

## **Submission from the CHRISTIAN MEDICAL FELLOWSHIP to the South African Law Commission**

This paper is a response to Discussion Paper 71 (“Euthanasia and the artificial preservation of life”), recently published by the South African Law Commission for public comment.

In summary, eight areas are addressed by the Paper:

- Cessation of life-sustaining treatment;
- The right to refuse life-sustaining treatment;
- The right to alleviate pain, even if it might shorten the patient’s life;
- The lawfulness of voluntary euthanasia and assisted suicide;
- The recognition of ‘advance directives’ (as defined in Paragraph 4.4 of the Paper);
- Recognition of a power of attorney to make decisions on behalf of the principal;
- Discontinuation of terminally ill patients’ treatment;
- Court orders relating to the termination of a patient’s life.

Our answers here will inevitably refer to points and questions explicit or implicit in the Discussion Paper, but is not a point-by-point response to the questions raised in the Paper. Responses are given to **nine** specific issues, as raised by the Terms of Reference of the House of Lords' Select Committee on Medical Ethics<sup>1</sup> in the United Kingdom, and these issues overlap in various ways with the eight points, as summarised above.

### **INTRODUCTION**

The Christian Medical Fellowship of South Africa is interdenominational and has some 800 members who are Christians and who desire their professional and personal lives to be governed by the Christian faith as revealed in the Bible. We have members in all branches of the profession, and through the International Christian Medical and Dental Association are linked with like-minded colleagues in well over 50 other countries. We are grateful for this opportunity to comment on the difficult issues falling within the terms of reference of Discussion Paper 71 of the South African Law Commission.

### **POSITIONAL STATEMENTS**

The following extracts from our *Affirmation on Christian Ethics in Medical Practice* are relevant to this Submission:

*“In Relation to Human Life*

*To acknowledge that God is the Creator, the Sustainer and the Lord of all life.*

*To recognise that man is unique, being made in the 'image of God' ...*

*To maintain the deepest respect for individual human life from its beginning to its end, including the unborn, the helpless, the handicapped, and those advanced in age.’*

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<sup>1</sup> British House of Lords **Report of the Select Committee on Medical Ethics** 31 January 1994

We hold the Bible to be the revealed Word of God and find this helpful in our approach to thinking about issues related to euthanasia, but recognise the complexity of the questions before the Law Commission.

We find from Scripture that the biblical concept of **justice** is balanced by the biblical concept of **mercy**, and hope that our own resolution of this balance will be clear in the following attempts to respond to the nine specific issues raised.

## ***1. The moral principles of the sanctity of life and the right to personal autonomy***

### *a. 'Sanctity of Life'*

Contrary to popular belief, this is not in fact a biblical *expression* but it is a biblical *concept*, derived from an understanding of:

- human life being created 'in the image of God' (Genesis 1:27);
- God's Commandment 'You shall not murder' (Exodus 20:13);
- the fact that just as we value something by what we are prepared to pay for it, 'God so loved the world that he gave his one and only Son, that whoever believes in him shall not perish but have eternal life' (John 3:16);
- the belief that God has the ultimate right over our bodies: 'You are not your own; you were bought at a price. Therefore honour God with your body' (1 Corinthians 6:19-20)

Thus we 'maintain the deepest respect for individual human life from its beginning to its end' -- but we do recognise that human life in the physical sense has a natural end. A goal of medicine is to recognise that natural end, and we see no requirement to give all possible treatments to all possible patients in all possible situations just because those treatments exist. It is precisely this sort of meddlesome medicine which does not recognise that the natural end is drawing near that has led to over-treatment of some patients and is part of the background to the Discussion Paper.

In other words, while believing it is always morally wrong and always unnecessary (see Section 8 below) intentionally to kill patients, we also recognise that a time may come when interventionist treatment need not be started or continued, and the patient should be allowed to die, with all appropriate care given. This is not euthanasia but good medical practice.

### *b. Personal Autonomy*

Over the last 20-30 years there has been a general move away from 'paternalism' (best summed up in the old language of 'doctor's orders' and 'doctor knows best') and towards 'autonomy'. Literally meaning 'self-determination', the concept is of 'rights' – in particular the right implicit in the well-known saying 'Whose life is it anyway?'

It is sometimes suggested that the 'sanctity of life' concept is solely a religious one, and that the language of 'autonomy' is secular and humanist. We do not accept this. As Christians, we are happy with the language of autonomy in so far as it reflects the unique individuality of each human being, created 'in the image of God', and ultimately accountable to Him.

However, we further recognise that humans are created for relationships, and are inevitably in relationships in society. The emphasis on **rights** should always be balanced by the concepts of **responsibilities** and **restrictions**.

As Christians we view these three concepts as follows:

- rights - things we may do

- responsibilities - things we must do
- restrictions - things we must not do

We are concerned that in a number of areas in medical ethics and elsewhere society has recently over-weighted rights and neglected the necessary balance with responsibilities and restrictions. We emphasise though our support for autonomy and our conviction that patients and their families should always be consulted as much as possible.

### *c. Further considerations on autonomy and euthanasia*

Autonomy is one of the main arguments used in favour of voluntary euthanasia, and we use this section to make some further comments here.

- Autonomy is not just about choice, but about choice that is fully-informed, rational, and free. Could a sick and frightened patient near the end of life truly be in a position to make such a choice? Depression, confusion, unrelieved physical symptoms, a sense of 'being a burden', and conscious and unconscious pressures from family, friends, carers or society could all invalidate the choice as being autonomous. We are convinced that one or more of these factors would be operating in the vast majority of requests for euthanasia, and our respect for autonomy means that we therefore oppose euthanasia.
- Unlike suicide, euthanasia is not a private act. For the patient's autonomy to be exercised, the doctor's autonomy must be affected. It would be argued that 'conscience clauses' would protect doctors with objections, but we are concerned that permissive legislation might drive from certain specialties doctors who otherwise ought to be there. We are also concerned about the effect on the character of the healer who becomes, however rarely and with whatever good intentions, the killer.
- Despite the objections recorded in (i) above, we accept that there would be a very small percentage of requests for euthanasia which were deliberated choices, which did genuinely reflect autonomy. Why should the Law not be changed to grant these patients their wish? The answer lies in our mutual inter-relationship in society. For the Law to be changed to allow patient A to exercise his carefully deliberated 'right' to be killed by a doctor, society would have to move away from a situation of absolute protection of all patients into an uncertain area of value judgements. These would inevitably be arbitrary and inherently unjust. Patient A's 'one in a hundred' request might be well thought through, but to permit it for him the Law would have to be changed and up to 99 cases of injustice might occur. Patient A's responsibility to society means he should forgo his 'right' to euthanasia. In any case, we would argue that euthanasia is always unnecessary (see Section 8).
- The evidence from The Netherlands (detailed in Section 9) makes it clear that where voluntary euthanasia is tolerated, euthanasia which is not voluntary will follow. This is clearly not an illustration of autonomy but the worst possible example of paternalism.

*We believe these four points mean that respect for autonomy is an argument **against** voluntary euthanasia, and trust that they will be considered by the law Commission in their deliberations.*

**Summary: We accord human life the highest value but recognise that it has a natural end and we have no duty to prolong dying. We respect autonomy and therefore reject voluntary euthanasia. We believe that conflicts between the two moral principles only occur if either is carried to an extreme.**

## **2. The extent of a doctor's duty of care to a patient**

As a fellowship of doctors we are nevertheless concerned that the issue of euthanasia is discussed almost entirely in terms of 'a doctor's duty of care'. Healthcare nowadays almost always involves

many people: a hospital or general practice multidisciplinary healthcare team (involving nurses, physiotherapists, occupational therapists, technicians, social workers, administrators, the chaplain, etc.) and of course family members and voluntary carers.

Many different people thus have a 'duty of care'. Doctors do indeed have a duty of care but they are also, and perhaps primarily, responsible for treatment. We believe that confusion between the concepts of **medical treatment** and **basic care** in the series of verdicts on Tony Bland<sup>2</sup>, for example, did not help the decision-making process. We do not see that the Courts needed to be approached about **medical treatment** decisions such as whether antibiotics could be withheld in the event of Tony Bland getting a chest infection, but do believe that more weight should have been given to the opinion of the nursing profession that feeding (even by naso-gastric tube) is always part of the **basic care** of all patients, except at the very end of their lives.

We have made it clear in (1a) above that there is a limit to the doctor's duty to give medical treatments, and we repeat that it is morally wrong to prolong the process of dying. However, we would argue that care must always continue and would wish to pay tribute to our colleagues in other disciplines and to the family and voluntary carers of our patients who do most of the caring at the end of life.

We are concerned that unless this confusion between **medical treatment** and **basic care** is resolved, recent and subsequent decisions may undermine this essential contribution.

**Summary: Medical treatments may become inappropriate; basic care must always continue, and the many different groups of carers need every encouragement.**

### ***3. The distinction between the withholding or withdrawal of medical treatment, and deliberate intervention to end life***

The Christian Medical Fellowship has always argued that the concepts of 'active' and 'passive' euthanasia are unnecessary and confusing. We believe it is more helpful to use the concept of **intention**. What did the doctor intend when he or she performed the act? What did the doctor intend when he or she omitted to act?

A deliberate intervention to end life is always morally wrong and should remain unlawful. An omission may be an example of euthanasia (and therefore morally wrong) if its intention is solely to cause death. However, an omission would be an example of good medical practice if its intention was, say, to maximise the quality of life remaining to the patient, or to respect the wishes of the patient and his family. The difference lies in the intention.

We recognise the danger that perhaps only the doctor truly knows his or her own intention, and for this reason would advocate that decisions of withholding or withdrawing treatment would normally be taken after the maximum possible discussion, with the patient, with family members, and with other members of the healthcare team, and according to accepted medical practice.

We are not impressed by academic debates which look at the philosophical question implicit in this issue in a vacuum, using artificial examples. Doctors and others will always have to implement medical ethics decisions in the front-line, and we believe that in the real world the concept of 'intention' greatly clarifies decision-making. (We would emphasise again that while medical treatments can properly be withheld or withdrawn, care must always continue.)

The distinction to be made is not therefore between 'passive' and 'active' euthanasia but between good medical practice and killing patients.

**Summary: The deliberate intervention to end life is always wrong. The morality of decisions concerning withholding or withdrawing medical treatment depends on the intention.**

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<sup>2</sup> Airedale NHS Trust vs Bland [1993] 1 All ER 821.

#### ***4. The different considerations arising in the case of patients who are legally competent and of sound mind, and of patients who are unable to express their own wishes***

Because of our respect for autonomy, we accept that competent patients can refuse treatments and refuse care. For the reasons given in Section 1, we do not accept that patients should be able to make doctors kill them.

Cases of patients who are unable to express their own wishes are obviously difficult. Our *Affirmation on Ethics* records our special concern for 'the helpless' and we would draw the Law Commission's attention to the biblical principle that, contrary to the natural tendency, it should be the strong who give way to the weak. In other words, the disadvantaged may require positive discrimination in the form of extra-special care. Those 'unable to express their own wishes' are obviously in a special category of 'the helpless'.

Because of our total rejection of intentional killing, we would always rule out euthanasia as an option (It would of course by definition not be voluntary euthanasia in these situations).

Decisions about withholding or withdrawing medical treatments should be taken on the same basis as outlined in (3) above, except of course that the patient cannot be consulted. Even if treatment is withdrawn, care should continue.

We express especial concern about arguments involving the language or concepts of 'best interests' and believe that the Tony Bland case may illustrate that too much attention was paid to the best interests of others. For example, whilst we recognise the reality of resource constraints, society must never permit such considerations to lead to intentional killing.

***Summary: There is no fundamental difference of principle in the approach to competent and incompetent patients. Intentional killing should never be considered for either group; withholding/withdrawing treatment decisions are more difficult with incompetent patients who deserve special protection; care always continues. 'Best interests' arguments need rigorous analysis as to whose best interests are being considered.***

#### ***5. The role of advance directives (living wills) and proxy decision-makers'***

##### *a. Advance Directives*

We want to give our patients the maximum possible involvement in their healthcare, and therefore accept that advance directives can be of some help in indicating patients' wishes. However, we believe that they should never become legally binding. Our reasons are as follows:

- i. Issues of timing -- when should they be implemented? There would have to be a clearly identifiable 'trigger event' -- either the onset of incompetence or the occurrence of another event in the already incompetent. Could all those responsible agree on this? Would incompetence have to be permanent, or temporary? How would 'permanent' be defined?
- ii. Issues of informed consent -- how could people precisely foresee future situations? No- one could foresee all future possibilities, nor how new medical treatments might affect those situations in years to come. People would be unlikely to update their documents regularly.
- iii. Changed minds -- the healthy do not choose in the same way as the sick. When we become unwell our attitudes to what we want change, but an earlier Advance Directive might still be in force...
- iv. Difficulties of diagnosis and prognosis -- could all concerned ever be sufficiently sure medically that implementation was appropriate?

- v. Advance directives may hinder communication rather than help it. Where there is some possibility of communication with a patient, but it is difficult, doctors may be tempted to rely on the directive rather than make the effort to communicate with the patient.
- vi. Advance directives indicate a lack of trust in the doctor and this 'vote of no confidence' does not encourage either party in the doctor-patient relationship to communicate.
- vii. We are concerned that the language of advance directives reinforces negative images of disability and disease and feeds patients' fears.

Legal powers are being sought to starve and dehydrate people to death. If these powers were obtained, it would not be long before it was argued that this was not 'compassionate' and that a lethal injection should rather be given as soon as the decision was taken. Thus we are concerned that legalised advance directives would sooner or later allow euthanasia in by the back door. We are opposed to them as legally binding documents. The proposed legislation (Page 75 – 77 of the Paper) does not address the refusal of a doctor to comply with an advance directive, only with the lack of criminal culpability if a doctor complies with an advance directive. This is confusing and will sooner or later lead to directives becoming legally binding documents. A clear position should be taken by the Law Commission.

#### *b. Proxy decision-makers*

Given the special problems of the incompetent, we recognise that some strategy is needed. In principle, we think that proxies are safer than pieces of paper signed years earlier, but in practice there would have to be many safeguards.

**Summary: Advance directives have some value as indicators of patients' wishes but should not have the force of law. We do, however, give cautious approval to the concept of proxy decision-makers.**

### ***6. The role of the courts in interpreting the law in the light of changing medical technology and practice***

In general, we see the law as an inappropriate instrument for the sensitive decision-making needed in situations at the end of life. Given the one ultimate legal safeguard that intentional medical killing by act or omission would always be unlawful, we would argue that the law need have no place in any of these decisions.

They would be made by full discussion with all involved in the clinical situation, and according to accepted medical ethics, expressed in Codes of Conduct if necessary. We recognise that medical technology and practice are changing but believe that consensus views of all the relevant professions would be achievable, provided again that intentional killing was ruled out by force of law.

**Summary: We would prefer no involvement of the courts except in maintaining a prohibition on intentional killing.**

### ***7. The case for change in the existing law, and the nature and extent of such change***

Following from (6), we are however concerned that the whole relationship between medicine and the law in this area has become far more uncertain, particularly in the light of the discussion following the case of Tony Bland.

If the law has to be involved further, we would support legislation which clarified the distinction between medical treatment and basic care and ensured that **minimum standards of care always continue** until natural death. Legislation should also reaffirm the previous prohibition on intentional killing, whether by act or omission.

**Summary: We recognise that further legislation may now be forced upon us and if so believe it should ensure that care always continues until natural death. The previous prohibition on intentional killing should be reaffirmed.**

### ***8. The role of the hospice movement and advances in the care of the terminally ill***

Our response to this issue gives an opportunity to counter the other main argument used in favour of voluntary euthanasia, namely that of 'compassion', and to justify our earlier statement that euthanasia is always unnecessary. Hopefully, everyone in healthcare is committed to reducing suffering and all would agree that to leave people suffering unnecessarily would be immoral. The questions are, what means for relieving suffering are legitimate and what means are not? Is it ever necessary to kill the patient in order to kill the symptoms?

Quite simply, the hospice movement and its derived specialty, palliative medicine, have answered that last question with a resounding 'no'. In the presumption that our hospice colleagues will be making submissions and going into considerable detail here, we will confine ourselves for the sake of brevity to making a few general points.

As stated, the 'compassion' element of the voluntary euthanasia argument stands or falls on *force majeure*. Over-simplified choices have been presented: 'Either we have voluntary euthanasia legislation or patients must die in terrible agony from terminal cancer'. By research of the highest standards and creative care, the hospice movement has come up with a middle way, so that pain and other unpleasant symptoms are controlled in all but a tiny percentage of patients. So successful has this been that pro-euthanasia organisations no longer campaign on the grounds of pain.

A powerful argument against permitting any sort of euthanasia to be legalised is that it would rapidly remove any incentive to be creative in caring when we can no longer cure. We believe it is no coincidence that in The Netherlands where euthanasia is sanctioned legally, there is very little of a hospice movement.

The drive for euthanasia now comes not from pain but from the concept of 'death with dignity'. We fully recognise that some diseases produce very distressing symptoms, but as Christians argue that man's dignity derives from being created 'in the image of God' and is reflected in the way in which the healthy view the sick, the way in which the strong view the weak. In other words, people should not lose dignity continually as diseases progress but should gain dignity from the way in which they are treated and valued.

In this context we hope the Commission will recognise that the very existence of pro-euthanasia legislation would send a strong signal that some lives were of too low a quality, perhaps 'not worth living', and would thus reinforce the negative images already all-too-prevalent in our society.

The success of palliative medicine where terminal illness is concerned gives us confidence that if the will were present, it is within society's ability to produce creative responses to problems like AIDS and dementia. There are already many encouraging initiatives and we are pleased that Christians are in the forefront of them. Conversely, we believe that if euthanasia in any form were permitted, we would soon lose a high standard of healthcare.

We are not of course pretending that all is well. People do still have bad deaths and suffer unnecessarily - but we would say this is bad medicine, and the answer to bad medicine is not killing patients but good medicine. We believe that good palliative medicine and similar initiatives should be encouraged, and we recognise that this means that (the healthy) society would have to pay the proper costs of such healthcare.

**Summary: The hospice movement and good palliative medicine have shown how much can be done for the dying if the motivation is there, and should be encouraged. Similar initiatives**

**need developing in other areas. Pro-euthanasia legislation would remove much of the incentive to care properly and creatively.**

## ***9. The experience of other countries***

### ***a. Western Europe***

We are seriously concerned about The Netherlands, where as reported in *The Lancet* on September 14<sup>th</sup>, 1991, the Rummelink Report of the Dutch Ministry of Justice confirmed that of the 128,786 deaths in 1990, 1.8% were due to 'euthanasia', 0.3% to 'assisted suicide', and 0.8% to 'life-terminating acts without explicit and persistent request'.

In other words, euthanasia was performed on more than 3,000 people in The Netherlands in 1990, and in more than 1,000 of those it was not voluntary. We do not accept the morality of those cases in which euthanasia was 'voluntary', but here is unequivocal evidence of the reality of the 'slippery slope' (even if denied by Labuschagne, as on p. 42 of the Discussion Paper) - where 'voluntary' euthanasia is tolerated, there is an inevitable progression to euthanasia which is not voluntary.

Further evidence of euthanasia which is not voluntary occurs with the newborn. In *The Lancet* of March 27<sup>th</sup>, 1993, Professor Versluys admits that 'about 10' babies are killed every year by acts of commission.

Much is made by those who advocate euthanasia of 'guidelines' and 'strict safeguards'. The Rummelink Report and other official Dutch figures confirm that their 'guidelines' are not followed - one criterion is notification after death to the appropriate authority so that compliance with the guidelines can be confirmed. There were 3,300 euthanasia deaths in 1990 - the number reported was 454. The fact that Dutch society tolerates situations like these further undermines respect for 'law'.

These figures speak for themselves. They demonstrate clearly that euthanasia which is tolerated (and now 'legally sanctioned' in The Netherlands) cannot be policed - not least because the 'key witness' is dead. We trust that the Commission will assess the Dutch situation carefully, when we are confident that it will conclude against the legalisation of euthanasia.

### ***b. The USA***

The medical culture is different in the United States, with a possible tendency to over-treat patients, compared to South African standards. This can make comparisons difficult. Further, there is a range of experience there because of different policies in different States on, for example, assisting suicide. The situation is under review by the American professions, but we would draw the Commission's attention to the outcome of referenda held in two States -- in November 1991 the voters in Washington rejected euthanasia by 54-46%, and in November 1992 California similarly rejected it by exactly the same margin.

***Summary: Experience from The Netherlands confirms the truth of 'slippery slope' arguments against euthanasia. We recommend that South Africa learns from Advance Directive legislation in the USA.***

## **CONCLUSION**

We hope that this brief discussion gives a clear overview and illustrates that our Christian principles would continue to work in practice. We believe that 'justice' and 'mercy' can be balanced, and that an appropriate Christian expression of 'autonomy' and 'compassion' can be achieved.



We hold that intentional medical killing is always wrong and with that safeguard protected in law believe that end of life decisions could best be made by all those involved in caring for patients, together with patients themselves where possible.

The whole of society would benefit further from improvements in medical practice in the context of a reaffirmation of our present law.

We repeat our gratitude for the invitation to contribute to these difficult discussions and wish the Commission well in their deliberations.