The proposed bill on euthanasia and comments by Doctors for Life (in Italics):

Issued: Fri 1999/10/01

The bill is quite different to the July press release by the Law Commission. We have found the Law Commission to be less than honest when they stated in the press release that "As regards to active voluntary euthanasia, the Commission does not make any specific recommendation". We find the recommended legislation under Option 2 to be very specific indeed. This deviousness, which is most obvious in section 5, seems to indicate an attempt by the Law Commission to dupe the media and the public as to the real intentions of the euthanasia bill.

*This euthanasia bill is based on the same principles as the German T4 program, which was condemned as a crime against humanity at Nuremberg: 1) They also allowed active euthanasia if the patient himself shall "earnestly and expressly" ask for it. 2) They also allowed his "nearer relatives" to ask for it "in case the patient is no longer able to express his desire". 3) They also allowed it for "incurable" (terminal) conditions but 4) They even demanded a second opinion by **two** experts (the South African legislation only demands one) who would carefully trace the history of the case and personally examine the patient.*

The bill legalises Physician Assisted Suicide (PAS) and active euthanasia. Even if the clauses legalising active euthanasia and PAS would be removed, there are numerous loopholes built into the legislation starting right from the beginning with the definitions. The South African Law Commission (SALC) has also re-defined traditional concepts in medical practice and given it a completely new meaning.

BILL

To regulate end of life decisions and to provide for matters incidental thereto.

To be introduced by the Minister of Justice

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:

Definitions

1. (1) In this Act, unless the context otherwise indicates-

'competent witness' means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no benefit;

'court' means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;

'family member' in relation to any person, means that person's spouse, parent, child, brother or sister;

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

The term "intractable and unbearable" is ridiculously inclusive and vague.

(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**.

This is a very broad definition. It covers all incurable illnesses such as manic-depressive illness, schizophrenia and intractable depression. It says that mental suffering equals physical suffering. Diabetes or hypertension qualifies, since they are not curable.

*How much suffering is "**not reasonable to be endured**"? Who's yardstick of "**not reasonable to be endured**" is used – the patient's, the doctor's, the family's and/or society's? It is so idiosyncratic as to be useless. One cannot believe somebody could expect this to help anyone care for patients appropriately and the potential for abuse is astronomical!*

'lawyer' means an attorney as defined in section 1 of the Attorney's Act, 1979 (Act 53 of 1979) and an advocate as defined in section 1 of the Admission of Advocates Act, 1964 (Act 74 of 1964);

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

*What is "**artificial feeding**"? Does this mean "artificially administered nutrition"? If the patient can't feed themselves orally, is that artificial feeding?*

Food and water (hydration and nutrition) does not fall under medical treatment. Even healthy people need food and water. We do not believe there is the danger of, artificially keeping a terminally ill patient alive indefinitely, simply by providing food and water. (With this we are not referring to intravenous food and nutrition but food and nutrition via a naso-gastric tube or gastrostomy). Would the conscience clause in section 10 also apply here?

'medical practitioner' means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

'nurse' means a nurse registered as such in terms of the Nursing Act 50 of 1978 and authorised as a prescriber in terms of section 31(14)(b) of the proposed [South African Medicines and Medical Devices Regulatory Authority Bill];

Could this possibly also include Traditional Healers with the new developments which are being considered by the Health Professionals Council and which may also register them as "medical practitioners" ?

'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;

*It should be stated clearly that **palliative care** does **not** include active euthanasia and PAS. The reason being that some people have lately been redefining the term "palliative care" to include PAS and active euthanasia.*

'spouse' includes a person with whom one lives as if they were married or with whom one habitually cohabits;

'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

*This has been poorly defined. Many chronic diseases will also **"inevitably cause untimely death"** – e.g. diabetes, coronary heart disease, hypertension etc.*

The definition of "untimely" is open to all sorts of interpretations.

***"Extreme suffering" –** what does that mean? Is that the doctor's opinion or the patient's opinion? Is it physical or mental suffering? **"extreme suffering"** has nothing to do with determining a terminal illness and, not having some time frame for the "untimely" death is ridiculous.*

This is amongst the most vague and broad language used in euthanasia legislation.

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

*The definition of "**Persistent Vegetative State/condition" (PVS**) as a terminal illness is **a major departure** from medical understanding and practice. To call them terminally ill opens the door to the wholesale termination of lives.*

Conduct of a medical practitioner in the event of clinical death

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.

***"Brain-stem function" –** This is the liberal definition of death and follows British practice only. The rest of the world prefers the "whole brain" definition because it is possible for a patient to have a severe brain stem infarct (a stroke involving the brain stem) with the preservation of some cortical 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.

Mentally competent person may refuse treatment

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.

More vague language. How is a 14-year-old "assisted by his or her parents"? Does this mean the parents make the decision alone or must both agree? Who has the legal right to refuse treatment?

(2) Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.

There is not enough clarity whether the conscience clause at the end of the law would also apply to this part of the legislation. It should at least have been repeated here to make sure that the doctor is protected against being coerced into taking part in a suicide.

(3) Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.

(4) Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made.

Conduct of medical practitioner in relieving distress

4.(1) Should it be clear to a medical practitioner or a nurse responsible for the treatment of a patient **who has been diagnosed** by a medical practitioner as suffering from a terminal illness that the dosage of medication that the patient is currently receiving is not adequately alleviating the patient's pain or distress, he or she shall -

(a) with the object to provide relief of severe pain or distress; and

(b) with no intention to kill

increase the dosage of medication (whether analgesics or sedatives) to be given to the patient until relief is obtained, even if the secondary effect of this action may be to shorten the life of the patient.

(2) A medical practitioner or nurse who treats a patient as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his or her conduct in treating the patient, **which record will be documented and filed in and become part of the medical record of the patient concerned.**

We do not understand the need for this section of the legislation. Firstly, there is no way to be certain of the doctor's intention except if he does not stick to the prescribed dosages – in which case one can refer to existing literature and do not need special legislation. One does not have to remind a brain surgeon that a double-effect risk of brain surgery could be the death of the patient. When double effect is spelled out in this manner for doctors interested in euthanasia, in other words interested in accomplishing the second effect – death, the implicit purpose appears to be to encourage them to practice "terminal sedation" as spelled out by the US euthanasia advocacy group "Concern for Dying". Secondly, in practice this (the second effect of killing a patient when trying to relieve pain) never happens if it is done properly. The permissible practice is to titrate up the dosage of the drug to try to achieve pain relief. In the words of Dr. Gary Lee, expert in pain control: "We don't see respiratory depression in patients not on the brink of death already, unless the intent is to cause respiratory depression. Where it becomes euthanasia is when one causes these effects earlier than when they would occur in the natural process".

*An example of the loophole that this piece of legislation offers, happened in America where a doctor ordered the nurse to "titrate to effect", the pain medication in a patient that was **not** having pain. When she refused, he simply wrote in the chart that the patient **was** having pain and incrementally increased the dosage of the morphine till the patient stopped breathing in order to cover his tracks as he killed the patient. The same could happen under this law in South Africa and who would know? Looking at the chart it would look like good pain care and unfortunately a double effect.*

The whole law is based on the supposition that ALL doctors will act honorably and competently (not make any fatal mistakes) both of which have odds somewhere along the likely hood of Durban getting half a meter snow in the middle of December.

Active voluntary euthanasia

Option 1:

No legislative enactment

Option 2:

Cessation of life

Nowhere in the world has euthanasia been controlled successfully through legislation.

As was shown earlier, the German T4 program also started off with certain criteria which had to be adhered to. These safeguards did not help however. It was doctors who started and ran the program. Within a short time the second doctor was rubber stamping as many as 100 applications and hour. Within a short while they emptied two third of the beds in mental institutions. They first used injections, but when it was to slow they built gas chambers. The first gas chamber to be used by the Nazis some years later, was dissembled at a mental hospital and re-assembled at a prison camp. 1939 were killing disabled soldiers. They had gone from killing the suffering and terminally ill (1920) to killing criminals (1933) to killing the mentally ill, the aged and disabled "weaklings"(1935) to genocide (1939).

*Neither did similar safeguards help in Holland. Holland went from active voluntary euthanasia for the terminally ill (1973) to active voluntary euthanasia for the chronically ill (1982) to Non-voluntary euthanasia of people in old age homes (1985) to infanticide of new born children with Down's syndrome (1989) to euthanasia for mental suffering (1994) **to no penalty for not sticking to the criteria/safeguards (1997)** and are now considering voluntary euthanasia for minors above 12 years of age.*

*Safeguards are also not working in Oregon. At first Oregonians were promised that euthanasia would only be practiced within a long-term, meaningful relationship between a doctor and the suicidal patient. The family doctors of the **very first two** women to be euthanised in the USA refused to do it. The general practitioner of the one woman actually diagnosed her as suffering from depression. The women called the Hemlock Society, which simply referred them to doctors who were willing to administer the lethal drugs, despite having had no long-term relationship with the patient. What her personal doctor diagnosed as depression, the medical director of Compassion in Dying dismissed as mere frustration.*

***Coercion into euthanasia is too subtle to control**. The Santa Rosa Press Democrat reported an interview with a 84 year old woman who said the following: "when I started losing my hearing about three years ago, it irritated my daughter. She began to question me about financial matters and apparently feels I won't leave much of and estate to her…. She became very rude…Then one evening (she)said she thought it was okay for older people to commit suicide…So I sit, day after day, knowing what I am expected to do"*

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-

This section again has no conscience clause. It needs to be clearly stated that a physician who cannot morally or ethically participate in these actions has to be able to refuse. There can not be any obligation for anyone to go along with this.

a. the patient is suffering from a terminal or **intractable and unbearable illness**;

As mentioned before, this safeguard was also used in Germany – they called it an "incurable" disease.

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

(c) the patient has been adequately informed in regard to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;

(d) the request of the patient is based on a **free and considered** decision;

Cliff jumpers also make "free" and "considered" decisions, that does however not change the fact that they, like the suicidal patient, are displaying emotional trauma.

(e) the request has been repeated without self-contradiction by the patient on two separate occasions at least seven days apart, the last of which is no more that 72 hours before the medical practitioner gives effect to the request;

This is the shortest waiting period we are aware of. Both Oregon and Holland require at least 14 days.

(f) the patient, or a person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;

(g) the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;

Who has the right to sign on behalf of the patient?

(h) an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner as contemplated in this section does not share or understand the first language of the patient;

i. **ending the life of the patient or assisting the patient to end his or her life,** is **the only way** for the patient to be released from his or her suffering.

The only way out in whose opinion? The doctor's who is killing the patient, the patient's or other doctors'?

*The cliff jumper thinks theirs is the only way too, that does not mean it is so. Obviously, before the law goes into effect, people with the same illnesses who are hospiced and not euthanised prove that euthanasia is **not** the only way. We do not believe that there is ever a situation where euthanasia is the only way out.*

(2) No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless **he or she has conferred with an independent medical practitioner** who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (i).

Experience in Holland has shown that the doctor simply chooses another doctor whom he/she knows is in favour of euthanasia, as the second independent practitioner.

*This clause is a reason for grave concern if you look at what subsection (1)(a), (b) and (i) say. This does not even say that the first medical practitioner must tell the other that euthanasia is being considered. It does not say when the consultation has to take place. If the patient has seen **any** other doctor for a chronic illness who may not even agree that the patient is incompetent but just says that there "is nothing more we can do" for any of the symptoms (parasthesia in a diabetic's legs, chronic intermittent angina, intermittent severe migraines which are resistant to therapy) then, with the vague wording of this section, the patient would qualify for euthanasia.*

(3) A medical practitioner who gives effect to a request as contemplated in sub-section (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.

(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act provided that all due procedural measures have been complied with.

Holland has proven the folly of holding killing doctors to "procedure".

What this says is that if the paperwork is okay, the doctor is totally absolved. He could miss the diagnosis and the patient is not terminally ill. He could botch the euthanasia and leave the patient with another disability and he couldn't be prosecuted. The family could say the patient was depressed and treatable but they could not sue for wrongful death or damages. The doctor gets to serve as both judge and executioner. This law strips the

medical licensure of their right to cancel licenses even if Dr. Kevorkian moves to S.A. and opens a clinic. Dr. Kevorkian couldn't be terminated from membership or have his privileges withdrawn by any medical society or facility as long as he followed the "procedure" correctly. With good paperwork, nothing else is considered.

An article in the Australian medical journal recently reported that in Holland, doctors form "consulting pairs" where, in over 90% of the cases, the second doctor agrees that the patient should be killed. If a doctor sends patients to a doctor that frequently disagrees with them on the diagnosis or treatment course they think is the right course, what does the doctor do? Of course, he starts sending his patients to a doctor that agrees with him/her.

(6) If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above may, at the patient's request and in the presence of the patient and both the medical practitioners, sign the certificate on behalf of the patient.

There seems to be a real possibility that the witness and the two doctors could conspire to kill the patient without his consent. If the law requires two witnesses to formulate an advance directive, why does it not require two here as well? The two doctors are likely to speak as one and one can imagine situations where there may be secondary gain for them to be able to kill patients as they please. Two physicians could certainly find a witness who would agree to "witness" the request if they could benefit from the patient's death.

(7) (a) Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state.

(b) Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.

(8) The following shall be documented and filed in and become part of the medical record of the patient who has been assisted under this Act:

(a) a note of the oral request of the patient for such assistance;

(b) the certificate of request;

(c) a record of the opinion of the patient's medical practitioner that the patient's decision to end his or her life was made freely, voluntarily and after due consideration;

(d) the report of the medical practitioner referred to in subsection (2) above;

(e) a note by the patient's medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the substance prescribed.

Option 3: Decision by panel or committee

Cessation of life

5.(1) Euthanasia may be performed by a medical practitioner only, and then only where the request for the euthanasia of the patient has been approved by an ethics committee constituted for that purpose and consisting of five persons as follows:

a) two medical practitioners other than the practitioner attending to the patient;

b) one lawyer;

c) one member sharing the home language of the patient;

d) one member from the multi-disciplinary team; and

e) one family member.

(2) In considering and in order to approve a request as contemplated in subsection (1) the Committee has to certify in writing that:

a) in its opinion the request for euthanasia by the patient is a free, considered and sustained request;

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

c) euthanasia is the only way for the patient to be released from his or her suffering.

(3) A request for euthanasia must be heard within three weeks of it being received by the Committee.

(4) (a) The Committee which, under subsection (2), grants authority for euthanasia must, in the prescribed manner and within the prescribed period after euthanasia has been performed, report confidentially to the Director-General of Health, by registered post, the granting of such authority and set forth -

(i) the personal particulars of the patient concerned;

(ii) the place and date where the euthanasia was performed and the reasons therefore;

(iii) the names and qualifications of the members of the committee who issued the certificates in terms of the above sections; and

(iv) the name of the medical practitioner who performed the euthanasia.

(b) The Director-General may call upon the members of the Committee required to make a report in terms of subsection (4) or a medical practitioner referred to in subsection (1) to furnish such additional information as he may require.

(5) The following shall be documented and filed and become part of the medical record of the patient who has been assisted under this Act:

(a) full particulars regarding the request made by the patient;

(b) a copy of the certificate issued in terms of subsection (2);

(c) a copy of the report made in terms of subsection (4).

This third option appears to be more vague than the others. Does it take a majority vote of the committee, a unanimous opinion or what? Where does the committee come from - who chooses them? It is called an "ethics committee" but who convenes it - the healthcare facility, the doctor who wants to euthanise the patient, the family or the patient him/herself? If the committee says "no", then what? Can the patient re-apply? Is there an appeal process? Who runs the committee? Who pays them? Are they volunteers? Do they only serve for that one case or are they a standing committee who rotates family members onto the committee? In short, having a panel decide appears to be a vain attempt to introduce further safeguards that won't really make any difference.

All it really does is to introduce a (probable) rubber stamp into the process without significantly affecting the outcome.

Directives as to the treatment of a terminally ill person

Living-wills/advanced directives are supposed to be a positive antidote to overzealous doctors keeping a patient alive by rendering undesired treatment. In principle we cannot find any fault with that. One wonders whether, with the present financial climate of the country and the workload of health professionals, the danger is not greater that desired treatment will be withheld.

The only choice discussed here, is the termination or withholding of life-saving treatment. This is a common trend. (Some living wills may offer the option of demanding life-saving treatment, but makes it more difficult e.g. If your decision is to fight for life it gets complicated and often you must create your own detailed treatment instructions. If on the other hand your choice is non-treatment one only need to tick in a box on the page.)

*The option for accepting care should however also be made available and easily accessible. The patient may well request that all appropriate medical treatment be given and such a directive should be followed just as closely as one limiting medical treatment. Take note also, that the power to withhold treatment is not restricted to withholding "extraordinary care", such as ventilators to assist with breathing, but "**to any medical treatment"** – from not treating a curable bacterial infection to withdrawing food and fluids.*

Experience in the United States have also shown that Health Professionals often appear to be confused about the legalities of a living will leading to the denial of care for people with treatable conditions as in the tragic case of Martha Musgrave.

6.(1) Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted or any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.

This is a very concrete promise! This implies that a young person with a recent high spinal chord injury which requires ventilation support, will not even have a trial of vent support for several weeks to make sure he/she is not depressed and to help him/her learn what the rehab potential is, before making an irreversible decision. It has happened in the USA that patients/family members wanted to change living wills after an accident/sickness, but were considered incompetent and starved to death.

(2) A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally

ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.

(3) A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.

(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator.

*This is the start of third-party euthanasia. It accepts the "**standard of substituted judgment**", where the family or guardian can decide as they/he would have expected the patient to decide. This principle has not held in American courts. The only time when a relative or guardian can decide is when the patient him/herself has explicitly stated before what their wishes would be under such circumstances. What about cases where the family member/guardian has a vested interest in the death of the patient, like being able to inherit from the patient?*

Conduct in compliance with directives by or on behalf of terminally ill persons

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; and

Terminal illness does not equate with mental competency but that is what 7. (a) says. The "therefore" should not be there. Secondly, the right to refuse medical intervention should not be based on whether the patient is terminally ill. The bio-ethical principle is based on the right of autonomy. In other words, if I say I don't want penicillin for my pneumonia and my doctor forces it on me, that is assault whether the doctor injures me or not. It would be no different than me kidnapping someone and bringing them to South Africa, even if it was for a vacation. I don't have the right to force someone to do something against their will unless I have been given that authority by law (e.g. a government drafting men into the army, a policeman arresting someone for breaking the law, etc.)

> (b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition because of his expert knowledge of the patient's illness and his or her examination of the patient concerned.

(2) Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.

(3) Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested family members of the patient of his or her findings, that of the other medical practitioner contemplated in paragraph (b) of subsection (1), and of the existence and content of the directive of the patient concerned.

What will the doctor do if one family member disagrees? Does this mean that there must be a unanimous vote? Who would qualify as "interested members? Are they spouse, children, grandchildren, cousins, uncles aunts, patents or who?

(4) If a medical practitioner is uncertain as to the authenticity as regard to the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.

> (5) (a) A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and the manner in which he or she implemented the directive.
>
> (b) A medical practitioner as contemplated in paragraph (b) of subsection (1) shall record in writing his or her findings regarding the condition of the patient concerned.

(6) A directive concerning the refusal or cessation of medical treatment as contemplated in sub-section (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might hasten the moment of death of the patient concerned.

Conduct of a medical practitioner in the absence of a directive

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.

(2) A medical practitioner as contemplated in subsection (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the interested family members of the patient, unless authorised thereto by a court order.

(3) A medical practitioner as contemplated in subsection (1) shall record in writing his or her findings regarding the patient's condition and any steps taken by him or her in respect thereof.

(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.

This is one of the most frightening sections. It allows for unilateral decision making by physicians, without requiring consent for withhold or withdraw actions! The mild caution in 8.(2) is ridiculously inadequate to prevent abuse ("if such conduct would be contrary to the wishes" is pitifully weak) This places WAY too much independent power in the hand of physicians who may not always be acting in the patient's best interest, particularly in a society that may be recognising killing as an acceptable part of medical care! Once again, there is a presumption that killing the patient (or allowing him to die) is the right thing to do UNLESS EVIDENCE EXISTS TO THE CONTRARY!

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.

According to the definition of "medical treatment", given at the beginning, the court will have the right to starve a patient to death. This section states that the court (the arm of

the state) can over ride the wishes of the family and withdraw care from the terminally ill patient (which is not well defined because all of us are "terminally ill" if there is no time limit). If the patient is in a coma and has an ill defined "terminal illness", the state can withdraw medical support/treatment even if the family refuses permission. Since South Africa has a socialised medical system, isn't there a conflict in interest here? It would be like having medical insurance companies decide whether a patient's medical support should continue. Doesn't the payer have every reason to withdraw care in order to save funds? How do you hold the government liable? One can't hold the doctor liable with this law because he is only an "agent of the government".

It seems as if SA is trying to find any option that would authorize a radical change in medical practice. It is particularly troubling when there seems to be a presumption that the decision should be to limit care or to kill the patient. In the court section, the family gets the "opportunity" to "be heard" by the court, but seems to be placed in the position of having to defend a decision to continue treatment. This is not so subtle coercion!

(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.

Interpretation

10. The provisions of this Act shall not be interpreted so as to oblige a medical practitioner to do anything that would be in conflict with his or her conscience or any ethical code to which he or she feels himself or herself bound.

Finally in section 10 we seem to find the necessary conscience clause! It is almost buried in the short title section and only if someone has the strength to wade through all the illogical. What about nurses? Would they be forced to participate? What about pharmacists? Would they be obliged to assist e.g. by supplying drugs with which to commit suicide?

Short title

11. This Act shall be called the End of Life Decisions Act 1999.

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IN THIS LAW THERE IS NOT:

1. A PRECISE DEFINITION OF TERMINAL ILLNESS.
2. REQUIREMENT FOR A WITNESS TO THE PATIENT'S WRITTEN REQUEST.
3. ANY PENALTIES FOR NOT FOLLOWING THE LAW OR NOT REPORTING.
4. NO REPORTING OF AGGREGATE DATA FROM THE GOVERNMENT TO SEE IF THIS "GRAND EXPERIMENT" IS WORKING

5. NO FUNDING OR PROMOTION OF HOSPICE OR OTHER ALTERNATIVE CARE. IT IS NOT EVEN MENTIONED AS A DESIRABLE THING.
6. NO DEFINITION OF COMPETENCY
7. NO EXAMPLE OF WHAT AN ADVANCE DIRECTIVE SHOULD LOOK LIKE OR WHAT A LEGAL ONE WOULD CONSIST OF. ARE WITHNESSES REGQUIRED.
8. WHAT WILL HAPPEN WITH INSURANCE POLICIES IF THE PATIENT REQUESTS DRUGS TO KILL THEMSELVES? IS IT SUICIDE WHICH MOST POLICIES SAY THEY ARE WON'T PAY BENEFITS FOR?
9. IS REQUESTING EUTHANASIA SUICIDE IF THE DOCTORS GIVE THE INJECTION?

This legislation, if passed as is, will be the most liberal in the world. It is more liberal than Oregan because:

A. A waiting period of only 72 hours as compared to the 14 days of Oregon.
B. Does not define mentally competent
D. No safeguards against coercion by a family member, doctor, health facility personnel or third party payer.

E. No reporting or oversight requirements and no listing of penalties for failure to comply. Who is going to know if this new law works or not?
F. Allows active voluntary euthanasia. Even Oregon doesn't go this far.
G. Allows court mandated active non-voluntary euthanasia for incompetent patient's if any "interested" person requests it. What a great way to open up needed beds in nursing home facilities!

Like Oregon
A. It doesn't require a psychiatric exam to rule out depression.
B. It doesn't require family notification.
C. Doctor just has to have perfect paper work. He is indemnified from all liability even if he misses the diagnosis or messes up the suicide. The family cannot sue the doctor who kills their loved one. He just has to write in the chart that the patient requested it, get another doctor to agree (In Holland, doctors find doctors who will agree with them and refer these cases to them) and document it. The patient is dead and the family has no recourse even if the doctor coerced the patient into it.

It is also more liberal than Holland (according to the law books) because it is still not legal in Holland, even though in practice it is tolerated.

<u>In summary</u>: The law appears to indicate that the writers presume that (1) patients want to die and to die quickly (2) society wants them to do so as well (3) even if they don't recognize that they really do want to die, we know that they really do want to (or at least ought to want to!) and (4) al physicians will agree with this presumption!

The supposed safeguards are inadequate and dangerous. Each is subject to interpretation (e.g. terminal illness, competent, prognosis, considered decision etc.) There is no specific addressing of depression, though some would argue that it is presumed under "competent". Yet it is so prevalent, so easily overlooked and so treatable.

It should also be repeated that the following associations have rejected active euthanasia: The British Medical Association, The American Medical Association, The Nursing Association of America and the American Psychiatric Association.