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Publication date

2009

Document Version

Final published version

Published in

Care of the seriously sick and dying: perspectives of Ghana

[Link to publication](#)

Citation for published version (APA):

van der Geest, S. (2009). End-of-life care in Ghana and the Netherlands: good death, bad death and euthanasia. In C. Opong, P. Antwi, & K. Wærness (Eds.), *Care of the seriously sick and dying: perspectives of Ghana* (pp. 265-289). (IAS studies in the changing cultures of care). BRIC.

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10. END-OF-LIFE CARE IN GHANA AND THE NETHERLANDS: GOOD DEATH, BAD DEATH AND EUTHANASIA

*Sjaak van der Geest*¹

This chapter compares what is nearly incomparable. It describes and discusses older people's wishes about end-of-life care in two entirely different circumstances: in my own society, The Netherlands, and in the Akan society of Ghana, in the small town of Kwahu-Tafo where I have been doing anthropological fieldwork intermittently from 1971 till today. The aim of this comparison is to raise questions about established cultural values and practices and to gain a better understanding why people seem to act so differently in the face of the universal phenomenon of death. My exploration will lead to the conclusion that apparently contradictory views and practices share common concerns about a good and dignified death.

In a recent collection of studies on good and bad death, we observed a striking similarity of perceptions across cultures and times. Some ideas of good death that seem almost universal include:

A death occurring after a long and successful life, at home, without violence or pain, with the dying person being at peace with his environment and having at least some control over events (Seale & Van der Geest 2004: 885).

¹ The research for this essay was carried out with the help of many people. I am most grateful to the elders and their relatives who shared their thoughts with me and to my Ghanaian co-researchers and friends Kwame Fosu, Patrick Atuobi, Anthony Obeng Boamah, Benjamin Boadu and Yaw Darko. This essay draws on several articles I published before on elderhood, death and funerals (in particular Van der Geest 2002 and 2004a).

That insight concerning good death will be the starting and closing point of this essay. I will argue that older people – and those around them – are drawn to very different actions to achieve the same ideal: a worthy end-of-life. In the Ghanaian context that worthy end is most of all realised in a well-organised and well-attended (public) funeral, whereas in The Netherlands the focus is more on the period before death and on the act of dying. Concerns about end-of-life care are predominantly *post-mortem* in Ghana and *pre-mortem* in The Netherlands. Euthanasia, which literally means ‘good death’, functions as a concept to sharpen the contrasts between views on desirable end-of-life care in both contexts.

Research

The Ghana research is based mainly on conversations with thirty-five older people and some of their relatives in Kwahu-Tafo, a rural town of about six thousand inhabitants on the Kwahu Plateau in the Eastern Province of Ghana. I used no randomised sampling to find this group, but asked my friends about older people in their neighbourhood and continued from there. The concept ‘old’ was not clearly defined before I began the research. This group was composed of people who were described by others as ‘old’. In fact, ‘old’ proved to be more of a term of respect than of calendar age *per se*. My only concern in selecting people was to guarantee some variation in my ‘sample’ in terms of sex, economic and social status, religious affiliation and number of children.

Usually a conversation with an older person circled around one topic, for example, his/her life history, the concept of ‘old’, the power of older people to bless and to curse, the care they received (and gave), their ideas about a successful and unsuccessful life, building a house, respect and reciprocity, love, sex in old age and - the topic of this paper - their views on death and funeral. These various topics were not planned beforehand but grew ‘naturally’ out of earlier conversations. It often meant that one topic was discussed with one person and another with

another one. With some elderly I only had one or two conversations, with others many more.

In addition, there were frequent, casual meetings, short visits to greet or to deliver a message. Observations during these visits constituted a crucial element of the research as they added depth and context to verbal accounts. All longer conversations were taped, translated and transcribed. Shorter informal meetings and observations were recorded in my diary. During most conversations a co-researcher accompanied me to ensure good understanding. Towards the end of the research period my co-researchers sometimes held their own conversations with the elderly, while I was writing my ethnographic notes. They discussed the contents of those conversations with me afterwards, adding their own views.

Much has been written about funerals in Akan society, but relatively little about dying and people's personal views on the meaning of death. My anthropological fieldwork was an attempt to grasp their emic point of view concerning death.

So much for my research in Ghana, what about The Netherlands? I never carried out systematic research in my own society, but there is a wealth of literature on death and on euthanasia in particular.² Apart from published books and articles, there is abundant information on euthanasia in newspapers and weeklies (feature articles, letters, news reports) and on the Internet. In addition, I got to know several cases of euthanasia in my own environment. My brother-in-law had euthanasia some years ago and that event greatly inspired me to write this essay. His death was unanimously regarded as good and dignified and both he and his wife were praised for the way they had organised

² Some publications on euthanasia in The Netherlands are: Keizer 1995; The 1997; Pool 2000 and 2004; Koppedraijer 2000; Kennedy 2002; Legemaate & Dillman 2003; Norwood 2005, 2006, 2007 and Chabot 2007.

and carried out this intimate ceremony around his chosen death. Drawing from the available literature and from my personal experiences as a member of Dutch society I trust that I can produce a reliable picture of good death ideas and practices in The Netherlands.

Good Death in Kwahu-Tafo

Contrary to what one might expect, death in Kwahu society is a private affair. Funerals are public events but sickbed and death occur in the seclusion of the house. Death remains strictly private until it is - literally - announced and preparations can start for the funeral. Death, indeed, is eclipsed by the funeral, in many ways. People may not know about someone's poor physical condition and sickness until it is all over. Even relatives may take comparatively little interest in the sickness of a person. Medical care is expensive and the outcome is uncertain, so the willingness to spend money on a sick person who is going to die anyway is limited (see Van der Geest 1995; Arhinful 2000). Money spent on a funeral, however, is much more certain to be effective and bear fruit. That difference in preparedness to pay is further promoted by the private/public distinction. Social critique is more likely to be voiced about a badly organised funeral, which everybody can witness, than about a poorly cared for patient, who is hidden in the house. It is this contrast between *pre-* and *post-mortem* care that played a significant role in our conversations with older people about their approaching death (and funeral).

Without any exception, each elder who discussed the topic of death with us indicated that he/she was not worried by it. Most of them emphasised that they were rather looking forward to it, as they were tired of living. One of them said: "Let it happen in a flash". "An old person is never afraid of death", he added. An older woman expressed that idea very briefly: "I want to go, I want to join my brothers". Another woman, said: "Whether I am afraid or not, it will come when it is time for me."

According to Òkyeame Opoku (O)³, in a discussion with my co-researcher (P), to die after one has prepared oneself, is no problem. Not to die is rather a problem.

- O. *When you see that you are old and may die anytime, you have to make the necessary arrangements to prevent problems after your death. For example, you can choose your successor.*
- P. *After making the necessary arrangements, do you look forward to death?*
- O. *After proper arrangements (Wo toto wo neèma wie a) you are not afraid if death will come in the morning, afternoon or evening. What I am afraid of is to lie in bed for a long time with sickness, but if you become old and die peacefully, it is a nice thing (èyè anigye deè koraa).*

Elsewhere I have argued that the òpanyin (elder)⁴ is someone who should show self-restraint and control of emotions (Van der Geest 1998b). It does not befit the elder to be anxious about anything, whether it is hunger, gossip, sex or jealousy. The elder is ‘cool and collected’ as a lorry inscription reads in Twi-inspired English. The only worry that keeps the elder busy is to

³ Òkyeame (often translated as ‘linguist’) is an official at the chief’s court. Yankah (1995: 3) describes the function of the òkyeame as ‘speaking for the chief’: “Being a counsellor and intermediary to the chief, he is responsible, among other things, for enhancing the rhetoric of the words the chief has spoken. In the absence of an òkyeame’s editorial art, the royal speech act is considered functionally and artistically incomplete”.

⁴ Òpanyin (elder) is a complex term. In a strict sense it usually refers to a person above approximately 50, who has been successful in life and enjoys people’s respect but the term is also more loosely used for any older person (cf. Van der Geest 1998b). The term may refer to women as well as to men, but is more commonly applied to men. In this essay I use the masculine form.

preserve and restore peace in the family. It is that code of restraint and good manners that may also prevent an elder from expressing anxiety about death. A real *òpanyin* does not show any fear of death. He is ready for it. His death should be as dignified as his life.

During one of my stays in Kwahu-Tafo, the dead body of a young man, a member of the family where I was lodging, was brought home to be buried. The stories about his death were confusing and contradictory but some said robbers killed him on his way to Abidjan. His death was senseless. Why did he go to Abidjan at all? "He died without a good cause", as someone said. His death was violent, untimely and served no purpose, a typical example of 'bad death' (*owu bònè*). It is the sort of death that is described in many Highlife songs, 'unnecessary' (which is the essence of tragedy). The surrounding people suspect evil intention or punishment; why else should the person have died?

'Bad death' in its widest sense is a death that comes too early, which terminates the life of someone who has not yet completed his course, has not yet come to full maturity. 'Bad death' helps to bring the concept of 'good death' (*owu pa*) into focus: the death, which *is* necessary because time is up and the person has lived his life to the end. One elder put it beautifully in the metaphor of a dead trunk of a tree in the forest. That tree did not die of any disease or fire but reached its end in a natural way. And another said: "Good death is when a person dies a natural death, after having put his things in order. Good death, therefore, is the first crown on an *òpanyin's* life and a successful funeral is the second. Or, more correctly: a successful funeral is part of a good death.

The different views and appearances of 'good death' are most felicitously captured in the term 'peaceful'. To die 'in peace' (*asomdwemu*) refers to at least five aspects of what is regarded as a good death. It first of all implies that the dying person is at peace with other people. Before one dies conflicts should be ended and

enemies reconciled, debts should be paid and promises fulfilled. Someone who has been able to achieve this is ready for his final departure. He is a real *òpanyin*, a peacemaker, a person who is respected by others. That respect will be shown during the funeral. His children, nephews and nieces, and grandchildren will remember him with affection, long after his death and mention his name during libation. And if he has built a house for them to live in, that house will bear his name for many years to come (Van der Geest 1998a). A life ending in conflict or with unpaid – social – debts is not ‘complete’, however.

A second condition of ‘good death’ is that the dying person is at peace with his own death. Death is as welcome as a good sleep after a day of hard work. One elder said he had finished what he had come to do and now wanted to go. Clearly this form of peace is only possible if the peace with others has been secured. In Kwahu-Tafo good death is the death of the *òpanyin* the older person who has reached full maturity and is no more concerned about the things of this world, the ultimate gentle-man (or gentle-woman).

Such a death is also peaceful in the sense that it is not caused by aggression or violence. A good death is ‘natural’, as many of the Kwahu-Tafo elderly emphasised, not caused by human hatred, a cruel disease or a fatal accident. There are no disgusting symptoms that suggest foul play or sinfulness.

The fourth aspect of peacefulness is to die in a place that holds the highest degree of peace: home. Dying at home implies being surrounded by relatives, good company. To die away from home is by definition ‘bad’, which can only partly be repaired by bringing the dead body home. The death of the young man who was killed by robbers near Abidjan in Ivory Coast is a case in point. His death was violent and untimely, and therefore bad, but the fact that it happened far away, added to its negative state. The tragedy of dying abroad was mentioned in many stories that people told me about relatives who travelled to Europe or

America. In most of these stories the body could not be brought home, giving the death its ultimate senselessness. Dying abroad is also mentioned in a 'classic' Highlife song *Obrè biara twa owuo* ('All hard work ends in death').

Dying away from home usually means dying away from relatives and dear ones, in loneliness, without anyone giving you some water to drink for your final journey. In 'Western' society dying 'alone' is becoming more common as people grow older and 'social death' makes its entry before physical death (Mulkay 1993; Seale 1995).

The last sense of peacefulness is that *others* have peace with someone's death for reasons covered by the four previous types of 'peace': because the person has completed his life; it has been good and 'enough'. Gratefulness for a rich and caring life that has ended softens grief about the person's death. Good memories will start and keep the deceased alive as ancestor.

Euthanasia in the Netherlands

In The Netherlands, as in many of the rich industrialised countries, a high standard of living and advanced medical care have led to a sharp increase in life expectancy (76 years for men, 81 for women). Ironically, however, what is widely regarded a blessing – long life – has turned into a spectre for many: the impossibility to die 'peacefully'. In an editorial to a special issue on death of the *British Medical Journal*, Richard Smith (2003) reminds us of Gulliver's visit to Laputa where people did not die. Gulliver was excited but soon discovered that they felt miserable because of their immortality. The fear of death has not only been replaced by the fear of dying, as one author in this special issue remarks, but also by the fear of not being able to die. Smith suggests that it is unlikely that the present generation will "... accept the squalid end that may happen in a health service preoccupied with life at the expense of death."

More and more people face a gradual decline of physical

and mental capacities without the perspective of a welcome death. Forty percent of the elderly in the Netherlands above the age of ninety now suffers from 'dementia'. Some speculate that if dementia remains unpreventable and incurable, and if people continue to grow older, nearly everybody will become demented before their eventual death. Dementia is the most distressing example of senile decay, but there are more incapacitating diseases which threaten to turn the last years of life in The Netherlands into prolonged periods of suffering and loss of identity.

It is no wonder that a growing number of people in The Netherlands started worrying about their end-of-life, in view of what happened to the generation of their parents who had been caught unaware. Public discussion in The Netherlands about euthanasia since the 1970's, has led to gradually increasing public support for euthanasia in certain situations. In the 1990's the policy of physicians and government paralleled this development. Until 2002, the Criminal Code prohibited euthanasia, but it was institutionalised via regulations. Legislators decided to allow euthanasia in certain situations. In 2002 this practice was legalized. The law now stipulates that in order to allow euthanasia there must be unbearable suffering, without prospect of improvement and a voluntary and well-considered request from the patient who is competent to express their will. A second physician must be consulted and the euthanasia has to be carried out with due medical care and attention. According to the Ministry of Justice, euthanasia is a life-terminating action on the explicit request of the patient. These rules also apply to assisted suicide. In 1995, 2.4% of all death cases in The Netherlands were due to euthanasia in the legal sense of the term. Recent figures show that the percentage has remained fairly stable. Interestingly, about 25% of people who die have asked for euthanasia at some moment in their life but only 10% of them actually die this way (Van der Wal et al. 2003: 46; Norwood 2005: 16).

The Dutch practice has led to diverse reactions, both

within and outside the country. For some it represents concern and empathy for the well-being and dignity of those who suffer without any prospect of improvement. For others it is a sign of a cold and dehumanising society, where the younger generations are unwilling to care for their parents and grandparents. Religious critique was added to it: decisions about the end-of-life lie with God and not with human beings. Critics also warned that – in an appropriate Dutch metaphor – legalized euthanasia would cause a ‘bursting of the dikes’ that is an explosive increase in the practice of euthanasia. Comparisons with Nazi practices during World War II put euthanasia in a particularly unfavourable light.

After ten years of condoned and legalised euthanasia, it is possible to draw up the first balances. James Kennedy, an American historian teaching in The Netherlands, lists five comments on the Dutch practice (Kennedy 2002). The first is that euthanasia never led to the predicted ‘bursting of dikes’ or – to use an American metaphor – to Wild West scenes. Euthanasia remained a carefully handled option, depending on negotiation between responsible stakeholders.

The second, closely related, remark is that not everybody who asks for euthanasia obtains it. The person who requests it must convince two medical practitioners that they are indeed suffering unbearably without a prospect of improvement. The request, moreover, should undoubtedly be voluntary, well considered and consistent. Two anthropological case studies in hospitals vividly describe the intricate negotiations between doctors, nurses and patients about euthanasia (Pool 2000; The 1997). A personal testimony, by a doctor in a nursing home who openly discussed the dilemmas of suffering and the wish to die, became a bestseller in The Netherlands (Keizer 1995).

A third important remark by Kennedy emphasises the special relationship between Dutch people and their general practitioner. Many Dutch patients deeply trust their physician and discuss their intimate feelings and anxieties with them. One could

say that for many Dutch people today physicians have replaced the pastors and priests of the past. Euthanasia, when it is granted, is the outcome of this mutual trust and respect between doctor and patient.

The fourth remark addresses a Dutch characteristic, *bespreekbaarheid*, which cannot be easily translated into English. Literally it means 'discussability'. It reflects a dislike of taboos. Whether good or bad, everything should be freely discussed and – if practised – practised openly. Dutch people disapprove of double standards – saying one thing and doing another – (which they believe is common in South European countries). The Dutch pride themselves on doing what they openly pronounce. Legalising euthanasia (like legalising abortion a few decades earlier) is, therefore, not a 'slippery slope' but rather a way of controlling the practice and acting responsibly. They see themselves – somewhat complacently - as living in a morally stable and transparent world (which is Kennedy's fifth comment). Norwood (2005, 2007) who studied euthanasia in the practice of Dutch general practitioners (a relatively neglected field) emphasises that 'euthanasia' in The Netherlands is more a way of talking about the end of life than a practice:

... euthanasia talk exists as a script for ideal ways of dying. Ideal Dutch death is well planned, well discussed, not extremely painful or full of undue suffering, and occurs at home, surrounded by family.... The Dutch are less focused on avoiding suffering, than they are on the desire to plan and control what might occur in death. It seems to be the process of planning among key participants (dying individual, family and the huisarts) that allows Dutch people to feel better about death (Norwood 2005: 116).

The trend towards euthanasia is not limited to the secularised part of the population. It may be true that religious organisations at first objected to the fact that euthanasia had

become condoned and legalised,⁵ but now religious as well as secular people support the practice. A striking example of a religious justification of euthanasia can be found in an e-mail message that a devout Catholic distributed among friends and relatives on the eve of the Dutch parliament's vote on euthanasia. The fragment below illustrates how euthanasia is gradually being seen as an act of mercy and is becoming a new kind of sacrament:

If a doctor is willing to help someone ending his/her life is that a praiseworthy, not a punishable act. I think it is a charitable deed, approved of by God. If life is God's gift to us, I do not believe that God is so narrow-minded to feel offended when we no longer can cope with His gift and want to return it to Him.... Let us not try to be more severe than God and force people to carry a burden, which is too heavy for them.

In a letter to a newspaper a theologian writes the practice of voluntary death is in line with old Christian ideas of mortifying the flesh (in Dutch the term for mortification and refusing to eat is the same: *versterving*; see also Pool 2004). Moreover, he continues in an interesting twist, accepting life as a gift does not imply that one should ask too much from the Creator by wanting to extend one's life endlessly (Van den Bercken 2001).

It is interesting to note that euthanasia in The Netherlands has drawn more attention to the *act* of dying. Death is no longer a "thief in the night" but an invited guest. The moment of death is chosen and, for that reason, necessitates a proper preparation and performance. The situation demands words, gestures and symbols

⁵ An interesting example of religious opposition to euthanasia is the 'Credo Card', which states: "The bearer of this Credo Card is a Catholic and requests spiritual assistance from a priest when in peril of death. He/she declares never to accept active euthanasia" (translation, SvdG). In 2001, 7500 Catholics were said to have purchased the card (De Vries 2001).

to make the event 'good' and dignified. There is no excuse for doing nothing. Euthanasia leads to the creation of new rituals, both religious and secular. One example may illustrate this new trend.

A Protestant pastor of about 65, with terminal cancer, indicated that he wanted to die while still clear and conscious, surrounded by his wife and children. Euthanasia was granted and planned at 5 pm. The whole day his wife and children kept him company. When the moment approached, they stood around his bed. He spoke to them, a kind of sermon that he had prepared before and prayed for each of them. One child read his favourite psalm and another recited a poem. The atmosphere was sad, but at times also cheerful. There was laughter. The pastor saw his death as liberation. At five o'clock two doctors and a nurse arrived. One doctor asked him (again) if he really wanted euthanasia. After the first injection, he fell into a coma, after which the family left the room. The doctor gave a second injection. The heart stopped. After that the family returned and emotions took over.

The growing acceptance of euthanasia is also confirmed by a study of 500 relatives and friends of people who have died of cancer (about 80% of all euthanasia cases are cancer patients). For 200 of them the relative's / friend's death had been advanced by euthanasia. The research showed that for those 200 people the death of their dear one had been more bearable than for those who had lost their relative / friend by 'natural' death. For both, the dying person and their environment, euthanasia was felt to be a good death (Smith et al. 2004).

If euthanasia is so conducive to ending one's life well, why do not more people in The Netherlands plan for it? Klinkenberg et al. (2004) held interviews with 240 proxy respondents of 342 deceased persons (aged between 59-91) in The Netherlands about that person's 'advance directives' (preferences for medical decisions at the end-of-life), such as: withholding treatment or euthanasia. Only 14% of the sample had written such a directive

and a quarter had designated a surrogate decision-maker. The authors conclude that getting to the end of their life, people usually do not act as autonomous decision-makers who know exactly what they want.⁶ Concerns about a good end to life tend to be ambivalent and inconsistent; people hesitate to write down their end-of-life wishes. Seymour et al. (2004) come to a similar conclusion in a qualitative study among 32 older people in Sheffield, UK:

...rather than emphasising the completion of advance statements, it may be preferable to conceptualise advance care planning as a process of discussion and review rather than the formation of a 'once and for all' decision (Seymour et al. 2004: 167).

Good death may be intensely wished for, but it is not a clear-cut thing one can simply choose. The awe of death affects people in The Netherlands and Ghana equally.

Euthanasia in Kwahu-Tafo

Early in the fieldwork, a German lady who had been living in Ghana for about thirty years confronted me with her opinion on the life of older people in Ghana. She said that I was misguided to expect their lives to be more pleasant and comfortable than those of older people in my own country. The only positive thing I would discover was that old people in Ghana are allowed to die.

⁶ Doctors too are ambivalent. General practitioners as well as institution-based physicians now show an increasing preference for 'palliative sedation', which feels less like killing and blurs the sharp boundary between life and death. Palliative sedation makes the patient fall 'asleep' and pass away gradually. The medical technique and the psychology may be different (for relatives as well as for the physician); the basic idea of palliative sedation and of euthanasia concurs.

Unlike in my own country where life is unduly prolonged by medical intervention and, occasionally, enforced artificial feeding, the wish of Ghanaian elders to die was respected, she said. Relatives would place food in front of them, and if they refused to take it, they were not forced. The lack of good medical facilities and poverty, particularly in the rural areas, were blessings in disguise. They saved the elderly from the torture of forcibly extended lives, which their peers in Europe and North America suffered.

A few days later I met a Ghanaian sociologist with degrees from Canada and the United States and we discussed intended and contrived deaths among older people. I quote from my field notes:

He stresses that in the olden days people who are too much a burden to their family would be 'cleared', that is killed, for example, by poison. Malformed babies were killed by giving them *akpeteshie*⁷ to drink. Old people, who felt they had become a burden, could also ask to be killed. One expression indicating that the old person no longer wished to live was: *mabrè* (I am tired). The ultimate phase for a person would be incontinence. "Sleeping in the toilet" is the end. A person would feel so disgraced, that he would rather die. The decision to kill an old person is a family decision, which will be taken by only a handful of close relatives. If it would become known, the people would be in trouble because the law strictly forbids this type of killing. He cites an example from another town: there are strong rumours that a certain businesswoman was killed by her own daughter, after the family had taken the decision.

These two people were the first *and* - except for one person - the last who tried to convince me that some form of informal euthanasia existed in Ghana. After I had arrived in Kwahu, every

⁷ *Akpeteshie* is a locally distilled drink.

time I brought up the topic, it was denied categorically. A headmaster listened to my account of how older people in my country were kept alive at all costs and with any technical means, even without their consent. When I had finished, he said:

We in Ghana would do the same, if we had the means. I would fight for my mother's life till the end. Unless the doctor says it is over. I will fight as long as she breathes, until she says: hmmm. It is not true that we put the food in front of someone and refuse to feed him if he cannot eat himself. I will spoon-feed her, wash her, take her to toilet, everything.

I (S) asked one elder (M) what he thought of voluntary death. The following discussion ensued:

- M. *It is perfectly good. At the moment one of my uncles is sick, so weak that he is praying God to give him way. Not he alone, but all the older sick people in bed are craving for death, especially those who can't control their bowels.*
- S. *Will the family sometimes help you to die?*
- M. *The family cannot help.*
- S. *Have you ever heard the rumour that some people quietly use poison?*
- M. *The suffering person can do it, if he gets access to the poison but not from outside.*
- S. *If you, for example, found yourself in such a situation, could you ask your wife to find some poison for you?*
- M. *No, no, she wouldn't do that. She would not like to hear of it.*

An older woman gave a concrete explanation for the fact that no one will be prepared to help an old person to die: such a person would contract the sins and the disease of the one dying: "If you help him, his sins will come on you (*Woyè saa a na woagyè ne bònè*

asoa)".

The only people in Kwahu-Tafo who told me that older people who become very pitiful (demented, incontinent) were sometimes killed, were some young men working at the town's 'lorry station'. One of them remarked:

Yes I know one instance when a certain rich woman thought that her brother who was an epileptic patient had become such a burden to her that she arranged with a doctor to poison him by injection. He gave him a bad injection (*Òbòdò no paneè bône*). The relatives gave him a fitting funeral but at the back of their minds, they were happy that he had gone.

My cautious conclusion is that euthanasia is indeed rejected on ethical and religious grounds although incidental cases will undoubtedly occur. Sick or older persons and those caring for them may wish their death, but they will find it impossible to do something because they fear the consequences. In Kwahu-Tafo, euthanasia is not seen as the way to a 'good death'.

Contrasts, Paradoxes and Irony

The extremely different circumstances under which older people in The Netherlands and in Kwahu spend the last years of their lives account for their different perceptions of achieving 'good death', but sometimes in unexpected and ironic ways.

Lack of financial resources, absence of health insurance and limited medical facilities in the Ghanaian situation prevent people from living long after sickness and fragility have set in. Being barred from the possibilities of prolonging life, as they exist in The Netherlands, makes prolongation of life extra attractive for people in Kwahu. Voluntarily ending life would, in that view, be a contradiction. Most of the older people were rather sardonic about death; they were ready for it but did not force the issue. They were relatively well, even those who did have physical health problems, such as poor eyesight and general weakness. Those who were *not* well had already died.

The opposite situation occurs in The Netherlands. Unlimited financial assistance from health insurance and advanced medical technology achieve what Ghanaian elders can only dream of. Life in The Netherlands is continuously prolonged, while the older people themselves may feel that it is 'enough'. They have gradually surrendered to medical technology and become dependent on others, who see it as their duty to prevent them from dying. It is in that situation that people, if they are still of sound mind, long for a dignified end of life. The irony is that Dutch as well as Kwahu elders feel attracted to what the others have and what is much less attainable to them. Relatives in their environment share that attitude.

Breaking points at which older Dutch people are inclined to consider voluntary death as desirable end-of-life care, are loss of a partner, loss of independence, an incurable chronic disease, forcible movement to a nursing home, and loss of cognitive abilities (particularly: not recognising one's own children). Such moments are less likely to present themselves, at least not in that intensity, in the Kwahu environment. Of course, people lose their partner, but there are many other 'partners' (relatives, house-mates) to replace them. Nearly all elders live with many other people, of all ages, together in the same house and enjoy other people's company after their partner's death. Moreover, separation and divorce are common in mid- or late life and many older people have accustomed themselves to a life without a marital partner. Moving to a nursing home does not happen, simply because such institutions do not exist in the region. Finally, the other conditions, chronic physical and mental debility, are relatively less common, since most people have died before these problems present themselves.

Risking stereotyping and romanticising old age in Ghana, I should point out that older people in Kwahu-Tafo, nearing their end of life, feel more connected to the community and experience more public respect and admiration than their – much older –

Dutch counterparts⁸. There is more ‘pleasure’ in their lives than in the daily routine of isolated and incapacitated Dutch elders.

The fear of being a burden to others, the most commonly expressed concern of older people in The Netherlands is virtually absent in Kwahu-Tafo. The mere idea sounds absurd to my Kwahu friends: how can your parents become burdensome to you, if they took care of you when you were small and needed them? Dutch requests for euthanasia are without doubt influenced by the fear of becoming a burden to children and others. Implicit in that fear is concern about autonomy and personal identity. Loss of self and autonomy towards the end of life scares many Dutch people, as a loss of dignity and a ‘betrayal’ of a successful life. That scare makes the euthanasia option more attractive to them. Risking a stereotype again, I have observed that elders in Kwahu-Tafo see their lives not so much in the perspective of individual self but rather as a family phenomenon. They experience dependency as something beautiful: the reward of a fruitful life.

A last, remarkable, difference in the attitude to euthanasia between Dutch and Kwahu elders lies in their relationship with their physician. As we have seen, Dutch people, certainly those who grow old and sickly, may develop trusting relationships with their family doctor, who visits them at home and have candid discussions with them about their pain and suffering and their wish to die. Eventually, euthanasia takes place within that relationship. Such personal relationships between older people and physicians are rare in Kwahu. People do not frequent doctors

⁸ Elsewhere, however, I have argued that older people in Kwahu-Tafo feel less respected and lonelier than a superficial glance may suggest. Although they are surrounded by people and treated politely, they feel neglected. They are particularly worried about the younger generation’s disinterest in them. The young do not ‘tap’ their wisdom and life experience, which produces a sense of redundancy in the elders (Van der Geest 2004b).

and even if they do, there remains a wide distance between doctor and patient in most cases. The doctor's mercy that is required for euthanasia is hard to find in Kwahu. The few cases of euthanasia that are whispered about in Kwahu-Tafo have mostly taken place outside the medical realm. The involvement of a doctor in the case cited earlier did not include the patient who died, but rather those who wanted to get rid of him.

Future

Ghanaians pride themselves on taking care of their older people and regard institutionalised care and euthanasia in 'Western' countries as unfortunate developments, indications of a declining willingness to care for the elderly. Treatment and living conditions of older people stand out as prominent differences between 'African' and 'Western' cultures. Some Ghanaians have pledged that the 'Western' style of old people's care should never be followed in Ghana. One of them, Peter Sarpong, anthropologist and Archbishop of the Roman Catholic Church, wrote some years ago:

I have always considered it degrading that in industrialised societies, old people are put in old people's homes where they are visited by their children from time to time. We must desist from creating or introducing such life's dead ends into Ghanaian life. For me, the day we adopt such a culturally humiliating system will be a gloomy one indeed. Let us continue to keep the aged in their homes with their children and grandchildren (Sarpong 1983: 19).

Euthanasia was not yet an issue when Sarpong made the above statement, but we may safely assume that his rejection of euthanasia would have been – and still is – similar. What will be the future of end-of-life care in Kwahu over fifty years?

Anthropologists are unreliable predictors of the future but I venture to forecast that economic growth and improvement of

well-being and medical care, with the ensuing lengthening of life, will eventually lead to 'Dutch conditions' in Ghana. I am not a neo-evolutionist, but I fail to see another option when Ghanaians become more mobile, have fewer children, live increasingly in nuclear families and grow older. The breaking points that affect the Dutch elderly will also be felt in future Ghana, maybe in fifty years, or, if that is too optimistic, later. The strategies for a good death will then have to change accordingly.

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