Pro Life

Comments on the Proposed Bill

"To Regulate end of life decisions and to provide for matters incidental thereto",

to be called the *"End of Life Decisions Act",*

submitted to the Minister of Justice during November 98

by the South African Law Commission. (SALC)

(But only released to the public on 30 July 1999) 82M

Please note that all material appearing in *italics* are quotations taken from the Proposed End of Life Decisions Act.

Pro Life rejects all forms of "Mercy Killing" or Euthanasia and all legislation intended to legalise Euthanasia

The fundamental question that must be answered in any civilised society is whether there are any circumstances that justify the deliberate killing of an innocent human being.

We assert that:

a) Nothing can justify the deliberate killing of an innocent human being.

b) Euthanasia is the deliberate killing of an innocent human being.

c) Euthanasia therefore, is always a crime of the utmost gravity.

d) Pro Life is totally opposed to the killing of innocent human beings and to all efforts to introduce legislation which allows this intentional killing.

We note that the report with its proposed legislation was released to the public only on 30 July 1999, and we ask why it has taken the SALC some 8 months after submitting it to the Minister of Justice, to release it. In our view, this tardiness indicates a disdain for the opinion of the public, and is certainly incompatible with the much vaunted ideals of transparency and democracy that should characterise our government and its various departments and associated organisations. We strongly suspect that the reason for the delay in making public this attempt to normalise "mercy killing" was that public knowledge of the Government's intention to legalise "Euthanasia on Demand", coming after its legalisation of "Abortion on Demand", may well have caused some loss of voter support for the ANC Government in the recent elections, despite the Government's empty posturing of "respect for human life". Accordingly, it would have been to the advantage of the Government to permit the public to know about its Euthanasia initiatives only after the election had taken place, (although the report containing its proposed Act had been sent to the Minister of Justice last November, long before the elections which took place in June 99.)

At the outset it must be noted that the investigation into this matter by the SALC was instigated by SAVES - The Living Will Society (South African Voluntary Euthanasia Society) in an attempt to embody in our law the practice of "mercy killing".

We also note the absence of any mention of "Passive Euthanasia" in the proposed Bill as well as its failure to define certain essential terms and methods which are used in the discussions of Euthanasia or Mercy Killing. Nor has the report or the accompanying proposed Bill attempted to consider the normative standards of good medical practice in the care of terminally ill patients.

Accordingly before our evaluation of the definitions provided by the SALC in its proposed Bill, we provide such a list of terms and standards of good medical practice in the care of patients in order to clarify the concepts and to clear up the various confusions that have arisen in considerations of the matter of Euthanasia and thereby to put the proposed Bill into perspective.

Pro Life's listing of methods and terms used in euthanasia

A patient may be euthanatized by:

1 "Active Euthanasia" an action or a series of actions intended to kill the patient.

2. "Passive Euthanasia" inaction or withholding or withdrawing help, care or assistance from a patient with the intention of causing his death.

"Voluntary euthanasia" is used for two different situations in which a patient is euthanatized:

a) Voluntary passive euthanasia is used for that form of killing when a doctor withdraws life-sustaining treatment from a patient in conformity with a patient's wishes, i.e. the doctor kills the patient by an act of omission.

b) Voluntary active euthanasia is used for that form of killing when the doctor takes a deliberate action, (i.e. a positive action) for example by lethal injection, to kill a patient at the patient's request.

In "Voluntary Euthanasia" the doctor murders the patient, and the patient commits suicide.

Involuntary euthanasia is also used for two different situations in which the patient is killed:

a) Involuntary passive euthanasia is applied to that form of euthanasia when a doctor kills a patient by withdrawing or withholding life sustaining measures without the patient's request.

b) Involuntary active euthanasia is applied to that form of euthanasia when a doctor actively kills a patient (i.e. by a positive action) - for example by a lethal injection without the patient's asking to be so killed.

In "Involuntary Euthanasia" the doctor murders his patient.

"Assisted suicide" is applied to that form of killing when a doctor assists or enables a patient to kill himself, i.e. to commit suicide. This can be accomplished in many ways, for example by providing the patient with the drugs, poisons, or apparatus, which he uses to kill himself. Dr. Kevorkian uses carbon monoxide gas for this purpose.

In "Assisted Suicide" the patient commits suicide, and the doctor is an accessory to murder.

A common method of euthanasia is that in which ordinary forms of medical treatment are withdrawn from a patient in order to kill him. In "Passive Euthanasia" the doctor acts to withdraw ordinary, non-burdensome treatment, from a patient who is not imminently in the dying process, with the intention of killing him. A particularly cruel method of euthanasia is that which causes a patient to die of thirst or starvation by withholding or by withdrawing fluids and food from him.

When we use the word murder as applied to euthanasia, we use it as it is still used in current law and as used in the various cases mentioned in the report. (In all of the cases that the SALC have put forward as examples of "voluntary active euthanasia", the accused were all charged and tried for murder, and in all but one case they were convicted of murder, notwithstanding the light sentences imposed on them.)

We do not use the word murder to heighten the emotive tone of the debate but to indicate in no uncertain terms that euthanasia is a form of murder. Murder is the deliberate killing of an innocent human being, irrespective of the way in which he is killed or of his "quality of life"; irrespective of the euphemisms that are used to disguise this killing; and irrespective of the fact that the motive is one of compassion. Among the various euphemisms used to disguise the reality of this intentional killing are; "euthanasia", "termination of life", "death with dignity", "aid in dying", "the elimination of suffering", and "helping to die well", "managed death", "playing God".

Principles of good medicine (Provided by Pro Life)

For a doctor to withhold treatment from an individual who is irreversibly in the imminent process of dying is not euthanasia.

The withholding of futile, excessively burdensome and heroic treatment from a patient who is dying is fully in accordance with good medical practice. However ordinary care and attention, must be given to every patient, including those irreversibly in the imminent process of death.

Obviously it is common sense to disconnect respirators and other apparatus and to stop all treatment when a patient is dead. The problem arises in the way that death is legally defined. In medical terms, death is clearly defined as the total and irreversible cessation of circulation, respiration, and brain function. The cessation of the function of the cortex of the brain is not brain death unless there is also death of the "vital centres" situated in the brain stem which control respiration, circulation and temperature.

It is not an act of suicide if a patient refuses to submit to excessively burdensome or heroic treatment. Furthermore it would be immoral for a doctor to force a patient to undergo treatment entailing excessively burdensome measures.

There is however an obligation on all to preserve their lives and health as best they can. There is therefore a moral obligation to submit to ordinary, non-burdensome, non-heroic treatment in order to preserve or restore health, or to ameliorate the complications and effects of illness and disease. The doctor is therefore also morally obliged to encourage the patient to undergo this kind of treatment.

Pro Life evaluation of the definitions in SALC's the proposed euthanasia Bill.

Pro Life notes with astonishment that despite the many comments from members of the public and various organisations, including those from Pro Life, concerning these very matters, that the SALC persists in using

imprecise terms and definitions in Section 1 (1) of its proposed *"End of Life Decisions Act".* We say persists, because the imprecision of these terms, and the danger to human life embodied in these imprecise terms, was earlier brought to the attention of the SALC by Pro Life in our two very extensive written submissions to the SALC on this matter. We made these submissions in response to the SALC's invitations to do so. Is not the South African public entitled to far greater precision on such an important issue and thus have some of their uncertainties allayed?

We wish to draw your attention to some of these imprecise terms that the SALC uses.

'intractable and unbearable illness' means an illness, injury or other physical or mental condition, but excluding a terminal illness, that-

(a) offers no reasonable prospect of being cured; and

(b) causes severe physical or mental suffering of a nature and degree not reasonable to be endured.

It must be pointed out that many diseases are incurable, although very few conditions and diseases are untreatable. To effect a cure is very different indeed from treatment which allows a patient to continue to live a reasonable life. Diabetes Mellitus is an incurable disease at present as is Coronary artery disease and the damage to heart muscle resulting from the arteries of the heart being blocked. The inclusion of mental diseases opens the way to patients suffering from psychoses, for example, such as Schizophrenia, and Manic-Depressive illness, or intractable Depression to be eliminated by "mercy killing". Downs syndrome results in incurable physical and mental conditions. Also in whose opinion is the degree of suffering to be classified as not "reasonable to be endured" and to be endured by whom, the patient, the family, the medical insurance company, the health care providers?

'life-sustaining medical treatment' includes the maintenance of artificial feeding;

"Life-sustaining medical treatment" **is not defined by the SALC except by classifying *"artificial feeding*" as being part of such treatment. By failing to define "life-sustaining medical treatment", the SALC has permitted almost any treatment whatsoever, including the most simple and routine medical treatments such as the administration of simple antibiotics as a treatment that can be withheld from a patient.**

Also, by classifying the ordinary basic humane actions of giving food and water to a patient as *"life sustaining medical treatment"* the SALC normalises the killing, by dehydration and starvation, of patients who are unable to feed themselves and who are fed by such simple means as a naso-gastric tube or a gastrostomy. Those patients who could be eliminated in this way include premature children and handicapped children and adults who are unable to swallow on their own or who have obstructed gullets or intestines.

'palliative care' means treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene;

We note the very limited view of palliative care embodied in this proposed Act. For example the basic essential function in palliative care of maintaining the satisfactory state of hydration and nutrition of the patient has been omitted, again opening the way to the "mercy killing" of patients by dehydration and starvation. We note also that in Section 7(1*), "palliative care"* is described as that *which "may contribute to the hastening of a patient's death"*. Why is this not included in the definition?

'terminal illness' means an illness, injury or other physical or mental condition that-

(a) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or

(b) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.

We note the very loose and imprecise use of the term *"untimely death"*. Some sort of time factor must be implicit in the term "*terminal illness"*. It is a fact that from the time of conception all human life is progressing towards death. In addition any illness whatsoever is capable of causing the *"untimely death"* of a patient. For example such extremely common conditions as diabetes mellitus, hypertension, arteriosclerosis, and being diagnosed as HIV positive will or may themselves cause the "*untimely death"* of patients. Also in modern medicine it is always possible to relieve the suffering of a patient and it can be confidently said that any patient who experiences "*extreme suffering*" is not being treated properly or adequately by the doctor responsible for his treatment. Pain relief even to the point of total anaesthesia is possible, however adequate control of pain is invariably possible.

2.(1) For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -

(a) the irreversible absence of spontaneous respiratory and circulatory functions; or

(b) the persistent clinical absence of brain-stem function.

(2) Should a person be considered to be dead according to the provisions of sub-section (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.

We note that the SALC would consider that a patient who is not breathing on his own and whose circulation is sustained artificially, yet has a fully functioning brain stem is dead. This is a fatal blunder. A patent is only dead when his brain is dead as well as having no circulatory or respiratory functions. Pro Life has pointed this defect out to the SALC in our submission to them of 11 July 1997 when we advised them that the definition should read as follows:-

*(a) the irreversible absence of spontaneous respiratory and circulatory functions; **and** (instead of or)*

(b) the persistent clinical absence of brain-stem function

But besides the SALC's defining death in this unscientific and illogical way of defining death, they then state that it is permissible to withdraw all forms of treatment from a "dead" person. Obviously the reason that they are obliged to do so is to allow doctors to withdraw treatment from patients who still have a functioning brain and accordingly are not dead. Could this situation be used to obtain or to "harvest" organs from patients who are not clinically dead? Is this the SALC's intention?

Clearly in order to satisfy their needs to promote euthanasia they are obliged to define death as they have done.

3.(1) Every person -

(a) above the age of 18 years and of sound mind, or

(b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian,

is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

It is of concern that the proposed Act will allow a child of 14 years of age the right to forego any life-sustaining medical treatment. In fact a child of that age is not even permitted in terms of South African Law to take part in sexual intercourse, the law considering such a person to be incompetent because of immaturity to take part in such activity. Yet here the law is to grant to such children, assisted by his or her parents or guardian, the right to commit suicide if they should so wish. Simply astonishing!

Option 2.

5.(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request if he or she is satisfied that-

(a) the patient is suffering from a terminal or intractable and unbearable illness ;

(b) the patient is over the age of 18 years and mentally competent;

Here we note that the SALC stipulates that a patient must be over the age of 18 years in order to ask the doctor to kill him or to provide him with the means of killing himself by suicide. However in 3 (1) the SALC considers that anyone over the age of 14 years is competent to precipitate his death by Passive Euthanasia, i.e. by refusing any treatment whatsoever for any illness whatsoever from which he may be suffering. We ask why the SALC has decided that in the case of "Passive Euthanasia" a patient of 14 years of age is competent to bring about his death, yet in the case of "Active Euthanasia" where he asks the doctor to kill him or where he asks the doctor to provide the means for him to kill himself, the patient must be at least 18 years old. What is the rationale for this bewildering contradiction? Could it be that the SALC feels that "Passive Euthanasia" is less morally serious, thereby allowing 14 year old patients to decide in favour of <u>being killed by neglect</u>, whereas the SALC considers Active Euthanasia to be a more morally serious matter and therefore the extra 4 years of maturity are required before deciding to kill themselves by swallowing drugs and poisons prescribed by the doctor or to be killed directly by the doctor. Has it escaped the mind of the SALC that patients killed by both Passive and Active Euthanasia are equally dead?

This section facilitates the killing of patients by doctors and of the doctor's co-operating with the patient in killing themselves by providing them with the means to do so, a process known as "assisted suicide". This is rejected by Pro-Life as being totally against all principles of morality and medical ethics and principles, particularly the fundamental medical injunction "First do no harm".

Option 3

Decision by panel or committee.

In this section the SALC offers Parliament the option of allowing committees or panels to facilitate "Mercy Killing". Pro-Life totally rejects this option.

The bureaucracy that would be entailed in the formation of "ethics committees" would be impossible to install and to maintain. Who would pay the members of such committees, especially the legal and medical practitioners? What credibility could be given to family members or home language persons? How would conflict be resolved? If there were no consensus who would have the casting vote? This practice could give rise to an appalling degree of corruption and malpractice.

<u>Advance Directives</u>.

Section 6 deals with advance directives.

The SALC ignores the possibility that a patient, despite having signed an advance directive some time before his present illness, possibly 40 or more years previously, would, if able to do so in his present illness, have chosen for the doctor to treat him fully and not to withdraw or to withhold essential life sustaining medicines and treatment and certainly not to withhold fluids and food from him. The fundamental problem of an advance directive is that it makes no provision for a patient to change his mind, should he happen to be unconscious or otherwise unable to communicate his wishes to the attending doctor.

Besides there is no need for advance directives in the management of patients who are irreversibly in the process of dying and when death is imminent. It is only good medicine not to administer drugs to a person who is irreversibly only hours away from death. It is not good medicine to prolong the dying process. In addition, advance directives restrict the freedom of the doctor to treat the patient as he would see fit and the implementation of such directives would frequently result in the premature death of the patient. The SALC does not clearly delineate the legal status it requires for "advance directives", nor does it specify any guarantee against wrongful use of these directives by the agents enjoying power of attorney. What if these agents could at the time they are invoked enjoy benefit from the death of the principal?

None of these important matters are considered by the SALC.

7.(1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-

(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and is therefore unable to make or communicate considered decisions concerning his or her medical treatment or the cessation thereof;

We draw the attention of the public to the fact that in this section the SALC implicitly acknowledges that in its view *"palliative care"* entails and permits the premature killing of the patient. However we must also point out the incorrect use of the word therefore as underlined and marked in bold type in (a) above. It does not inevitably follow that a patient with a terminal illness is therefore not able to communicate his views. He may well not be able to do. Also here in this section as well as in other sections in which the phrase *"terminal illness"* is used the lack of clear definition by the SALC of what a *"terminal illness"* is, opens the way for a very wide interpretation by the doctor and thereby may hold serious risks for the patient so classified. The patient is at the mercy of the doctor's interpretation of what constitutes a "terminal illness", and it could well happen that as a result of personal evaluative bias by the doctor, patients not actually terminally ill, may be incorrectly defined and managed as such, much to their serious risk, and being bought to their premature death.

8.(1) *If a medical practitioner responsible for the treatment of a patient in a hospital, clinic or similar institution where a patient is being cared for, is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his or her opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him or her and who is competent to submit a professional opinion regarding the patient's condition on account of his or her expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.*

This section permits a doctor with the assistance of a colleague to kill any patient by neglect, dehydration and starvation, who in their opinion is in a state *of "terminal illness"*. Again we point out the potentially lethal consequences of the SALC's astonishing failure to clearly define a *"terminal illness"*.

Right throughout this grossly flawed proposed legislation, the killing of a patient by so-called *"passive euthanasia"* is proffered by the SALC to the public as a sound and legitimate form of medical "treatment" as if it were beyond any moral question whatsoever. It is only when the issue of *"active euthanasia"* is under consideration that the SALC shows some hesitation and then offers certain options in its proposed Act to members of Parliament.

Powers of the court

***9.**(1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.*

(2) A court shall not make an order as contemplated in subsection (1) without the interested family members having been given the opportunity to be heard by the court.

(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who have expert knowledge of the patient's condition and who have treated the patient personally or have informed themselves of the patient's medical history and have personally examined the patient.

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not thereby incur any civil, criminal or other liability whatsoever.

This section permits a court to order the cessation of medical treatment.

There is no definition whatsoever of who or what an interested person might be. 9(1) Could it be the hospital staff, the physician in charge, the Department of Health, the Medical Aid Society or even a family member anxious to get rid of the burden of care or to benefit from the death of the person concerned?

Concerning 9(2) above, we observe that while the family of the patient will be given an opportunity to object to the "mercy Killing" of their relative, it seems that the court may disregard their wishes. Clearly what would arise in such a situation is that the State could allow the death of a patient by euthanasia against the wishes of his family. Furthermore a doctor who kills a patient contrary to the pleas of the family *"shall not incur civil criminal or other liability whatsoever".* **We find this provision ominous and sinister in the extreme.**

If the doctor in attendance on the patient is in conscience against euthanasia, could the court commission another doctor to expedite the killing of the patient and what would be the first doctor's obligation to protect his patient from being killed?

Interpretation.

The following is found in Section 12 (1) of the Constitution: "Everyone has the right to freedom and security of the person which includes the right-(d) not to be tortured in any way; and (e) not to be treated or punished in a cruel, inhuman or degrading way." And 27 (1) "Everyone has the right to have access to-(b) sufficient food and water."

Has the SALC considered its promotion of the killing of patients by thirst and starvation as found in this proposed Act in the light of the above mentioned sections of the Constitution, especially in the case of a non-competent patient? Incidentally in this connection we do not find any definition of what constitutes a competent person in this document.

We note that Justice Thirion in Clarke v Hurst, (the legal case that the SALC has apparently set great store by), would apparently not find that the deliberate killing of an incompetent patient by cutting off his oxygen supply, by starvation, by dehydration or by injection, to be wrong if society does not think so. Thirion stated as follows: ***"But now, if it would be reasonable for the applicant in the present case to discontinue the artificial nutritioning of the patient knowing that such a step would result in the death of the patient, why would it not be reasonable for someone to simply suffocate the patient to death? The deprivation of food would as assuredly kill the patient as the deprivation of oxygen. I think the distinction is to be found in society's sense of propriety - its belief that things should happen according to their natural disposition or order*****. It is clear from this statement that Justice Thirion considered the action of killing a patient by means of starvation to be acceptable because the public would see such a form of killing a patient as being concordant with a natural death. Clearly the SALC in its proposed Bill also hold this view that to kill a patient who is suffering from a so-called and poorly defined** ***"terminal"*** **condition by starvation**

or thirst is fully acceptable. Obviously the SALC holds the opinion "that society would accept the euthanasia of a patient dying a slow death by starvation or thirst but would not accept the much quicker method of killing a patient by a lethal injection because of the greater propriety of the first method!"

We aver that the doctor is called to be a healer, not a killer. The law should protect citizens, irrespective of their adverse circumstances, from being murdered by their doctors. Furthermore we assert that no method of deliberate killing is compatible with the vocation of medicine or with a civilised society.

We ask if the statement that a doctor is not obliged to act against his conscience will protect such doctors from all civil, criminal or other liability? What positive protection will be afforded to such doctors?

And we ask, what legal protection does a doctor have who refuses to perform active or passive euthanasia in the case of an advance directive or of a request from a patient or the family, or who contravenes a court order in this matter? He refuses on grounds of conscience. Is he, like his euthanatising colleague, really free from all liability, whether criminal, civil, or disciplinary? What protection for such doctors is written into the proposed Bill? We have found none. For example will a doctor who refuses to withdraw food and fluid from a patient, be protected from civil claims brought against him by the relatives of the patient, the medical benefit society, or the medical insurance company, or by the court who all may want the patient dead.

We also note that the SALC implicitly assumes that the law should have the power to dictate the ethical norms of the medical profession and the disciplinary action taken by the profession against doctors who ignore such ethics. Does this mean that the SALC proposes that South African Law should disregard the Hippocratic Oath, and the various declarations of the World Medical Association?

The SALC's requests for submissions by the public on the issue of Euthanasia (1994 and 1997) seem to have been merely smokescreens to camouflage the obvious intentions of SALC and certain pro-euthanasia elements in Government and civil society, such as the South African Voluntary Euthanasia Society (SAVES) intent on achieving the passing of a euthanasia law, which we note, that should it be passed would be the most "progressive" Euthanasia law in the world. The many *caveats* introduced by the SALC as procedures and guidelines, will most likely never in practice be adhered to, and in our view are offered by the SALC merely to obscure the central moral issue that Euthanasia is murder, and to draw the minds of people through a labyrinth of "protective measures", to make the basic immorality of Euthanasia to appear to be less immoral.

Pro Life totally and unhesitatingly rejects as seriously flawed from a legal point of view and intrinsically immoral the Proposed Bill *"To Regulate end of life decisions and to provide for matters incidental thereto",* to be called the *"End of Life Decisions Act",* which was submitted by the SALC to the Minister of Justice during November 1998.

Pro Life strongly urges all persons of good will concerned with the standard of morality in our country to reject in toto this sly and tawdry attempt to impose mercy killing on South Africa and to do it via a decision of Parliament, (in the same undemocratic manner that the legalisation of the killing of unborn children by the Choice on Termination of Pregnancy Act was forced on us) while ignoring and by-passing the democratic views of the South African public on this crucial moral issue.

Submitted on behalf of Pro Life on 2nd August, 1999,

by

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