of the patient surviving in a severely impaired state?

6. Should the patient be allowed to die, with the risk that perhaps if treatment had continued they may have recovered?

7. How can honour and love be at the heart of the assisted-dying debate?

8. Should we disregard advance directives to withdraw treatment where there is a chance that the patient will recover competence?

These questions were grouped and analyzed thematically as will be seen below

CHAPTER 2

CASE STUDY 1

Nelly

Nelly (not her real name), a 56 year female patient was admitted in Critical Care Unit (CCU) of a Kenyan public hospital. She was ventilator dependent by tracheostomy (an artificial hole made on the throat to facilitate breathing, bypassing the normal passage from the nose to the lungs). She is a retired primary school teacher, a protestant Christian, married and a mother of 7 children.

She was admitted with ascending paralysis which started on the lower limbs progressively to affect respiratory muscles. Nelly could not feed, move or breathe without help (mechanical ventilator). Doctors made a working diagnosis of Gullaine Barré Syndrome (GBS) or its variants [never became conclusive].

GBS is a debilitating illness, more sudden in onset but also life threatening because the paralysis may affect muscles of breathing). Wikipedia defines Guillain–Barré syndrome, as an acute polyneuropathy, a disorder affecting the peripheral nervous system. Ascending paralysis, weakness beginning in the feet and hands and migrating towards the trunk, is the most typical symptom, and some subtypes cause change in sensation or pain as well as dysfunction of the autonomic nervous system. It can cause life-threatening

complications, in particular if the respiratory muscles are affected or if there is autonomic nervous system involvement. The disease is usually triggered by an infection.

She went in and out of depression many times. She was managed by the psychiatrist with counseling and antidepressants without much improvement. At one point after one year she summoned her children to the bedside. She was only able to move her eyes. It was not possible to ascertain what exactly she communicated to them.

Around the same time, a full hour memorial service was held inside the Critical Care Unit staff lounge as a joint effort between CCU staff, the chaplain and the relatives. [This type of service was the first of its kind, just falling short of what would usually be done in a funeral context].

The opinion of experts from three medical disciplines; neurosurgery, anesthesia and internal medicine (physicians) was that the condition was irreversible; it was only expected to deteriorate until death. That is, she wound never be able to live without total life support with ventilation, nasogastric tube feeding, turning and cleaning.

Nelly was very close to the CCU staff, they knew her likes and tastes; for instance she was fond of pediatric patients who got admitted the CCU bed next to hers. She had been moved through all the six CCU

beds slots at different times of her stay. Her cognitive functions remained intact most of the time.

She made friends even in that state e.g. whenever a nurse would go for annual leave, one wish they had was 'to come back and find Nelly still alive'. She was resilient and could pull through odd and ends circumstances including multiple drug resistant organisms in her spectrum etc. A silent attempt for 'less aggressive care' was contemplated in a ward conference to discuss way forward. The family was divided on this; however they consulted their lawyer who constrained them against seeking to terminate life.

At times stress levels could get very high among the nursing staff on advocacy and health care providers Christian perspectives on end of life issues. Nursing care was performed professionally-the patient was suctioned, put back on ventilator, bathed, fed, turned, and her dressings were done.

A written order was issued by hospital management to resume full support. Efforts were even made for fundraising for a portable mechanical ventilator to use at home. Nelly went into deep coma 3 months to her death after 1year 4 months in CCU. It was thought she succumbed, possibly due to complications of prolonged hospital stay like nasocomial(hospital acquired) infections. She had accrued a Hospital Bill of nearly Ksh 3 Million (US$37,500) in the year 2009. A

support group(Gullaine Barrè Support Group Kenya) was founded in her honour.

CASE STUDY 2

Richard

This story was broadcasted on 13th July 2010 in a BBC documentary "Between Life and Death" On October 23rd 2010, Richard aged 33 was riding a motorcycle when he hit a truck at high speed. He was found six meters away from his bike and suffered terrible injuries, was paraplegic and was non responsive after treatment. He was believed to be in a coma until a consultant found that he was able to respond to questions by moving his eyes.

His father aged 70 gave permission for doctors to withdraw treatment. But the physician wanted to wait a bit longer. The father said, "They help open eyelids and asked him to move his eyes if he could hear them and he moved his eyes around so we knew he was not brain dead".

Richard was in Neuro ICU for 6 months before a team of physicians asked him whether he was happy for them to go on treating him. He answered 'yes' three times showing that this was a consistent response. They then asked if he wanted to go on living. He blinked his

eyes rapidly, “yes”. Richard could also move his head slowly an inch or two.

Some year or so earlier a friend to Richard had lost both legs in a car accident. Richard had shared with his parents at that juncture that he would not want to be kept alive if something similar happened to him. Richard may have changed his mind, he may never come off the ventilator but he has a chance of life to which we are all entitled. This is a case of the very person who gave advance directives apparently changing his mind when the reality of the decision strikes him (fortunately or unfortunately or he was already in it).

CASE STUDY 3

Terry

This was a case of a severely brain damaged 31 year old woman on feeding tube for 20 years. She collapsed in the house due to? Cardiac arrest induced by anorexia nervosa. Subsequently she got brain damaged due to hypoxia/anoxia to the brain. She could breathe and maintain her heart beat, had impaired vision and could move her limbs. She needed a feeding tube for nourishment and hydration.

Her brother, sister in-law and her husband said she had expressed a wish not to be kept artificially alive. The family had debated about life support when her grandmother was in a nursing home unconscious for

weeks on a ventilator. Her husband testified that Terry had said "if I ever have to be a burden to anybody I don't want to live like that."

That country's law considered a feeding tube as a life support device at par with a respirator. It also allowed oral end-of-life wishes. Despite objections from her parents, the court ruled that she be disconnected from the life support-meaning the feeding tube. In the year 2000 orders to remove the tube were issued and eventually the tube was removed for 3 days in April 2004. This generated heated activism e.g. Terry 'Death by starvation-please pray for her'.

In the twenty or so times Terry's case was heard in the state courts, both father and mother said NO, the husband said YES. Every time the court held that it was upon her husband to make the decision. She died on 31st March 2008 (cause of death; euthanasia).it raised a lot of public outcry.

In a final postscript to Terry's short life the autopsy conducted after her death established that her brain damage was even worse than the experts had said while she was alive, and that everything the "save Terry" activist had said was incorrect. Her brain weighed ½ that of a healthy human being; damage that left her unable to think, feel, see or interact in anyway with her environment. There was no chance she could have recovered.

Before 1999 the state law had it that it was necessary for two physicians to determine if the patient had "a terminal condition" from which there was no reasonable probability of recovery in order to withdraw or withhold their life prolonging procedures. The revised law now allows two physicians to determine if the patient is in an end stage condition or persistent vegetative stage (PVS), (Britain and other European countries1999).

CASE STUDY 4

Smith

A typical scenario below in clinical ethics touches on professional-patient relationship as well as obligations of the individual caregiver and the rights of the individual patient. Smith, 2011 in *Daughter vs. NURSE: Moral Courage* posted in allnurses.com. Smith, a nurse had her mother diagnosed with a terminal condition. The patient is quoted as questioning the doctor's advice to get her cancer treated thus; "What if I don't want any treatment for this cancer?" The response from the doctor was... "Well, I think you are being very selfish at this point".

Smith reminded the Doctor that this was not his decision to make. Further, the patient had the right to be educated about her diagnosis and treatment options, and would require more time to come to reach

a decision. She added, 'I told him that he had No RIGHT telling any patient that they were being selfish!! He angrily stood up and left us alone in the room'.

Smith observed that nurses are taught to become the patients' advocates. They ought to take into consideration the wishes of the patient. They must find that inner moral courage and strength to be able to help their patients to make the best choices and decisions regarding their personal care and spiritual wellbeing.

The cases of Nelly, Terry, Richard, Brian and Smith have many common issues like the obvious dilemma they all created. However some of them had given 'implied' advanced directives on what should happen in case they ended up in vegetative state while Nelly (above) had not given any such directives. Anecdotal evidence also shows that many Kenyans do not give advance directives or living wills. [5]

[5] Smith, T. 2011, *Daughter vs. NURSE: Moral Courage,* http://allnurses.com/general-nursing-articles/daughter-vs-nurse-536157.html, accessed 23rd July 2012

CASE STUDY 5

Anthony Bland

In *Airedale N.H.S. Trust v. Bland* (1993); it was held that there is no valid distinction between omission to treat a patient and the abandonment of treatment which has been commenced.

The case law *Airedale NHS Trust v. Bland*(1993) made it clear that artificial nutrition and hydration through the use of naso-gastric tubes, intravenous lines and so forth is a form of medical treatment and thus no different from other forms of treatment. As such it can be both lawful and ethical to withdraw and /or withhold it in certain circumstances. (Hendrick, 2000)

In this case the House of Lords' decision was that treatment could be withdrawn from Anthony Bland, a young man crushed in a stadium disaster 3 years earlier and was in or 'near' persistent vegetative state (PVS) but his brainstem was still functioning.

In law he was still alive since he was able to breathe and digest food, but could not see, communicate, hear taste and smell. His bowel was evacuated frequently by enema. He had suffered repeated infections. With constant nursing care he could be kept alive for many years but he would never regain consciousness. It is an example on how the law has developed albeit in a piecemeal basis, however inconsistent. (Hendrick, 2000)

CHAPTER 3

MORAL OBLIGATIONS & ETHICS

The conference of Medical Royal Colleges in UK in 1976 and 1979 led to a new definition of death, brainstem death i.e. the irreversible loss of brain function. The following criteria were satisfied

1. The patient must be in deep coma;

2. The patient must be apnoeic (absence of breathing);

3. The patient must have irrecoverable structural brain damage; and

4. Reversible causes of brain stem depression must have been excluded

This thus means that a patient meeting this criterion but on ventilator for life support may be declared dead for medical and legal purposes (Jennett, 1996)

Is The Kenyan Public Getting Enlightened About End of Life Issues?

Questions are increasingly being raised about the role of health care professionals in making end-of-life decisions for patients. The general public is increasingly getting open-minded, they may already be wondering whether health care providers participate in making decisions that shorten the lives of patients or not, and if this should be

accepted or not. Health care professionals must therefore anticipate this debate and prepare themselves to deal with it in advance.

The medical profession is not infallible: clinicians may make mistakes and there may be uncertainty in diagnosis & prognosis. There may be errors in diagnosis & treatment. An example of public enlightenment was coverage by some Kenyan national TV channels on one day two different story lines with a similar theme. One was dubbed *'The New Cancer'* construed to mean medical negligence and another one '*Utepetevu hospitalini…*' in Kiswahili implying laxity in Kenyan hospital which could have lead to loss of life [6] [7].

Anecdotal evidence shows that many Kenyans do not give advance directives or living wills. In the African custom the great majority prefer not to think about their own death in any way. Indeed, most people do not even leave a will directing what to do with their material possessions.

[6] *'The New Cancer,'* NTV PM Live 13.00HRS on 30th March 2011 and 'Justice *wanted,'* on NTV Tonight 21.00HRS on 4th April 2011.

[7] '*Utepetevu hospitalini…,*' Citizen TV Nipashe, 19.00 HRS on 30th March 2011.

Pledge to Uphold Ethics

'Respect for life is above science' observed Dr.Antoinette Kankindi a Philosophy Lecturer at Strathmore University when she made a presentation in the debate which she compared Value of life versus Euthanasia(Kankindi, 2011)[8].

This is also as exemplified in the Hippocratic Oath extract: *'I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. I will not give a lethal drug to anyone nor will I advise such a plan…'*

Hippocrates, in the fourth century BC said that the object of medicine was to get rid of the patient's suffering and reduce the violence of the disease, but abstain from intervening in cases that were beyond the powers of the art (Doucet, 1996).

The International Council of Nurses states that, "nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate sufferings" (Nursing subsector policy 2006).

[8] Kankindi, A. February 2011, The role of Euthanasia in chronic illness" Philosophical questions ,paper presented at the 26th General Assembly Federation Of African Medical Students, Moi University, Eldoret, Kenya.

An extract from Nurses pledge, *'...do solemnly pledge: That I shall abstain from unsafe practice or acts of negligence and shall not knowingly administer any harmful treatment, nor withhold necessary care…'* (Nursing Council of Kenya). There are primarily two approaches to ethics education for nurses: the first consists of introducing nurses to the principles of right action and the second is a virtue ethics approach, which places greater emphasis on attitude in caring[9].

The Goals of medicine according to Sir William Osler were, "To cure sometimes, to relieve often, and to comfort always." However more modern goals of medicine include: avoidance of premature death, preservation of life, prevention of disease and injury, promotion and maintenance of health, relief of pain and suffering, avoidance of harm, promotion of well-being (Varelius, 2006).

Guiding Principles of Medical Ethics

There are four principles upon which medical ethics are based—autonomy (of the patient), *non-maleficence*, beneficence (on the part of the doctor), and justice. These principles were laid down by Beauchamp and Childress in 1979, and form the framework within which medical ethics is now normally taught to student doctors and nurses as reported in (Warnock, 2005). In autonomy we respect a

[9] Vanlaere L, Gastmans C. Ethics in nursing education: learning to reflect on care practices. Nurs Ethics 2007; 14: 758–66

patient's right to self-determination, but surrogacy may be invoked where a patient loses the capacity to express their wishes.

While in *Beneficence*-we should promote good for our patient, always. In the Ethical principle of *non-maleficence* states 'First do no harm' while the justice principle refers to distributive justice. It challenges us to ask, "What is a fair or just distribution of scarce medical resources?" Would it be fair to indefinitely sustain someone on life support when withdrawing that treatment would benefit another? Appleton Consensus gives guidelines on how to deal with end-of-life decisions in various scenarios(Stanley 1989,pp15,129-139).

CHAPTER 4

EUTHANASIA

From Greek *eu* (good) *thanatos* (death) It means pleasant, gentle, soft death. Action or omission that causes death. Onga'any (2010) puts the purpose as: eliminate or avoid pain.

A deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person's suffering where the act is the cause of death, also defined as mercy killing of hopelessly ill or injured persons where the doctor or the family members actively participate in the death of the patient [Also see Appendix II]

Voluntary- patient (with the legal/mental competence) asks for it. Involuntary- inconsistent with patients wishes, where these are known (usually in patients who have lost capacity to communicate their wishes).Non-voluntary- patient is unaware that it is being considered, whether their wishes are known or not (of life and death report 1995, pp 14).

- Ortothanasia : left to die by omitting medical assistance.
- Suicidal Euthanasia: self inflicted without help

- Homicidal Euthanasia: liberate from agony and eliminate lives devoid of value

- Direct Euthanasia & Indirect Euthanasia: to procure death

Brian Pollard (an anesthesiologist) who from 1982 founded and directed one of the Australia's first Palliative care services distinguishes Euthanasia which he defines as a form of homicide (a crime) even if legalized from some medical actions (e.g. withholding and withdrawing treatment) that are labeled euthanasia; since the intention (mens-rea) to take life is lacking. These includes not commencing treatment that would not provide benefit to the patient, withdrawing treatment that has been shown to be in-effective, or giving high doses of opioid painkillers, that may endanger life (the legalization of euthanasia, 1982).

A Kenyan national newspaper column expressed this as: 'I always feel uneasy about euthanasia [assisted suicide] and turning off life support machines. What if the patient is comatose physically but alive in his mind? What if he cannot communicate his wishes? What if the doctor or relatives misinterpret his signals?'(Loughran 2010)

In the case of Airedale N.H.S. Trust vs. Bland (1993); it was held that there is no valid distinction between omission to treat a patient and the abandonment of treatment which has been commenced.

Appleton Consensus gives guidelines on how to deal with end-of-life decisions in various scenarios (Stanley, 1989).

What might be some of the Implications of legalizing Euthanasia?

'One of the most important developments in recent years is the increasing emphasis placed on health care providers to contain costs. In such a climate, euthanasia certainly could become a means of cost containment...'. Moreover financial considerations, added to the concern about "being a burden," could serve as powerful forces that would lead a person to "choose" euthanasia or assisted suicide. This was the argument of (Ong'any 2010).

The focus should not just be on the actual moment and manner of physical death, but on the period (days, weeks or months) leading up to the moment of death with an emphasis on achieving the best quality of life possible (a leaflet Church of Scotland: End of Life Issues, A Christian perspective)[10]

[10] www.churchofscotland.org.uk.

Upholding The Sanctity of Life Versus Euthanasia

History has taught that Euthanasia is a rejection of the importance and value of human life and that could be why there are few countries in the world today where euthanasia is legal. That is why almost all societies for thousands of years have made euthanasia a crime. There are strong religious & secular traditions against taking human life. It is argued that assisted suicide is morally wrong because it contradicts these beliefs, e.g. the Judeo-Christian worldview on ethics. In his book (Christians, 1995) asserts that man is created in the image of God. You cannot take away what you cannot give; it underscores love as a basis for ethics.

Moreover, Mason (1996) observed 'none of us has ever died, and thus euthanasia is one subject on which it is impossible to say that a given view is right or wrong'. I agree to the extent that as far as I know only Jesus Christ of Nazareth, the Son of the Living God, who was, who is and will be forever has a credible life-death-resurrection metaphor. "*He that is* our God *is* the God of salvation; and unto GOD the Lord *belong* the issues from death". Psalms 68:20 (KJV)

Christian Life Resources position statement 'Any practice of euthanasia, the intent of which is to shorten one's own life or the life of another person, is a practice condemned by the Word of God and therefore is wrong. All people are to protect life and carry the burdens of others. Apart from God's expressed permission, it is wrong to take

human life, even when we do not like the quality of that life'. Available online http://www.christianliferesources.com/category/end-of-life-issues

"For you created my innermost being; you knit me together in my mother's womb" Psalm 139 v.13. "Don't you know that you yourselves are God's temple and that God's Spirit lives in you? If anyone destroys God's temple, God will destroy him; for God's temple is sacred, and you are that temple." 1 Corinthians 3 v 16-17(KJV)

A colleague nurse whose testimony I value gave this answer during the debate. 'Personally, as a nurse in my practice in critical care settings, I have witnessed many deaths, people in their last minutes of their lives…I say it is a privilege to care for someone at the end of their life'.

Moreover Christ shared man's mortal nature that by His dying men might be freed from death. **"** Forasmuch then as the children are partakers of flesh and blood, he also himself likewise took part of the same; that through death he might destroy him that had the power of death, that is, the devil; and deliver them who through fear of death were all their lifetime subject to bondage. For verily he took not on *him the nature of* angels; but he took on *him* the seed of Abraham". Heb 2:14-17 (KJV).

When To Resuscitate or When Not To Resuscitate

Ong'any (2010) clarifies that- DNR does NOT mean: "DO NOT TREAT!" DNR means: "DO NOT RESUSCITATE". It is appropriate to discuss/obtain DNR status while continuing treatment, especially of recurrent/progressive/emerging disease processes.

Palliative care: Affirms life and regards dying as a normal process, neither hastens nor postpones death, this is according to the submissions by Dr. Helena Musau on palliative care to the conference FAMSA conference (Musau, 2011)[11].

Purnell in 1998 analyzed the implications of 'Slow Code' -ineffective resuscitation, allowing a patient to die, A Slow code as described by Hutchinson Sally is a responsible subversion or rule bending…colluding of a premeditated act anticipated to result in a patient's death.. Physician may put the nurses in this dilemma by tacitly not ordering a DNR when death is imminent. The decision to participate in a slow code is upon the individual nurse since a slow code is a form of passive euthanasia, and is illegal; it violates the nurses practice act.

[11] Dr. Helena Musau, 2011, on palliative care to the conference FAMSA conference ,Eldoret Kenya

Little is documented on Slow codes except what is covertly revealed by those who participated by word of mouth because of the need for self preservation (Purnell, 1998).

According to Mutheu and Kachulah, 2006 in their introduction they had noted the following: That ICU patients have high risk to death. The nurse caring for the dying patient and family requires many skills. The nurse must posses the ability to offer compassion, assess the multitude of symptoms that occur at the end of life and participate in symptom management[12].

The nurse as a member of the health care team focuses to help promote a healthy and positive dying experience for all involved. This was presented by (Mutheu and Kachulah, 2006).

The British Medical Association in 1999 noted that all health professionals involved in the care of the patient have an important contribution to make. It further stated that 'nurses often have a particular insight into the patient's wishes and may have spent considerable time with the patient and the relatives'. (BMA, 1999)

Death is a process not an event. This is according to Chumba, 2009, who describes the physiology aspect of death from a pathologist's

[12] Mutheu, V, and Kachulah, J. November 2006, Care Of A Dying Patient On Mechanical Ventilation, Paper Presented to The Kenya Intensive Care Nurses Chapter-Annual Scientific Conference, Eldoret.

point of view, while this may not necessarily agree with what Bond and Dax (Bond, 2010) who wrote '…nor should ICU care be used to prolong the natural process of death'. Since Kenya does not have euthanasia related laws then emotional and spiritual issues usually arise for the close family and friends and the health care providers.

Figure 1: Relatives, clergy and significant others have a critical role in making decisions on end-of-life issues (Portrait is courtesy of The Nairobi Hospice , used with permission)

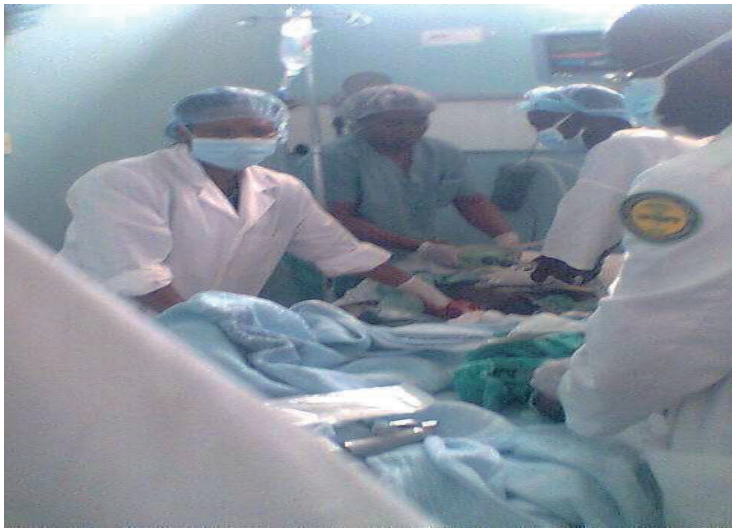

Figure 2: A concerted resuscitation effort by a team of health-care providers at Moi Teaching & Referral Hospital Eldoret, Kenya: Courtesy of Kenya Intensive Care Nurses Chapter, North Rift, 2011, used with permission)

CHAPTER 5

THE LAW BINDING ALL PLAYERS

All professional efforts directed at solving human problems, are performed under the control of the law. The purpose for this is to increase the benefits without infringing the rights of both the individuals and the society.

Medicine and the law are therefore both viewed as interlocked institutions promoting and maximizing the wellbeing of physical, emotional and community health, the extent to which this is true is debatable. This was an observation by (Ochieng, 2002), sort of emphasizing that the law binds all players in as much as though ethics play a critical role during dilemmas.

Is it legal and ethical to withdraw or withhold treatment with the aim of easing the needless prolongation of dying even though death maybe foreseen as a consequence? The practice is regarded as murder in under the South African law and also in Kenyan as we shall see below.

Jurisdictions from elsewhere as It Relates To Euthanasia and Withholding Treatment.

The following jurisdictions allow euthanasia and Physician Assisted Suicide(PAS) to varying extents:

– Netherlands (2002), Belgium (2002)

– Luxembourg (2009)

– France (passive euthanasia legal, active illegal)

– Australia Northern Territories (allows PAS)

The United States of America-Oregon State (1997), Washington State (2009), Judicial decisions (Quinlan, Cruzan, Schiavo).

We explore The Constitution of Kenya 2011 and the Penal code here below:

The Constitution of Kenya, 2010

Some of the articles have empowered the citizenry to demand for the highest attainable health care, a right to access information as it relates to the services offered to them. It is therefore critical that nurses align themselves within the limits of what is expected of them.

Article 26. (1) Every person has the right to life. (2) The life of a person begins at conception. (3) A person shall not be deprived of life

intentionally, except to the extent authorized by this Constitution or other written law.

The Laws of Kenya

The reader is notified that provisions of the penal code do not always apply in medical malpractice because they regulate matters of criminal nature and not civil matters. Nevertheless as regards end- of-life issues the following sections formed part of the discussion by panelists in the FAMSA, Eldoret conference:

Penal Code (Cap 63)

202. (1) Any person who by an unlawful act or omission causes the death of another person is guilty of the felony termed manslaughter.

(2) An unlawful omission is an omission amounting to culpable negligence to discharge a duty tending to the preservation of life or health, whether such omission is or is not accompanied by an intention to cause death or bodily harm.

213. A person is deemed to have caused the death of another person although his act is not the immediate or the sole cause of death in any of the following cases –

(d) If by any act or omission he hastened the death of a person suffering under any disease or injury which apart from such act or

omission would have caused death…[In other words Euthanasia is criminalized]

218. It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing the act; and he shall be deemed to have caused any consequences which adversely affect the life or health of any person by reason of any omission to observe or perform that duty.[In other words Duty of care]

Compare this to Kant's categorical imperative, where ethics for Kant is reducible to reverence for duty for the sake of duty. Christians et al, 1995

225. Any person who - (a) procures another to kill himself ; or (b) counsels another to kill himself and thereby induces him to do so; or (c) aids another in killing himself, is guilty of a felony and is liable to imprisonment for life [In other words Physician-assisted Suicide criminalized]

Other Common acts in the laws of Kenya touching on diverse end-of-life issues

•The pharmacy and poisons act cap 244: Provides for conducting inquiries and inquests into deaths arising from suicide, accidents, homicide, or suspicious deaths

•Human tissue act cap 252: Allows for the use of bodies of deceased persons for therapeutic, purposes, medical education and research.

•The public health act: procedures of exhumations, the establishment of cemeteries, and disposal of bodies etc

•The anatomy act: Makes provisions of donating bodies to schools of anatomy: Prohibits the illegal removal of parts of the body. Cadaveric organ donation (ie receiving organs harvested from a deceased person) is rare in Kenya. There are no clear guidelines while Knowledge, Attitude and Practice, cultural issues complicates it.

CHAPTER 6

DISCUSSION & CONCLUSION

Health care providers ought to be well informed of their ethical and legal obligations as well as their beliefs be they religious or otherwise. They ought to seek out resources early including spiritual encouragement. Care and support for the carers is important as they strife towards a positive and dignified outcome for the patient.

We the Christian health care providers find ourselves caught between the proverbial 'rock and hard place.' We do get carried away because we are humans too. We empathize and at times feel guilty of not doing enough. Our hope rests then in our values, though at crossroads be need to reflect on what has happened and debrief ourselves.

Professional help does become necessary now and then. We need to encourage ourselves with such words as these**: "**Why art thou cast down, O my soul? and why art thou disquieted within me? hope in God: for I shall yet praise him, *who is* the health of my countenance, and my God". Psalms 43:5 (KJV). In the ICU context this might mean remembering that there are many others who we care for and have a chance of making it.

That they need us and we cannot afford to be grounded for long by dwelling in the by-gone. After all ours is a God of the living. Matt 22:32(KJV). The reader would be directed to a clearly representative

resource site on the Christian believer vis-a-vis end of life issues for example:
http://www.apologeticspress.org/apcontent.aspx?category=7&article=58

'We have no obligation to sustain life at all costs,' stated a clergyman who represented a mainstream church in the debate, coming short of giving its stand on the matter. '…Whose ego are we trying to satisfy?' an interrogative statement was made, possibly intending to strongly to affirm yet another stand by another man of the flock, a chaplain for that matter at the end of the discourse in Eldoret.

A patient seeing a doctor or the nurse enters a contract with the doctor or the hospital where the doctor or nurse works. The health care professional or the hospital owes the patient duty of service. The contract takes the form of an implied agreement for the doctor to diagnose the patient's complaint and treat in the normal manner according to acceptable medical procedures and refer where necessary to the specialist in the field. The contract does not guarantee cure

Legalized euthanasia would most likely progress to the stage where people, at a certain point, would be expected to volunteer to be killed. It is paradoxical that laws against an action can be broadened and expanded once something is declared legal. This is especially true for

Kenya where parliamentarians have tended to pass self serving and self preservation bills.

The general public is increasingly getting enlightened, they may already be wondering whether health care providers participate in making decisions that shorten the lives of patients or not, and if this should be accepted or not. Health care professionals must therefore anticipate this debate and prepare themselves to deal with it in advance. Would it be fair to indefinitely sustain someone on life support when withdrawing that treatment would benefit another?

There may be no clear policy on DNR existing in any Kenyan hospital as yet. This is a 'slippery slope' argument of all times concluded Dr. Frank Njenga, a prominent psychiatrist in Kenya and a discussant in the debate.

Call To Action

This author feels that Christian perspective may be a better option compared to other forms of reasoning on end-of- life issues as tools to reflect critically on their care practices. The Christian finds hope, and in it the possibility that despite everything, to live and not suffer death, an inner sense of something greater than oneself. He/she recognizes a meaning to existence that transcends one's immediate circumstances (Berniquez, 2006). However, the health care provider usually falls short of prevailing in many situations where

professionalism takes first place and not their Christian values or moral reasoning abilities. How does the Christian health worker relate to God as the Father who welcomes his children returning to Him? How does he/she help the dying person to pray? Being present during this precious moment praying with the dying might mean opening up to them the horizons of divine life.

The Gospel is the word of life that conquers death and opens up the greatest hope to the dying person (Jn 1:14) 'this word that was made flesh, and dwelt among us, full of grace and truth'. This Gospel must be announced to the dying person. The hospital chaplain has a special obligation here, since he is called to minister to the dying within the broader limits of the pastoral care of the sick (http://www.lifeissues.net/).

This can be through organizing religious services as happened in Nelly's case above, forming and sensitizing health care workers and involving relatives and friends. It is a privilege moment to pray with the dying person. If at peace with God, the dying person is at peace with himself and with his neighbor. We cannot change the fact that as Christian health workers these events are unavoidable and we ought to make the most of them with the interest of the patient at heart. The heart of nursing is the patient (Kowal, 2010). Best practice based on evidence, ensures that the heart of nursing is always protected and cared for.

The Christian health worker–faithful to the task of "always being at the service of life and assisting it to the end" (http://www.lifeissues.net) cannot cooperate in any euthanistic practice even at the request of the one concerned, and much less at the request of the relatives. In fact, the individual does not have the right to euthanasia, because he does not have a right to dispose arbitrarily of his own life. Hence no health care worker can be the executive guardian of a non-existent right.

More research needs to be done to address the spiritual aspects of end-of- life on the Christian health professionals. The scenarios above all depict critical care/ intensive care units' setting and not palliative/terminal illness' settings or what is commonly referred to as living with the dying, which would be out of the scope of this book and the experience of the author.

CONCLUSION

Ethical dilemmas on end of life issues are real challenges facing the Christian health care providers on a day to day basis. The innumerable questions raised above at the beginning of the debate never got conclusive answers and may remain so for sometime to come. No pragmatic policy guidelines exist to safeguard the Kenyan medics on euthanasia or withholding treatment.

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Clear thinking about crucial issue:Charter For Health Care Workers:

page 114-150 http://www.lifeissues.net/

Appendix I

A SPECIMEN OF AN ADVANCED DIRECTIVES, LIVING WILL

To My Family, My Physician, My Clergyman, My Lawyer-
If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes:
If there is no reasonable expectation of my recovery from physical or mental disability
I_____ ___Request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age-it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that medication be mercifully administered to me for terminal suffering even if it hastens the moment of death.
This request is made after careful consideration. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandate. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing that responsibility and mitigating any feelings of guilt that this statement is made.
Signed_____Date_____

_____
Witnessed by:_____

Courtesy Euthanasia Education Council, Life and Death and Medicine

Appendix II:

The Definition of Terms.[13]
Term Definition
Euthanasia**-** ***X*** intentionally kills ***Y*** for ***Y***'s benefit (Death which is not a benefit to a person is not euthanasia)
Passive Euthanasia -***X*** allows ***Y*** to die
Active Euthanasia -***X*** performs an action which itself results in ***Y***'s death
Voluntary Euthanasia -***Y*** requested death himself
Non-voluntary Euthanasia -***Y*** has not expressed a preference
Involuntary Euthanasia - Against ***Y***'s wishes
Suicide- ***Y*** intentionally kills himself
Assisted Suicide -*X* intentionally helps ***Y*** to kill himself
Murder -*X* intentionally kills ***Y***

[13] Derived from: Gillon R. Introduction to the course. The Annual Intensive Five-Day Course on Medical Ethics.

Appendix III

An abstract case report done by the same author 'Ethical Issues For Doctors And Nurses: A Case Study From Moi Teaching And Referral Hospital: Eldoret, Kenya'. By: *Kamau S. Macharia, Kirima. J. Mutuma*, *Mwangi. H. Ruiru.* Presented FAMSA conference17/2/2011 at Medical Education Complex, School of Medicine, Eldoret Kenya. Article accepted for publication in the Kenya Journal of health Sciences on 26th November 2012.
ABSTRACT
Background: Occasionally, a patient in critical care can die no matter what we do. Others may have had a good chance of recovery if admitted, but then limited resources impact on admission. Profound ethical questions confront the medical personnel as they watch and wait helplessly.
Setting: Critical Care Unit, Moi Teaching and Referral Hospital, Eldoret
Objectives: To explore dilemmas on end of life which have a heavy bearing on Doctors and Nurses: legally, morally and ethically.
Materials and methods: A case study of ZX derived from the local setting involving a patient who was in the Critical Care Unit for one year sixty five days. This was experiential: a best case scenario.

Consent to highlight and publish the case study was sought from a relative of the deceased. The case study consist of a content analysis of the patient file, ethical issues arising were noted and were cross-checked to ensure they reflect the entries in the patient file. This study seeks to dissect some ethical issues experienced in management of ZX.

Conclusion: Modern health care has given rise to extremely complex and multifaceted ethical dilemmas. More often the health care workers (Physicians/nurses) are unprepared to manage these competently. There is no Law or guidelines in Kenya on end-of-life issues, making ethical dilemmas inevitable. ZX case brings out four topics that pose particularly vexing problems to the health care givers in their practice of medicine: Respect and equal treatment; Communication and consent; Decision making for incompetent patients; and end of life issues. Professional health care providers associations in Kenya should issue pragmatic policy guidelines to safeguard the Kenyan medics.

Key words: DNR, Ethics, End-of-life, euthanasia, dilemmas.

Appendix IV

ext 2527
Fax:254-053-33041
E- Mail:
Kjhs.mu@gmail.com

Moi Teaching & Referral
Hospital OPD Building
PO Box 4606, 03100
Eldoret. KENYA

MOI UNIVERSITY
KENYA JOURNAL OF HEALTH SCIENCES
Journal of the Schools Of Medicine, Public Health and Dentistry

26th November, 2012

To:

Simon K. Macharia

Dear, Macharia

RE: MANUSCRIPT FOR PUBLICATION

Your manuscript titled***" Ethical dilemmas for doctors and nurses on End – Of – Life Issues: A Case study of MTRH. "*** has been accepted for publication in the next issue of Kenya Journal of Health Sciences. Please provide the soft copy of the final draft of the manuscript to enable us publish the paper.

Thanks for your continued support.

PROF. P.M. GATONGI
EDITOR – IN – CHIEF, KJHS

Prologue

It takes a great team of skilled and dedicated people to see a concept, and then turn it into reality. The kind of team I worked with in this project. I appreciate each person who has contributed. To each and every health care provider : who want to make their life count, who want to make a difference, who look forward to a better day, who see possibilities, who do not want to look for excuses, who believe in doing their best with the interests of their patients at heart.

These do share the credit for this study: Moi Teaching & Referral Hospital ICU/HDU staff, Moi University Town campus and University of Kabianga. These have made invaluable contributions towards writing, reviewing and editing the manuscript.

I would like to thank in particular the following for their contributions and assistance, without which the book would not have been accomplished: To my esteemed client through a significant other, for consenting to allow me to highlight and publish this case. The impetuses to write this article would not probably have come to be were it not for the very lively debate organized by The 26th General Assembly Federation of African Medical Students' Associations (FAMSA) Conference 17/2/2011 at Medical Education Complex, School of Medicine, Eldoret Kenya.

I am indebted to Dr. Lukoye Atwoli of Moi University School of Medicine for 'Framing the Debate'. To Josphat Kirima, a student of Moi University School of Law, for his assistance with technicalities on legal issues. To Henry Mwangi of MTRH, Eldoret who together with Josphat Kirima worked with me on one of the case reports (See Appendix III, IV). To my sister Doreen Mutegi-Mureithi and Pastor Daniel Mureithi of Christian Renewal Ministries, Eldoret Kenya for believing in me. My brother Ken Kamau of Brookhouse School and my sister Nancy Wakiogora of Kariobangi South for all the support.

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