Physician-assisted suicide and voluntary euthanasia — a response

I wish to thank Dr Hampton[1] for contributing to an important public debate on physician-assisted suicide (PAS) and voluntary euthanasia (hereafter 'euthanasia') by responding to my editorial.[2] He voices an important concern, shared by many people, about the slippery slope, namely that well-intentioned legalisation of PAS and euthanasia would lead to wrongful killing of the vulnerable. The Editor of the *SAMJ* must be congratulated on making space available in his columns for this purpose.

I claim that the moral case for legalisation of PAS and euthanasia is more 'compelling' (p. 868[2]) than the alternative. If that is what Hampton means by my 'attempting to seize the moral high ground',[1] then I concur. That Hampton and others are not persuaded is not surprising, since a conclusive argument in heavily value-laden issues such as these is not always possible. The fundamental question is this: which position best accounts for both patient autonomy and patient well-being (best interest)? I think a pro-PAS and euthanasia view does, but I take opposing arguments very seriously. Legalising PAS and euthanasia would take important decisions about terminal illness and enduring unbearable suffering (induced by pain or distress) out of the twilight zone of guilt and fear of criminal prosecution, creating the space for taking these decisions in a compassionate and dignified manner.

My argument is crucially dependent on the recognition of the primacy of patient *autonomy* or *self-determination*. Autonomy requires *informed consent*, which is given by an individual *competent* to choose for PAS or euthanasia, and whose choice is both *voluntary* (free from coercion or undue influence) and based on adequate *information* (about matters such as diagnosis, prognosis, and effectiveness of pain management).[3] Given this autonomy requirement, it is regrettable that Hampton invokes examples that would not

be condoned by my analysis. Let me spell it out: if anyone with Down syndrome, amyotrophic lateral sclerosis, Alzheimer's disease, clinical depression or any other disease does not meet the requirements of informed consent, PAS and euthanasia would not be ethically permissible. (An advance directive which makes provision for conditions brought on by, for example, amyotrophic lateral sclerosis or Alzheimer's disease may meet the requirements of informed consent once the patient is no longer competent.) Likewise, by no stretch of the imagination could 'I needed the bed' be grounds for euthanasia.

Hampton makes much of *non-maleficence* (doing no harm), but some might find his position excessively paternalistic, assuming that others know better what constitutes a harm for me. There may be tragic situations in which from the patient's perspective death no longer constitutes a harm, but rather a benefit. Note that autonomy and non-maleficence are linked: when patients autonomously request PAS or euthanasia, they freely decide what is a harm to them, even though, tragically, that may be continued life. In short, Hampton's view that non-maleficence, as judged by others on behalf of the patient, has blanket primacy over autonomy opens the door for paternalism that may be both oppressive and cruel. Nothing in my analysis undermines the basic imperative not to harm; on the contrary, I contend that overzealous insistence on continued life may constitute a greater harm.

Where there is inadequate public health care to protect the vulnerable, one must be especially vigilant so that what becomes legal is carefully circumscribed and governed by stringent procedural guidelines. Hampton justifiably demands that I spell out such guidelines, a task for a separate publication. They would relate to determinations such as the following: whether the patient has a terminal illness or endures unbearable suffering; whether a decision is neither coerced nor unduly influenced by third parties; whether a choice is based on all the relevant information; whether there have been two separate requests with time in between for adequate reflection, consultation with family and friends ('assisted suicide' may be a more accurate term than 'PAS') and counselling; and whether two physicians have independently certified these determinations. I would not routinely involve the courts in these determinations. For me, too, one single death without consent would be one too many. But to imply that the present *status quo* alternative is free from abuse is simply not true. And there would have been even more misery if compassionate physicians did not already do what is illegal.

It is sad, indeed paradoxical, to link my support for PAS and euthanasia, grounded in both autonomy and well-being, and underpinned by stringent procedural guidelines, with the Biko killing. PAS and euthanasia, properly administered, are modes of ending life filled with compassion and regard for human life which is terminal or made unbearable by enduring suffering (as in the moving case of Diane presented by Quill[4]). Biko requested neither PAS nor euthanasia but died in the most brutal circumstances while detained *against* his will. If I am correct in understanding that Hampton honestly believes that, were PAS and euthanasia legalised tomorrow, they would hasten the death of at least a thousand patients in circumstances of unspeakable cruelty, I too share his concern for the future of medicine in South Africa. Finally, it seems to cheapen the rhetorical and historical power of the Biko killing, an incident that should inspire moral outrage, by equating it to an issue, like PAS or euthanasia, upon which reasonable people of good will can and do disagree. (As a student leader in the early 1970s, I met with Biko when it was still frowned upon to do so. In the month he died I publicly objected to the government's complicity in his death. For these personal reasons, too, I find the linkage between Biko's death and my argument unfortunate.)

Hampton is wrong to see pain-relief care, on the one hand, and PAS and euthanasia, on the other, as mutually exclusive. In my analysis I stress the crucial importance of hospice care, pain relief and palliative care as a constant background condition. However, it is a fact that there is suffering, induced by pain or distress or both, that is unmanageable, and I do not think physicians should be placed in a position where they are prohibited by law from acting in their patients' best interest. I am unfamiliar with any published medical literature on the willingness of managed care providers to fund euthanasia. However, if such practices are both ethical and subject to rigorously applied guidelines, then it would be no worse to profit from them than from funerals or cremations.

Hampton claims that the majority of South Africans consider killing unacceptable, adding that the Constitutional Court attaches such value to human life that it proscribes putting a murderer to death. Apart from newspaper reports that many South Africans support the death penalty, a number of constitutional rights would seem to support the constitutionality of PAS and euthanasia, rendering Hampton's implied analogy with the death penalty invalid. A submission to the Law Commission suggests '. . . that forbidding such practices [PAS and euthanasia] would be unconstitutional on the grounds that it would violate the right "to freedom and security of the person", and specifically the rights "not to be deprived of freedom arbitrarily or without just cause" and "to . . . control over their body". Moreover, on a technical point, the Constitution speaks of a right to life, but not of a duty to live. Given their conceptual logic, rights may be waived. If continued life is no longer in somebody's interest, that person should be free to waive that right to life.'[5]

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