The ethics of physician-assisted suicide and euthanasia

In attempting to seize the moral high ground in the debate on the ethics of physician-assisted suicide and euthanasia, Professor Landman[1] suggests that personal autonomy or individual self-determination is the overriding ethical principle and implies that death is a therapeutic option in cases of uncontrollable and dehumanising suffering. This would represent a major ethical shift in a profession whose first principle has been to do no harm. In an article broad in

generalisations but short on specifics, Landman reveals a lack of understanding of the therapeutic alternatives, particularly in relation to pain relief and the terminally ill. It is implied that the only alternatives in this situation are sedation to the point of death or euthanasia. There have been major advances in the treatment of pain in the terminally ill that offer these patients adequate analgesia with retention of the capacity to relate to those around them. Euthanasia is the ultimate form of therapeutic nihilism in this situation, and it would be a more positive use of resources to concentrate on the provision of adequate pain relief rather than the easier option of euthanasia. It is worth noting that managed health care providers in the USA, who are sometimes less than willing to fund useful treatment, have expressed willingness to pay for euthanasia.[2] Their motives are obvious. The combination of poor ethics and profit incentives leads to bad medicine.

Landman suggests that it would not be responsible to euthanase a young person with a family because of depression; does he then imply that it would be reponsible in an older person with no family responsibilities? I have recently experienced just such an episode in an elderly relative who might have taken that option at the lowest point of his depression. I am relieved that his physicians persevered with his treatment, and after a long and emotionally draining time he has returned to his life. In Landman's brave new world he might not have, my children would have been deprived of a grandparent, and he would have been robbed of the rest of a productive life.

The issue of what are termed dehumanising diseases, such as Alzheimer's disease or amyotrophic lateral sclerosis, is a complex area. Landman implies that an intact peripheral or central nervous system is essential to the definition of humanity; this seems to me to be highly restrictive, and excludes from humanity an uncomfortably large group of people. Is Down syndrome a dehumanising disease, for example? These diseases present almost insurmountable problems in the area of consent: if patients' autonomy is the central issue and they cannot communicate, who will speak for them?

Landman states that in a multicultural democracy, a particular group has no right to impose its views on another. There is broad agreement among all groups in this country that killing is not acceptable. It is not even necessary to invoke God in this debate, as an atheist with any moral sense will support this position. This country has a bitter history of not assigning sufficient value to the lives of others. If we are to have any hope of breaking free from this history, we need to resist anything that further devalues life. The constitutional court articulated this in its decision on the death penalty, stating that no murderer is so without value that he deserves death.

Landman accepts that poor judgement and error could lead to problems, having attempted to suggest that the documented cases in Holland where patients have been euthanased without consent, and at least one case with an expressed refusal, do not represent a major difficulty with his argument. One single death without consent represents a major problem to me; if the statement 'I needed the bed' does not chill him, it should.[2] Landman has a faith in undefined guidelines, safeguards and monitoring that would be touching if it were not so out of touch with reality. These were all in place when Steve Biko was arrested; the collusion of ethically deficient doctors and a coercive state led to consequences that are not yet resolved. I hope that we do not have to repeat the experience. The ethically challenged and politically correct should not define how we practise now, as the State and the ethically defective should not have then. The only thing that stands between us and thousands of cases like Biko's is an agreement on time-honoured ethical principles that does not allow us intentionally to harm or to terminate a patient's existence.

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1. Landman W. The ethics of physician-assisted suicide and euthanasia (Editorial). *S Afr Med J* 1997; **87:** 866.
2. When death approaches do we have last rights? *Sunday Independent* 1997; 29 June: 19.

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