

Euthanasia in Ghana Today

James Yamekeh Ackah¹

Faculty of Religious Studies, Catholic University College of Ghana, P.O.Box 363, Fiapre – Sunyani

Benjamin Spears Ngmekpele Cheabu²

Faculty of Public Health & Allied Sciences, Catholic University College of Ghana, P.O.Box 363, Fiapre – Sunyani

Abstract

Euthanasia is a least explored concept in Ghana. This study sought responses from 1028 respondents in Sunyani. Principal to questions posed was the right to die, circumstances that may necessitate aiding or allowing one to ask his or her life to be taken, legalization of euthanasia and the relationship that may exist between respondent demographic characteristics and their responses. The levels of agreements and disagreements in favor of the defense of life irrespective of the circumstance stood in stark contrast to what is recorded in other countries. 83.7 percent of respondents disagreed on the inducement of death for merciful reason which is also reflected in respondents' belief that under any circumstance the physician should try to protect the life of the patient. On the right to die, 78 percent of the respondents reported a disagreement to the proposition of one having the right to choose to die. Consequently 70.2 percent of the respondents disagreed that there should be legal avenues by which an individual could pre-authorize in the case of an intolerable disease. Of statistical significance ($p < 0.5$) were respondent's gender and inducing death for merciful reasons; highest educational attainment and support to legalize euthanasia; ethnic background and the right to choose to die; ethnic background and inducing death for merciful reasons; age of respondent and right to choose to die; and one's religious affiliation and inducing death for merciful reasons. These correlations provide some similarities to studies in Europe especially with regard to gender, educational level, age and religious affiliation.

Keywords: Euthanasia, death, dying, Ghana, religion

Introduction

Death and dying are recognized end-of-life issues with growing concern in the West and acknowledged by many Ghanaians. In Ghana, the means to death and dying thereof are seen and categorized as good or natural, and bad or unnatural, depending on the circumstances surrounding the said death of the individual or group of persons³. Present-day debates across the world on euthanasia have been fraught with no point of convergence, specifically on the growing public sensitivity to a 'right to die' for terminally ill patients as one of the main constituents of these debates. Difficult as it is, some countries have concluded a stance on euthanasia even though many are still in the nascent stages of considering a decision. The absence of any such empirical survey in the lived experiences of the Ghanaian people provides the contextual motivation for this paper, especially in the midst of the changing paradigms in medicine, more and more from a 'quantity of life' to a 'quality of life approach' and from a paternalist approach to that of the patient's autonomy.

Unlike the Ghanaian notion of a *good or natural death* which may denote the type or mode of death, a 'good death' is now being connected to choice and control over the time, manner and place of death (DelVecchio Good *et al.*, 2004; Emanuel & Emanuel, 1998; McNamara, Waddell, & Colvin, 1994; Payne, Langley-Evans, & Hillier, 1996). Miescher (1997:529) writes that a bad or accidental death includes: 'deaths caused by accidents or suicides, by certain illnesses (tuberculosis, syphilis or leprosy), or during childbirth' (see also Sarpong 1974: 35; Baare 1986: 55-56). A 'bad death' could be called a 'good death' in one sense, that is, when it produces or provokes the strongest emotions among individuals and in the said community. The concept of a 'good death' (*Owu pa*⁴) is a death which, according to hearsay evidence among the Akan⁵ in Ghana, is necessary because the individual has exhausted his time shared out to him by God, the creator. Established on an anthropological fieldwork in the rural town of Kwahu-Tafo in southern Ghana, an exploration of the views of elderly people

¹James Y. Ackah holds a Doctorate in Dogmatic/Systematic & Ecumenical Theology, Univ. of Innsbruck. He is currently the Dean of Students and Lecturer at the Faculty of Religious Studies, Catholic University College of Ghana (CUCG)

² Benjamin Spears N. Cheabu holds a Bachelor of Science degree in Public Health and Allied Sciences, University of Ghana, Legon. He is a Senior Research Assistant at the Faculty of Public Health and Allied Sciences and a Catechist at the St. Augustine's Chaplaincy - CUCG.

³The good or natural and the bad or unnatural deaths are categorizations of death shared by many African ethnic groups even though the definitions may vary from culture to another.

⁴'Owu pa' means 'good death' in Asante (Twi).

⁵'Akan' is a fluid linguistic category depicting communities in the central and southern belts of Ghana who are neither Ewes nor Gas, and who speak Twi or Fante as their mother tongue and usually can understand both.

about death pointed out that they looked forward to death. Their readiness for death did not, however, include an acceptance of euthanasia¹. This could be ascribed to the belief in the inviolability of human life which most Ghanaians embrace. Providing context in the Akan people of Ghana, Agyemang admits that people in Ghana categorized euthanasia as a bad death which has consequences for the deceased and his or her relatives, that is, immense shame and social stigma upon the family².

The concepts of euthanasia have had several meanings, depending on its usage. It is reported to have been first used by the historian Suetonius who used it to describe how the Emperor Augustus, “dying quickly and without suffering in the arms of his wife, Livia, experienced the ‘euthanasia’ he had wished for”³. The Life Charitable Resources Trust (2011) reports that until the Hippocratic Oath, the role of physicians in ancient Greece was both to cure and to kill and that in ancient India, the River Ganges was used to drown incurable patients. Additionally, it reports that many societies, from ancient Rome to a few in sub-Saharan Africa, also exposed sickly newborns⁴ outside and overnight to die.

Defining euthanasia

An attempt to define euthanasia is impossible without reference to its etymology. Euthanasia is derived from the Greek words: eu, "good", and *thanatos*, death⁵. Consequently, euthanasia has been labeled and associated with ideas and notions such as mercy killing, death with dignity, assisted death and the likes. Beauchamp and Davidson (1979) provide two common distinctions in euthanasia literature: (a) voluntary and involuntary euthanasia, and (b) active and passive euthanasia. Euthanasia is the act of causing the death of a person for his/her alleged benefit. The word euthanasia, coming from the Greek, literally means a good death or easy death. Euthanasia, therefore, presents itself in a number of forms. The terms of reference however are found in the intention of the will and in the methods used. In this study, euthanasia is defined as “*an action or omission which of itself or by intention causes death, in order that all suffering may by this way be eliminated*”.

Legality of euthanasia

In most African countries, euthanasia is illegal. This is in stark contrast with many western countries. Assisted suicide is legal and permitted in Switzerland and in three states in the United States of America - Washington, Oregon and Montana. However, some countries like Australia, Israel, New Zealand, Norway and Turkey reject and do not permit euthanasia. In Switzerland, there is one of the four clinics in the world, *Dignitas*, which accepts patients from various countries with the purpose of terminating their lives according to the patients' wish. Holland, Belgium and Luxembourg have legalized euthanasia. Uruguay has approved the “right to die”. Switzerland and Germany have legalized “assisted-suicide”. France, in November 2004, recognized by law the right of patients to passive euthanasia. In the United Kingdom, the “double effect reasoning”⁶ is in effect. Ghana, like many African countries, has no clear-cut positions on euthanasia (legality and practice) but relies in the case of Ghana, on aspects of the criminal code to advance a proscription of euthanasia.

Religion in Ghana

Three main religions are recognized to be practiced in Ghana - Christianity, Islam and the African Traditional Religion (ATR). These religions constitute the fabric of the Ghanaian life. The above mentioned have great influence on the society's perspective of life, death and the hereafter. Mbiti strengthens this notion by referring to Africans as being notoriously religious in his classic work, *African Religions and Philosophy*⁷. The Christian community in Ghana comprises 71.2 % of the population, followed by Islam 17.6%, with a small proportion of the population either adhering to African Traditional Religion (5.2 %) or not to any religion (5.3%)⁸. The Congregation for the Doctrine of the Faith refers to euthanasia as “*an action or omission which of itself or by*

¹S. Van der Geest ‘I want to go: How elderly people in Ghana look forward to death’ (2002) 22(1) *Ageing and Society*, 7-28.

²K. Agyemang, ‘The Impact of new medical technology upon attitudes towards euthanasia among Akans, Cultural Heritage and Contemporary Change, http://www.crvp.org/book/Series02/II-5/chapter_ix.htm

³Suetonius’ *De Vita Caesarum – Divus Augustus (The Lives of the Caesars – The Deified Augustus)* to describe the death of Augustus Caesar.

⁴ Ancient Sparta is reported to discard sickly and deformed babies upon inspection to die.

⁵ Macer D. *Bioethics Dictionary*. Bangkok: UNESCO and EUBIOS Ethics Institute. <http://www.unescobkk.org/index.php?id=3613> (Accessed on 24-2-2007)

⁶The principle of double effect or “double effect reasoning” governs actions that have two morally significant effects. This reasoning originates from Thomas Aquinas’s reflections on self-defense (Cf. Thomas Aquinas, *Summa Theologiae* II, 2, question 64, art.7, www.newadvent.org). Aquinas maintained that one may kill another in self-defense (good effect), even if the attacker dies as a result of the defense (bad effect). The bad effect, though it may be foreseen, is not the primary intention of the act.

⁷Mbiti, John S., *African Religions and Philosophy*, London. Heinemann, 1969, p. 1

⁸Ghana Statistical Service. National Population Census, 2010.

intention causes death, in order that all suffering may by 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". The Roman Catholic Church (RCC) considers euthanasia as ethically wrong irrespective of the distinctions made in terms, to the types or forms of euthanasia (voluntary, non-voluntary, involuntary, passive or active)¹. The RCC's position is not mutually exclusive of other Christian denominations. Islam is the second largest recognized religion in Ghana. Islamic law (sources of Islamic law include the Holy Quran, the Hadith, the consensus of the Ulama (Ijam) and analogical deduction (Qiyas) and some Muslim moralists) is strongly opposed to euthanasia. For Islam, God is creator and sole law giver and for that matter the sanctity of life is not negotiable. It is recorded in the Sahih Bukhari 4.56.669 that the Prophet said: "*Amongst the nations before you there was a man who got a wound and growing impatient (with its pain), he took a knife and cut his hand with it and the blood did not stop till he died. Allah said, 'My slave hurried to bring death upon himself so I have forbidden him (to enter) Paradise.'*" Surah 17:33 of the Quran provides justification for the aforementioned, stating that "*Do not take life, which Allah made sacred, other than in the course of justice.*"

According to John Mbiti, in Africa, 'God is not dead' and that God was already known in Africa before the introduction of Christianity and Islam. Thus, Africans had a profound sense of God, a belief in the sanctity, sacredness and preservation of life.² Social morality is dependent on religion and Bolaji Idowu's proposition of the Yoruba people can be extrapolated to many African people. He says: "With the Yoruba, morality is certainly the fruit of religion. They do not make any attempt to separate the two; and it is impossible for them, for them to do so without disastrous consequences".³ By implication, the killing of a person by his consent or that of his family members was unheard of and a practice repulsed by the African Traditional Religion. For the African therefore, death and dying form an integral part of existence.⁴ For that matter Amadi reports that the killing of kinsmen, the antithesis of caring for him was not just a crime but an abomination. So unborn children were protected and life was considered sacred. The sense of the sacred and of religion is well known in the indigenous African culture.

State of the Problem and Rationale of Paper

At the dawn of the Third Millennium current traditions and cultural values were challenged as a result of advances in science to preserving and prolonging life. Mobilizations of forces to promote the destruction of life can be observed: the beginning of life - by the legalization of abortion, and in the ending of life - by the legalization of euthanasia⁵. Support for euthanasia is known to vary according to socio demographic characteristics; and that many previous studies have been limited to health professionals' attitudes towards euthanasia (legislation). This is important because medical professionals will be the primary actors (Ben Diane *et al.*, 2003; Grassi, Magnani, & Ercolani, 1999; McGlade, Slaney, Bunting, & Gallagher, 2000). More Americans support euthanasia today than they did in the 1950s (Anderson and Caddell, 1993). The current state of acceptance or otherwise of euthanasia is not well known especially in sub-Saharan Africa. An awareness of public opinion is, nevertheless, also important since individuals and families would be initiators of the requests for euthanasia and subjects of the decision-making process (Genuis, Genuis, & Chang, 1994). As a result the following questions were sought to be answered:

1. Do Ghanaians believe in the right to choose to die since it has been an important argument for the euthanasia debate elsewhere (Benson, 1999; Blendon, Szalay, & Knox, 1992; van der Maas, Pijnenborg & van Delden, 1995)?
2. Under what circumstances should euthanasia be allowed, according to the Ghanaian?
3. In what ways are socio-demographic variables related to the Ghanaian's attitude towards euthanasia?

The paucity of peer reviewed studies on public's acceptance of euthanasia presents a categorical imperative to rely on studies in other world regions, especially in Europe and the Americas. The cultural diversity of these regions makes any transfer of their responses already known and changing unacceptable. Owusu-Dapaa (2013) suggests that empirical data from social and anthropological studies conducted in Ghana reveal that poverty is the motivation for "informal" euthanasia practice in Ghana rather than a genuine desire on the part of patients to die or a desire of their relatives to see to their accelerated death. This, he continues, contradicts the widely held reasons given in the literature in the Western world, where the practice or quest for legalization of euthanasia is seen as a necessity for providing respite from pain or hopeless quality of life.

Geest purports that euthanasia exists in different forms in Ghana. He (Geest) notes that certain family

¹ Smith & Kaczor, Life Issues, Medical Choices, p. 98 – 100.

²The Encounter of Christian Faith and African Religion. John Mbiti. Christian Century, August 27 – September 3, 1980, pp. 817 – 820. Available at www.christiancentury.org

³Amadi E., Ethics in Nigeria Culture, Ibadan, 1982, p. 58.

⁴Soya, J.H. *The Ama-Xhosa: Life and Customs*: Lovedale Press, CapeTown, 1964.

⁵Cf. Congregation for the Doctrine of the Faith. Declaration of euthanasia „Iura et bona". In: W trosce o życie. Chosen documents of the Holy See. Ed. K. Szczygiel. Tarnów 1998 p. 333.

members request physicians to withhold care for their relatives because of lack of funds to sustain treatment. Kwasi Agyemang (*The Impact of New Medical Technology upon Attitudes towards Euthanasia among Akans*) emphasizes the Akan belief in *nkrabea* (destiny) and the inevitable mortality of man. The antithesis of the belief in destiny is expressed in the popular Akan parlance that “given the option of humiliation or indignity and death, the Akan prefers death”. Given the ambiguity in preference for death mentioned therein, it becomes imperative to ascertain the Ghanaian stance on euthanasia in recent times.

First, the growing support for the ‘right to die’ evidenced in western literature (Benson, 1999; Blendon, Szalay, & Knox, 1992; van der Maas, Pijnenborg, & van Delden, 1995) signals a trend which could emerge in the Ghanaian community during euthanasia legislation. Among the American people, 62% of adults believe “a person has a moral right to end their own life if they are suffering great pain and have no hope of improvement”. The support, Pew Research Center reports, is higher, 65% among younger people between 18 and 49, compared with 54% of people 75 and older.¹

Second, the circumstance under which euthanasia needs to be permissible has to be understood within the Ghanaian context. The circumstances vary (See Ben Diane *et al.*, 2003; Grassi, Magnani, & Ercolani, 1999; McGlade, Slaney, Bunting, & Gallagher, 2000), even though there are some similarities.

Third, Cohen *et al.* (2006), in their seminal paper, provide a review of European public acceptance of euthanasia. The authors describe and compare acceptance of euthanasia among the general public in 33 European countries. They used the European Values Study data of 1999–2000 with a total of 41 125 respondents and achieved a response rate of 63%. The staggering results of the study which relied on socio-demographic and cultural factors showed that weaker religious belief was the most important factor associated with higher acceptance for euthanasia. Further, younger cohorts, persons of the non-manual social classes, and people with a higher level of education were reported to have a higher acceptance of euthanasia. Similarly, age (De Moor, 1995; Finlay, 1985; Hamil-Luker & Smith, 1998; O’Neill *et al.*, 2003; Rynnanen *et al.*, 2002); gender (Bachman *et al.*, 1996; DeCesare, 2000; Rynnanen *et al.*, 2002); educational level (Caddell & Newton, 1995; Finlay, 1985; Suarez-Almazor, Belzile, & Bruera, 1997); and religious identity (Achille & Ogloff, 1997; Caddell & Newton, 1995; DeCesare, 2000; De Moor, 1995; Finlay, 1985; Hamil-Luker & Smith, 1998; Hare, Skinner, & Riley, 2000; Suarez-Almazor *et al.*, 1997) were notable socio demographical variables that impact the acceptance or otherwise of euthanasia.

Methods

The study was carried out from September 2014 through January 2015 in Sunyani, the capital of the Brong Ahafo region of Ghana. It comprised a population-based study of randomly selected individuals who professed knowledge of euthanasia and were 18 years or older. A total of 1028 respondents participated in the study. Using a validated self-completed questionnaire, 12 third year university students were recruited and trained about data collection for the purpose of the study. The Sunyani municipality was divided into 10 zones from where data collection was done randomly to a cross-section of households. The questionnaire consisted of 22 questions. Whilst seven questions elicited respondents’ demographic data, 14 questions considered questions on euthanasia. These included the moral right of a person to end his or her life or request for his or her life to be taken; legalization of euthanasia and other end-of-life decisions. Providing no categorical definition of euthanasia, we relied on respondents’ broad understanding of euthanasia to provide their responses on questions posed. The survey consisted of a statement explaining the study, the voluntary nature of the questionnaire as well as the commitment to confidentiality. Upon consent of the respondent, the questionnaire was administered. The SPSS version 21 for Microsoft Windows and Microsoft Excel version 2013 were used to enter and analyze data obtained. General descriptive statistics and chi square tests were employed.

Results and Discussion

Study Sample

The study sample comprised 1028 respondents who have been residing in Sunyani for at least 24 months. By gender distribution, males were 423 representing 41.1 percent and females 605, representing 58.9 percent. On religious affiliation, 449 representing 43.7 percent reported as Roman Catholic; 347 representing 19.7 percent reported as Muslims; 7 respondents reported a profession of the African Traditional Religion (ATR); whilst 22 respondents, representing 2.1 percent reported as unaffiliated to any religion. Marital status of respondents recorded the following: 575 representing 55.9 percent reported married, 35 representing 3.4 percent, 17 representing 1.7 percent reported as separated, 43 representing 4.2 percent reported being in consensual vision or cohabitating whilst 358 representing 34.8 percent reported as persons who have never married. The age distribution of respondents was under the following categories: 35.6 percent of respondents were of 18-28 years old; 41.3 percent were 50-59 whilst 3.5 percent of respondents were 60 and above. Only one respondent did not

¹<http://www.pewforum.org/2013/11/21/chapter-2-views-on-the-morality-of-suicide>. Assessed on November 7, 2014.

report his/her age category.

For highest educational attainment, 26 representing 2.5 percent reported having completed Junior Secondary or High School, 90 representing 8.8 percent reported completing Senior Secondary or High School, 889 representing 86.5 percent reported having attained a form of tertiary education whilst 23 representing 2.2 percent reported having no formal education. With regard to ethnic background 567 respondents representing 55.2 percent reported belonging to the Akan; 86 respondents representing 8.4 percent reported as Ga-Dangme; 127 representing 12.4 percent reported as Ewe whilst 248 representing 24.1 percent reported the Mole-Dagbani ethnic affiliation.

Study Questions

The first group of study questions posed was on what one would have to say if there was a moral right to end his or her life or a if one could request for one's life to be taken. The following situations/scenarios were tested:

- a) When one is in the face of suffering great pain with no hope of improvement.
- b) When one has an incurable disease.
- c) When one is ready to die because living has become a burden.
- d) When one is extremely a heavy burden on family and friends.

The following were reported: In the face of suffering great pain with no hope of improvement, 247 (24%) reported that one had the moral right to end his/her life or request it to be taken whilst 780 (75.9%) of respondents disagreed. One respondent provided no response to this question.

In the case that one had an incurable disease, 204 (19.8%) reported that one possessed the moral right to end his life or request it to be taken whilst 820 (78.8%) disagreed. Four respondents provided no response to this question.

On the morality to take one's life or request it to be taken when living has become a burden, 161 (15.7%) agreed to the proposition whilst, 866 (84.2%) disagreed. One respondent provided no response for this question.

In the case that life has become an extremely heavy burden on family and friends, 149 (14.5%) reported one should have the moral right to end his life or request it to be taken whilst 877(85.3%) disagreed. Two respondents provided no response to this question.

Following the above scenarios, respondents were asked if they would support legalization of euthanasia in such event. Majority, 88.7% were against any support for the legalization of euthanasia in Ghana while 11% reported support for euthanasia legalization with three respondents providing no response.

The second part of the study provided propositions of agreement or disagreements given the circumstance peculiar to each proposition. Respondents therefore indicated 'agree' or 'disagree' and 'no response'. The table below provides the propositions and respondents' level of agreement and disagreement.

	Proposition	Agree	Disagree	No Response
A)	Even if death is preferable to life in the judgment of a terminal patient no action should be taken to induce the patient's death.	729(70.9%)	297(28.9)	2(0.2%)
B)	Under any circumstances I believe that physicians should try to protect the lives of their patients.	872(84.8%)	156(15.2%)	-
C)	To me there is no justification for ending the lives of persons even though they are terminally ill	837(81.4%)	191(18.6%)	-
D)	I believe it is more humane to take the life of an individual who is terminally ill and in severe pain than to allow him to suffer	233(22.7%)	794(77.2%)	1(0.1%)
E)	I bear no ill-feeling toward a person who, in order to spare the loved one from further unbearable pain, hastens the death of a loved one.	212(20.6%)	811(78.9%)	5(0.5%)
F)	I believe there should be legal avenues by which an individual could pre-authorize his/her own death in the case of an intolerable illness	302(29.4%)	722(70.2%)	4(0.4%)
G)	It is cruel to prolong intense suffering for someone who is terminally ill and desires to die	284(27.6%)	742(72.2%)	2(0.2%)
H)	Inducing death for merciful reason is acceptable	167(16.2%)	860(83.7%)	1(0.1%)
I)	One should have the right to choose to die	226(22%)	802(78%)	-

The responses of the propositions provides evidence of what the Ghanaian would agree to or otherwise in the light of those circumstances. The levels of agreements and disagreements in favor of the defense of life, irrespective of the circumstance, stands in stark contrast to what is recorded in other countries. 83.7 percent of respondents disagreed on the inducement of death for merciful reason which is also reflected in respondents' belief that under any circumstance the physician should try to protect the life of the patient. 84.8 percent reported the latter.

Contrary to the growing support on the right to die (Van der Maas, Pijnenborg, and Van Delden, 1995;

Benson, 1999) 78 percent of the respondents reported a disagreement to the proposition of one having the right to choose to die. Consequently 70.2 percent of the respondents disagreed that there should be legal avenues by which an individual could pre-authorize in the case of an intolerable disease. The question therefore of the Ghanaian believing in the right to die has weaker support since 22 percent agreed to it.

Seeking to provide statistical evidence for any relationship that reported demographic characteristics may have on respondents choices to the propositions posed therein, a cross tabulation on respondents' gender, age, marital status, ethnic background and highest educational attainment were tested on specific propositions. They included the following propositions:

- a) One should have the right to choose to die.
- b) Inducing death for merciful reasons is acceptable.
- c) I will support the legalization of euthanasia.

Of statistical significance (Pearson's chi-square – p value of < 0.5) was respondents gender and inducing death for merciful reasons; highest educational attainment and support to legalize euthanasia; ethnic background and the right to choose to die; ethnic background and inducing death for merciful reasons; age of respondents and right to choose to die; and one's religious affiliation and inducing death for merciful reasons. These correlations provide some similarities to studies in Europe especially with regard to gender (DeCesare, 2000; Ryyananen *et al.*, 2002); educational level (Caddell & Newton, 1995; Suarez-Almazor, Belzile, & Bruera, 1997); age (Hamil-Luker & Smith, 1998; Ryyananenet *al.*, 2002, O'Neill *et al.*, 2003) and religious affiliation (Achille & Ogloff, 1997; Hamil-Luker & Smith, 1998; DeCesare, 2000; Hare, Skinner, & Riley, 2000).

Contribution to knowledge and Practice: The responses were generated from the lived experiences of the respondents as Ghanaians. This may assist in formulating end-of-life policies as well as addressing related ethical issues in areas where the phenomenon is least explored. The paper's findings may increase knowledge in this area.

References

- Achille, M. A., & Ogloff, J. R. (1997). When is a request for assisted suicide legitimate? Factors influencing public attitudes toward euthanasia. *Canadian Journal of Behavioural Science*, 29(1), 19–27.
- Anderson, J.G. and Caddell, D.R. (1993), "Attitudes of medical professionals toward euthanasia" *Social Science of Medicine*, Vol. 37 No. 1, pp. 105-114.
- Baare, A. (1986). *Omgaan met de dood: Emotiesendodenrituelenbij de Akan in Ghana (Coping with death: Emotions and death rituals among the Akan in Ghana)*. M.A. thesis, Cultural Anthropology, University of Amsterdam.
- Bachman, J. G., Alcer, K. H., Doukas, D. J., Lichtenstein, R. L., Corning, A. D., & Brody, H. (1996). Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. *New England Journal of Medicine*, 334(5), 303–309.
- Ben Diane, M. K., Peretti-Watel, P., Lapiana, J. M., Favre, R., Galinier, A., Pegliasco, H., et al. (2003). Opinion of general and specialized physicians toward euthanasia. Results from the French survey on attitudes and practices against palliative care, 2002. *Annales de Medicine Interne (Paris)*, 154(7), 441–447
- Benson, J. M. (1999). The polls-trends—End-of-life issues. *Public Opinion Quarterly*, 63(2), 263–277.
- Blendon, R. J., Szalay, U. S., & Knox, R. A. (1992). Should physicians aid their patients in dying? The public perspective. *Journal of the American Medical Association*, 267(19), 2658–2662.
- Caddell, D. P., & Newton, R. R. (1995). Euthanasia: American attitudes toward the physician's role. *Social Science & Medicine*, 40(12), 1671–1681.
- De Moor, R. (1995). Religion and moral values: The case of euthanasia. In R. De Moor (Ed.), *Values in western societies* (pp. 31–50). Tilburg: Tilburg University Press.
- DeCesare, M. A. (2000). Public attitudes toward euthanasia and suicide for terminally ill persons: 1977 and 1996. *Social Biology*, 47(3–4), 264–276.
- DelVecchio Good, M. J., Gadmer, N. M., Ruopp, P., Lakoma, M., Sullivan, A. M., Redinbaugh, E., et al. (2004). Narrative nuances on good and bad deaths: Internists' tales from high technology work places. *Social Science & Medicine*, 58(5), 939–953.
- Emanuel, E. J., & Emanuel, L. L. (1998). The promise of a good death. *Lancet*, 351(Suppl. 2), SII21–SII29.
- Finlay, B. (1985). Right to life vs. the right to die: Some correlates of euthanasia attitudes. *Sociology and Social Research*, 69(4), 548–560.
- Genuis, S. J., Genuis, S. K., & Chang, W. C. (1994). Public attitudes toward the right to die. *Canadian Medical Association Journal*, 150(5), 701–708.
- Grassi, L., Magnani, K., & Ercolani, M. (1999). Attitudes toward euthanasia and physician-assisted suicide among Italian primary care physicians. *Journal of Pain and Symptom Management*, 17(3), 188–196.
- Hamil-Luker, J., & Smith, C. (1998). Religious authority and public opinion on the right to die. *Sociology of Religion*, 59(4), 373–391.

- Hare, J., Skinner, D., & Riley, D. (2000). Why older age predicts lower acceptance of physician-assisted suicide. *Wisconsin Medical Journal*, 99(7), 20–27 46.
- K. Agyemang, ‘The Impact of new medical technology upon attitudes towards euthanasia among Akans, Cultural Heritage and Contemporary Change, http://www.crvp.org/book/Series02/II-5/chapter_ix.htm (last visited: 6/4/2014)
- McGlade, K. J., Slaney, L., Bunting, B. P., & Gallagher, A. G. (2000). Voluntary euthanasia in Northern Ireland: General practitioners’ beliefs, experiences, and actions. *British Journal of General Practice*, 50(459), 794–797.
- O’Neill, C., Feenan, D., Hughes, C., & McAlister, D. A. (2003). Physician and family assisted suicide: Results from a study of public attitudes in Britain. *Social Science & Medicine*, 57(4), 721–731.
- Owusu-Dapaa, E. (2013) Euthanasia, Assisted Dying and the Right to Die in Ghana: A SocioLegal Analysis *Med Law*; Dec. 32(4): 587-600
- Rurup, M.L., Onwuteaka-Phiupsen, B.D. and Van Der Wal, G. (2005), “A suicide pill for older people: attitudes of physicians, the general population, and relatives of patients who died after euthanasia or physician assisted suicide in The Netherlands” *Death Studies*, Vol. 29, pp. 519-534.
- Ryynanen, O. P., Myllykangas, M., Viren, M., &Heino, H. (2002). Attitudes towards euthanasia among physicians, nurses and the general public in Finland. *Public Health*, 116(6), 322–331.
- Sarpong, P. (1974). *Ghana in retrospect: Some aspects of Ghanaian culture*. Accra/Tema: Ghana Publishing Corporation
- Suarez-Almazor, M. E., Belzile, M., & Bruera, E. (1997). Euthanasia and physician-assisted suicide: A comparative survey of physicians, terminally ill cancer patients, and the general population. *Journal of Clinical Oncology*, 15(2), 418–427.
- S. Van der Geest ‘I want to go: How elderly people in Ghana look forward to death’ (2002) 22(1) *Ageing and Society*, 7-28-
- Van der Maas, P. J., Pijnenborg, L., & van Delden, J. J. (1995). Changes in Dutch opinions on active euthanasia, 1966 through 1991. *Journal of the American Medical Association*, 273(18), 1411–1414.

The IISTE is a pioneer in the Open-Access hosting service and academic event management. The aim of the firm is Accelerating Global Knowledge Sharing.

More information about the firm can be found on the homepage:

<http://www.iiste.org>

CALL FOR JOURNAL PAPERS

There are more than 30 peer-reviewed academic journals hosted under the hosting platform.

Prospective authors of journals can find the submission instruction on the following page: <http://www.iiste.org/journals/> All the journals articles are available online to the readers all over the world without financial, legal, or technical barriers other than those inseparable from gaining access to the internet itself. Paper version of the journals is also available upon request of readers and authors.

MORE RESOURCES

Book publication information: <http://www.iiste.org/book/>

Academic conference: <http://www.iiste.org/conference/upcoming-conferences-call-for-paper/>

IISTE Knowledge Sharing Partners

EBSCO, Index Copernicus, Ulrich's Periodicals Directory, JournalTOCS, PKP Open Archives Harvester, Bielefeld Academic Search Engine, Elektronische Zeitschriftenbibliothek EZB, Open J-Gate, OCLC WorldCat, Universe Digital Library, NewJour, Google Scholar

