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Review Article

Conceptualizing the notions of human-being and human-person in terminal discharge: A Moral Account on end-of-life Care in Tanzania

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Abstract: Terminal discharge or discharging terminally ill patients from hospitals in Tanzania as any other end-of-life care decision does not go without moral dilemma. Although the resolutions of end-of-life care decisions in hospitals in Tanzania focus much on material order rather than moral order, this paper shows the moral imperative of terminal discharge. The paper picks one of the controversial bioethical moral issues that are always raised in end-of-life decisions; '*the distinction between human beings and human-person'* and analyzes it through linguistic categories of Kiswahili language. From the reflections on the semantic charge of human beings (*binadamu in Kiswahili*) and human-person (*mtu in Kiswahili*), it is possible to infer that their distinction holds to moral criterion that may influence terminal discharge in Tanzania. The former is a quality that is inborn in so far as anyone who is born as a human being has nature humanity (*ubinadamu*). The latter, however, introduces a nuance according to which the moral component enables to take humanity away from animality up to humanness (*utu*). The question is that of knowing, in terminally ill discharge, whether the end-of-life decision makers act out of humanity (*ubinadamu*) or humaneness (*utu*).

Keywords: terminal discharge, human-being (binadamu), human-person (mtu), humanity (ubinadamu), humanness (utu)

Introduction: Terminal discharge of dying patients is a practice often accompanied by mixed feelings and conflicting moral attitudes in Tanzania. Terminal ill patients are usually discharged from health facilities on the ground of insufficiency in infrastructure and resources. This kind of discharge is sometime requested by the patient's relatives and sometimes advised by the health providing staff. Treatments are interrupted because there is a medical certainty of the imminent patient's death or because of lack of alternatives. Whether requested or advised, the terminal discharge raises moral concern. Is the terminally ill patient treated as a human being (*binadamu* in Kiswahili language) or a human person (*mtu* in Kiswahili language)? It is evident that Kiswahili is an official language of Tanzania and one of the most widely spoken languages in Africa and is on its way to becoming the lingua franca of Africa. The moral dilemma of discharging terminally ill

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patients (*terminal discharge*) is begins with the fact that in Tanzania euthanasia is not legalized, on one hand, and on the other and as a common perception to most of the people, 'terminal discharge insinuates passive euthanasia'[1].

The problem this article intends to discuss is related to the search for a maxim or a rule of action. Material scarcity, poor equipment, and sometimes, lack of qualified medical personnel may constitute undeniable factors conducive to deciding whether to discharge the dying patient or not. However binding circumstances might be, there has to be a criterion in the light of which the decision to act should be made. After field research, there arises the hypothesis that most of the time, dying patients' relatives and medical personnel decide out of either humanity (*ubinadamu*) or humaneness (*utu*). Are those maxims, altogether or separately, sufficient reason to let the patient's life end with dignity? By analyzing linguistic categories of *ubinadamu* and *utu*, this paper endeavors to highlight this moral dilemma and suggest a principle of solution. In order to settle this problem, I have structured this article in three parts. The first part analyzes the moral distinction lying behind the linguistic categories often used by Tanzanians, namely *ubinadamu* and *utu*. The second part discusses quality end-of-life care and develops the reflection of terminal discharge Tanzanian tertiary hospitals. The third part describes home-based end-of-life care in Tanzania in connection with Tanzanian conceptions of *utu* and *ubinadamu*.

Methodology: This study was methodologically qualitative where phenomenological hermeneutical approach was used to evaluate the subjective experience of the individual participants of the research. Phenomenological hermeneutics was also used as a tool to understand personal and moral introspective experiences of the people and interpreting them. The personal and moral subjective experiences of dying patients, their relatives and family members as well as the medical personnel regarding the concepts of human-being (*binadamu*) and human-person (*mtu*) in relation to the terminal discharge's decision in the end-of-life care were studied. Although data collection method of this study was mainly textual and anthropological, the analysis was collaterally referred to along with the development of ideas in deductively structured arguments.

Discussion:

1.The moral distinction between *ubinadamu* and *utu:* Many liberal philosophers claim that not all human beings (*binadamu*) are human-persons (*watu)* is the plural form of *mtu*, which is the derivative of *utu*) and the most influential one according to Johaness Sun in his article, "are all human beings persons?", is Peter Singer, whose "ideas are made widely known in his books *Animal Liberation* (1975) and *Practical Ethics* (1979)"[2]. Peter Singer in his work 'Practical Ethics' states that, 'person' is often used as if it meant the same as 'human being'. Yet the terms are not equivalent; there could be a person who is not a member of our species. There could also be members of our species who not persons[3].

The differentiation of human being and human-person can be traced back to Scholastic tradition. During that period, there existed two schools of thought. The first was the traditionalists' school. It held that all human beings are persons. The second was liberals' school, which alleged that not all human-beings are human-persons[2].

The concept of person can have some closeness with the African notion of *ubuntu* (humanness). Mawere and Mubaya attempt to define the concept 'ubuntu' this way;
Loosely defined, Ubuntu is a system against whose values the members of a community measure their 'humanness'. These values, like Ubuntu system from which they flow, are not innate but are rather acquired in society and are transmitted from one generation to another by means of oral genres such as fables, proverbs, myths, riddles, and story-telling[5].

Ubuntu philosophy calls for individual person to act and behave in conformation with the larger society, as James Ogude puts it by borrowing John Mbiti's familiar phrase, "I'm because we're"[6].

In his book, *The Self and the Community in Contemporary African Society: An Existential Perspective*, Kochalumchuvattil quotes Archbishop Desmond Tutu's description of Ubuntu.

Africans have this thing called UBUNTU, the essence of being human. It is part of the gift that African will give the world. It embraces hospitality, caring about others, willing to go the extra mile for the sake of others. We believe a person is a person through another person that my humanity is caught up, bound up, and inextricable in yours. When I dehumanize you I inexorably dehumanize myself. The solitary individual is a contradiction in terms and, therefore, you seek to work for the common good because your humanity comes into its own community, in belonging[7].

This means that the African perception of humanity is its social conformation. He who goes against social norms, even if he is sound of mind, is an evil being, as the Swahili proverb says *mkataa wengi ni mchawi'* (the one who rejects others is wicked). Such a person fears that, when involved in social interaction, his evil deeds will be exposed. Mawere and Mubaya assert that in African cosmology, ubuntu symbolises the backbone of African spirituality and moral conduct[5]. The concept of Ubuntu can be translated as humanity, humanness, or humaneness and is not merely a factual description of human nature, but constitutes also a rule of conduct and social ethics"[5].

Finding the moral distinction between the notions of human-being (*binadamu*) and human-person (*mtu*) in Swahili context is a crucial step towards not only exploring the attitudes of Tanzanians on a dying person but also digging their perceptions about death and dying with dignity. In Tanzania, Kiswahili is the medium of communication. As such it bears all thought sensitivity. In a hospital setting, a nurse or physician may not be aware that sometimes the decision on end-of-life care he or she makes is affected by his/her perception of human-being (*binadamu*) and human-person *(mtu*). In the ordinary Kiswahili language, human-being (*binadamu*) and human-person (*mtu*) are used with different perspectives. Some Swahili speaking persons use them interchangeably, whereas others differentiate them. Furthermore, the notion of humanity (*ubinadamu* or *insia*), which is the nature of human being, is sometimes understood as humanness (*utu*). "In Kiswahili, the conception of humanity is semantically linked to morality, which is an exclusively human quality, in distinction from all other creatures"[10]. Let me use, as an illustration, this stanza of a popular song[11] by Marijani Rajabu to show how these two terms are often confused.

Dunia sasa imani imekwisha, (confidence is over in nowadays world).
Nyoyo za watu zimebadilika, (Human beings' hearts have changed)
Wala hakuna uaminifu tena, (There is no more trust).
Si wanawake, si wanaume, si kwa wazee wala si vijana, (be it about women, men, elderly, or young persons)
Sote tunakwenda mzabwa mzabwa, (All of us are disarrayed).
Kwenye watu kumi binadamu mmoja (among ten human beings there is only one with humanity**).**

The stanza shows explicitly that '. *ubinadamu'* has been used in the sense of '*utu'*. In the Swahili context, for example, humanness (*utu*) is a value that every human being should have. In his book *Philosophizing in Mombasa: Knowledge, Islam, and Intellectual Practice on the Swahili cost*, Kai Kresse shows that *mtu* in Swahili context is defined with four criteria[10]. First, *mtu ni utu* which means a human being is humanity since a human being is a moral agent. Second, *mtu ni watu* which takes us back to Mbiti's statement of "I'm because we are", to show that human being is a social being. Third, *mtu si kitu* which means that human being is not a thing and he or she should not be treated as merely means but the end in himself or herself. The fourth criterion is *utu ni kitendo*, which means humanity is action[10]. Goodness or morality must be realized in actions. This is similar to another Swahili saying that '*ada ya mja hunena, muungwana ni kitendo'* with literal translation

that '*words are for human beings but actions are for the persons'*.

From these reflections on the semantic charge of *ubinadamu* and *utu*, it is possible to infer that their distinction holds to moral criterion. The former is a quality which is inborn in so far as anyone who is born as human being has by nature humanity (*ubinadamu*). However, nature is a component which keeps humans closer to animals. Hence, nature cannot be a component that belongs specifically to human beings. The latter, however, introduces a nuance according to which the moral component enables to take humanity away from animality to humanness (*utu*). Humanness (*utu)* implies basically morality (*utu ni kitendo*), sociality (*utu ni watu*), and respect for human dignity in oneself as well as in others (*utu si kitu*). The question is that of knowing, in terminally ill discharge, whether the decision makers (both health care providers and patient's relatives) act out of humanity (*ubinadamu*) or humaneness (*utu*). Before answering this question, it is pertinent to describe the way terminal discharge is conducted in tertiary hospitals in Tanzania.

2. Quality end-of-life care and terminal discharge in Tanzanian tertiary referral hospitals: The need for patient's autonomy might have a great contribution to the introduction of medical ethics in hospitals since "autonomy is the right of patients to make decisions about their treatment free from controlling interference from others, and from personal limitations that prevent a meaningful choice"[14]. This means that there was a paradigm shift of the physician-patient relationships from paternalistic attitude to the observation of the patient's autonomy. The relationship between the physician and the patient in contemporary medicine has become less paternal with regard to advances in medical science and technology[15]. This implies that there is a room for a patient to discuss with the care provider and consent to the type of treatment.

Considering moral values, rights, and duties in medical treatment and research is the order of today's medicine and healthcare provisions in the globe. This also includes overseeing professional attitudes of medical practitioners when performing their duties. Biomedical ethics was introduced not only to safeguard the broader relationships between physician and patient but also to monitor progress achieved in medicine and medical technology, as Mappes and Zembaty alleged, "the physician-patient relationship has become increasingly impersonal as the growth of medical knowledge and technology has made modern medicine more complex"[16]. The advancement of technology in medicine came with the demand of more 'trust' (the concept which has normative value) in the relation between medical staff and patients. According to Christiane Stüber, "the quality of health care is likely to rest, at least partly, on the existence of relations of 'trust' between patients and medical staff"[17]. In view of this, the conventional principles have been used to find a solution to the ethical dilemmas which have been emerging frequently in the medical field and especially in hospitals. In today medical field, a patient is involved in discussing and deciding on the fate of his or her treatment, as it is clearly stipulated in the new version of the Hippocratic oath, known as the Declaration of Geneva, which was introduced and adopted by the World Medical Association in 1948[18].

Quality of end-of-life care for a long time has been seen as a matter pertaining to health care providers only and the opinions of patients and patients' relatives have not been properly included[19,20]. Quality of end-of-life care includes among other things decisions for terminal discharge, which means discharging terminally ill patients from hospitals for home-based end-of-life care[20].

There are a number of moral issues that are claimed to challenge the end-of-life decision making process in hospitals and by hospital administrations in Tanzania. Tanzania is a pluralistic country with people of different ethnicity and religions. Terminal discharge in Tanzania takes a lead as a resolution to the end-of-life decision making. Decisions makers at the end-of-life care for example in Muhimbili National Hospital (which has a status of a state hospital with multiple specializations and

bearing Medical school at the same time) often find themselves in a moral dilemma in making decision of terminal discharge. Although the relatives of terminally ill patients are often the ones who initiate the request for terminal discharge for their sick relative who is probably incompetent to consent, it is difficult for end-of-life care givers to directly accept this advice without finding themselves in an ethical dilemma. There are reasons that are openly discussed in hospitals in Tanzania behind terminal discharge, example, scarcity of hospital resources and palliative care facilities. But the moral reasons behind terminal discharges are rarely and/or secretly given or are not discussed at all. However, according to the explanation of nurses at Muhimbili National Hospital (MNH), there are times when they get 'moral injury', because they see that they have to convince the patients' relatives to agree to terminal discharge, even though they know in their hearts that at home the patient cannot get proper palliative care and thus shorten his or her life even more. Moral injury according is caused in two way folds; one is through 'commission' when one takes action that violate his or her own moral held values and the other is through 'omission' when one fails to act in line with his or her own deeply held values[21]. The nurses work in the intensive care unit (ICU) in MNH also know that generally at the hospital there is a shortage of medical equipment and palliative care gears. Again a situation which causes more moral injury to the nurses is when they realize that the family of a terminally ill patient does not have the ability to pay for fast track health service at the hospital. Nurses together with relative of terminally ill patients mostly find themselves in moral dilemma what should be done to the situation where it is not convenient for terminally patient to stay at the hospital where there is no sufficient end-of-life care and to discharge him or her to home where there is also no conducive environment for end-of-life care.

In the context of this study, this moral dilemma is looked at from the point of view of the service providers' distinction between the concepts of human-being (*binadamu*) and human-person (*mtu*). It was found that through their perception of human-person and humanness in general, to discharge a terminally ill patient is similar to hasten his or her death, something that is not different from passive euthanasia. In other words terminal discharge presupposes taking terminally patients from a place where he or she can get life-prolonging care to a place that their lives are simply going to be further shortened. Again at home settings and as far as the perception of indigenous Tanzanians regarding the concepts human-being (*binadamu*) and human-person (*mtu*) is concerned, the manner in which the discharged terminally ill patient will be given home-based end-of-life care is determined by their perceptions of these concepts. The terminally ill patient will receive good home-based end-of-life care or not depends on how he or she lived with other people before reached terminal illness. The way terminally ill patient was observing humanness (*utu*) or not, is therefore determines the how his or her home-based end-of-life care will be. To observe humanness here means the manner in which the terminally ill patient socially lived with other people.

There are four tertiary referral hospitals in Tanzanian. Apart from MNH other tertiary referral hospitals in Tanzania are Kilimanjaro Christian Medical Center (KCMC), Bugando Medical Center (BMC) and Mbeya Regional Referral Hospital (MRRH). These hospitals have been given status as well as capacity building to meet medical referral services in all regions of Tanzania. For example, MRRH mainly serves the southern zone of Tanzania, KCMC, northern of Tanzania and BMC, western and Lake Zone of Tanzania. MNH in addition to being a national hospital with multiple specializations and bearing Medical school at the same time, to a large extent provides services to people from the Eastern regions and the coast of Tanzania including Zanzibar. In Tanzanian tertiary referral hospitals terminal discharge is not a norm although medical and clinical care providers in the end-of-life care units from their point of view think that it is better for the terminally ill patients to go back for home-based end-of-life care, considering that the hospitals do not have enough resources for palliative care. This follows that terminal discharges' decision always cannot go without ethical dilemma in

Tanzanian tertiary referral hospitals. This, along with many other factors, can be attributed to two main reasons. First, most of terminally ill patients who are discharged from hospitals and referred to home hospice, are the ones whose families cannot afford hospital bills. This implies that even at home where a patient is taken, families cannot afford to take care of them. The homes' environment of these discharged terminally patients are not likely conducive to keep them and cater for palliative care for longer time as compared to hospitals' space. The terminally ill patients are likely to suffer more at home for there is no well-established hospice care system outside hospital settings in Tanzania. Discharging terminally ill patients from hospitals and sending them home without considering what will be the situation there, is against the basic bioethical principle of non-maleficence. "In medical ethics this principle has often been treated as effectively identical to the celebrated maxim *Primum non nocere*: "Above all [or first] do no harm"[22]. The moral puzzle here may be 'is sending terminally patients back home where there is not palliative care not violating the principle of 'do no harm' which according to medical profession is entitled to all patients'? Second, when terminally ill patients are discharged, they are removed from the environment of professional medical care to places where palliative care may be negatively influenced by the culture of the place, the attitudes and perceptions of the people around dying persons.

Many hospitals in the world today have established hospital ethics committees to discuss ethical issues arising in medical and clinical care and make subsequent and morally reasonable decisions[24]. There are no ethics committees (HECs) in tertiary hospitals in Tanzania; nonetheless some ethical issues are dealt by the department of social welfare. Another example is Ocean Road Cancer Institute (ORCI), a specialized cancer institute in Tanzania, where the palliative care team is the one that advises relatives of a concerned terminally ill patient to consent to the discharge the patient for home-based end-of-life care. However, decisions of this nature are always left to the discretion of individuals in the palliative care team since there is no formal hospital ethics committee.

Terminal discharge is among the issues or rather the leading issue that is usually facing moral constraints in hospital administrations in Tanzania. Discharging a terminally ill patient from hospital would mean interrupting treatment. Such an act indicates the decision of ending one's life. No terminal discharge can be performed without the consent of the patient or of a person with a power of attorney in case the patient is unable to make consent. Some health care practitioners do not believe that such a decision needs ethical attention. Terminal discharge decisions should be considered as an issue that requires moral attention.

When the moral justification is not established there is the possibility of speaking of passive euthanasia, an action which according to Tanzania legal framework is not allowed. The penal Code of the United Republic of Tanzania (Cap. 16. R.E. 2018, Section 203) by implication forbids euthanasia and all its forms because it is regarded as also an intentional killing[25].

The intention to discharge terminally ill patients however is always influenced along with other things by individual feelings of health care providers who may think of acting humanely (*utu*) while they are acting humanly (*ubinadamu*). As far as ethics is concerned, any decision regarding the discharge of terminally ill patients should be made not out of humanity (*ubinadamu*), rather out of humanness (*utu*) on the ground that the former refers simply to a natural component whereas the latter is a moral requirement.

The terminally ill individual, despite his vegetative like condition, is a human person and should be treated as one. Looking at him as a dying person is an attitude related to the nature of humanity (*ubinadamu*). He should be looked at primarily as human person who deserves love, attention, compassion, and sympathy. That is what we do when a baby has just been born. That tiny little creature is looked at not only as a being with human

shape and organs (*binadamu*), he or she is a human person (*mtu*). That is why we kiss it, we nurse it, we handle it with care, we sing for it, we smile at it, etc. In short, we treat it with humaneness (*utu*). Looking at a terminally ill patient from human perspective only is considering him as a burden, burden to the hospital facilities and staff, burden to decision makers, and burden to everyone.

3.Home-based end-of-life care in Tanzania after terminal discharge: A discharged terminally ill patient at home may cause his or her family members and relatives to have deep feelings about the so oncoming patient's death. The condition at home where the discharged terminal ill patient is exposed may raise the questions on the moral justification of the terminal discharge from hospitals in Tanzania. If at home the environment is not conducive for palliative care, the question 'why should terminally ill patient be discharged?' is inevitable. In Tanzania although there is a National guideline for home-based care service[24] in practice there is scarcity of hospice care facilities. Terminal discharge by Tanzanians gives an impression of the end of medicine and medical treatment at hospitals and is perceived as a simply a statement that "death of a terminally ill patient is around the corner". It follows that what is overwhelmingly in the emotions and thinking of the relatives and family members of the discharged terminally ill patients is the 'death' of the patient. The understanding of the concept of 'dying and death' in African ontology can be easily through the spectrum of the concept 'vital force' in African perspective. 'Vital force' as was introduced by an African philosopher Placid Tempels is the spiritual level that a person can have while living that is empowered by God, ancestors, or even other creatures that can help him to sustain life[25]. During terminal illness this force can help a patient to die peaceful and tolerate the suffering. The concepts of human-being (*binadamu*) and human-person (*mtu*) as they used in unprofessional environment in Tanzania can affect not only terminal discharge's decision at hospital as we have seen earlier but also end-of-life care outside hospital settings. Understanding the concept of 'vital force' as it used in in African ontology, is therefore *sine qua non* because of its direct link in the conceptualization of the notions of human-being (*binadamu*) and human-person (*mtu*).

Thanatologically speaking, dying that observes humanness (*utu*) includes not only quality end-of-life care for terminally ill patients but also soothing the bereaved family members, relatives and friend after the death of the terminally ill patient. In hospitals 'vital force' as perceived by Africans, can be courage-giving factor to both nurses in the hospital and relatives and family members of terminally ill patients and reduce their emotional burden when the patient dies. Humanness (*utu*) observance to terminally ill patients should therefore be applied to both end-of-life care givers in hospital settings and those at home-based end-of-life care. Gogo (located in the central part of Tanzania) is an example of ethnic group in Tanzania whose people have their proper way of conceiving end-of-life care with humanness (*utu*) outside health institutions. People from that tribe hold that;

When an old man fell ill for a long time, suffered from an incurable disease to the extent of unconsciousness, he or she was moved from his or her home and sent to the forest. In the forest the dying patient was tied to a big tree and left alone. In the forest this old and terminally ill patient faced the danger of wild animals such as hyenas and wild birds. The reason for leaving him in the wild was that a patient would be killed by wild animals instead of dying at home. However, this patient was visited every morning by his close relatives to see if he had already died naturally or from being attacked by wild animals. If the patient was found still alive, a way was found to give him food or water so that he would not die of hunger or thirst. Their intention is to get away from the guilt that they have participated to kill the patient. No one wanted to be seen that was the end-of-life final decision maker.

The enigma is if their intention was for the terminally ill patient to die, why would they not let him starve to death at home instead of sending him to the forest to end his life by wild animals?

This attitude towards dying patients by Tanzanians speculate the motivation that leads people especially close relatives or friends to the patient to continue to care for the person even though they are clearly aware that he or she is unconscious and unresponsive. Their motive behind as

portrayed in the story above is to avoid guilt conscious that they might have participated in killing the patient for omission of end-of-life care.

Laurent Magesa in his book "What is not Sacred? African Spirituality", writes, "African death is perceived as mysterious and ambiguous"[26]. Magesa continues to say that there is no African community where death and dying are not perceived without mixed feelings or with ambiguity[26]. There must be questions as any death must have two explanations. Firstly, that it is natural and a way to go to the world of ancestors and connect with them, but secondly, death is described as a bad thing that is sometimes sought for a supernatural reason behind it, even if it happened by accident. Explaining his experience among Luo people, Kirwen as written by Magesa says;

Death "is reviewed as a rite of passage from physical life to the ancestral world." Various linguistic images are used to explain this. Among them, people say that the dead person "has gone on a long journey to another country." In additional to rituals of purification of the entire homestead and "chasing away of evil spirits," there are rituals related to cleansing of persons at time of death: … An honourable death is the way that God provides for the living "more ancestors who become intermediaries between God and the living members of the lineage. Death, though not welcome, is [therefore] not a loss." The living, therefore, have reason to celebrate[26].

Conclusion: The conceptions of various notions in health care delivery can affect the clinical and/or administrative performance especially on the provision of end-of-life care to the people of a particular culture. From a moral stand point the luck of clarity in understanding humanity (*ubinadamu*) and humanness (*utu*) become a source of moral dilemma in end-of-life decision in hospitals. The moral distinction of these notions also brings challenges in the terminal discharge in hospitals in Tanzania. Although in ordinary Kiswahili language, the notions *binadamu* (human-being) and *mtu* (human-person) are often used interchangeably, the moral significance of their differences has been found in the end-of-life care and terminal discharge in hospitals in Tanzania and outside hospital settings. Since terminal discharge's decision in hospitals is done with the engagement of the relatives of the terminally ill patient, their perceptions about the notions of human being (*binadamu*) and human-person (*mtu*) has been see to affect in one way or another end-of-life decision making especially the decision for terminal discharge. Despite tertiary referral hospitals in Tanzania been following professional and ethical standards in making end-of-life decisions, it appears that at the end-of-life decision making, decision makers being physicians, nurses, and hospital administrators, are not free from moral dilemma or even moral injury in executing end-of-life care and especially when terminal discharge becomes a must option. The conception of the notions of human-being (*binadamu*) and human-person (*mtu*), by end-of-life caregivers in both hospitals and outside hospital settings in Tanzania, is also affecting the bioethical idea of dying with humanness (*utu*) which calls for humane treatment of a terminally ill patient to death. Three recommendations can be made in terminal discharge decisions in tertiary referral hospitals in Tanzania as long as this study is concerned. One, the patient even if unconscious and incompetent to make a decision, with a hopeless prognosis and lower vital signs, should not be cared with perception such that his or her state of being human is diminishing to death (terminal) as not to be given other attention like palliative care, spiritual and moral assistance. Two, terminal discharge decision should not be made mechanically basing only on the facts at the surface level like scarcity of the hospital's facilities but should consider the moral foundation of both end-of-life care providers, terminally ill patients, and relatives and family members of terminally ill patients. Thirdly, ethicists should be highly engaged in end-of-life decisions in tertiary referral hospitals in Tanzania, as "according to hermeneutic philosophy, the ethicist should act as a facilitator, fostering the process of moral deliberation"[27].

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