

EUTHANASIA – MIDRAND SEPTEMBER 2011

Madam chair, fellow panellists, ladies and gentlemen: Thank you for inviting me to take part in this seminar.

I am sure that every one of us is motivated by a compassionate desire to limit the suffering of dying people in our land.

But as a doctor, I am filled with trepidation about the idea of including euthanasia in the package. Why am I concerned?

To lobby for euthanasia will be a departure from 2400 years of ethical wisdom in medicine. It was about 400 BC that Hippocrates first had doctors swear: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."

Jewish, Christian and Islamic physicians agreed with this stand, citing God's 6th commandment: "You shall not murder."

Acceptance of the sanctity of human life has been an essential pillar of the practice of medicine every since.

It is this ethic which underpins their sacrificial service, which allows us to trust our doctors. It is commitment to the sanctity of human life, which gets an exhausted doctor out of bed in the middle of the night to work hard to save a life. Medical practice as we know it is impossible without it.

You just have to look at examples of nations, which have debunked that ethic to test the truth of that statement.

In the 1920's, German physicians led the campaign, which allowed euthanasia for terminally ill men and women.

And by 1939 the government was practicing genocide.

In Alexander's 1949 report on the Nuremburg War Crimes Trials in New England Journal of Medicine he wrote:

"... it became evident to all who investigated that (the Nazi crimes) had started from small beginnings. It started with the acceptance of the attitude that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the number of those included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted, and finally, all non-Germans. It is important to realize that the infinitely small wedge - the lever from which this entire trend of mind received its impetus - was the attitude toward the non-rehabilitable sick."

But surely the Nazis were a special case?

Well, consider the fully researched case of Holland, a nation whose people suffered so gallantly to save Jews from the Nazi death chambers.

In 1973 a physician gave a lethal injection to her mother, and that event sparked a strong campaign to legalise euthanasia.

In 1981 criteria were promulgated for voluntary euthanasia for people with terminal illnesses.

In 1982, criteria for voluntary euthanasia were extended to include people with chronic illnesses.

Good research shows that doctors are very poor at correctly judging the quality of life of their patients. Yet since 1985, Dutch doctors have been making value judgements on patients' lives and killing them without their permission. Reporting of cases is very erratic, but in reported cases of euthanasia in 1996, 56% of the patients had been killed without their consent. You will appreciate that doctors are less likely to report cases when they have broken the rules that when they have obeyed them!

Doctor assisted suicide has been allowed for mental suffering in Holland since 1994. So now, doctors are assisting depressed people, who have a treatable condition, to commit suicide. One doctor helped a young woman in her early 20s to kill herself because she was depressed as she could no longer dance. Her feet had been damaged. When challenged, he could only reply, "We do not like doing this kind of thing, but that was her request."

Now 16 year olds may legally make a decision for voluntary euthanasia without parental consent.

By 1997 it became clear that there are no penalties for not obeying the rules because the whole issue in Holland is so muddled, both legally and ethically where doctors are concerned.

Holland has since lagged seriously behind other European nations in its delivery of terminal care.

Dutch doctors receive some of the best training in the world, yet in palliative care so many now fail the ethical tests of respecting the patients' autonomy, of avoiding malfeasance and of acting justly. They practice the worst forms of paternalism.

Holland has a good judiciary and police service. Yet many people carry cards in their wallets instructing that they should not be killed by a doctor if hospitalised. They no longer trust their medical fraternity,

Now, we South Africans do not live in a stable country like Holland or Switzerland. We live in a fragile democracy with a recent history of a low intensity civil war. Many of our people are very poor and angry. We also have deep racial and political divisions, with their associated continuing violence. In those respects we are a bit like Germany in the 1930s.

In addition, we have serious problems with the management of health care, policing and justice.

We are not even able to police our abortion legislation properly. Our courts can only obtain a 2-4% rate of successful prosecution of our vast numbers of rape cases.

There is not the slightest possibility of our policing legislation for any sort of active euthanasia, and it will be impossible to confine it to well structured "havens" if it is made legal in this country.

Given our present political instability, there is a real chance of its being turned into an instrument of oppression.

In these circumstances, the introduction of doctor assisted suicide will carry in its train large numbers of wrongful deaths, a vast amount of litigation within families, and a tide of grief for a nation already overwhelmed by grief because of HIV, broken homes, and violence.

It will be another powerful influence tearing at the throat of good patient care in situations in which ethical standards are already low.

Then I must challenge the almost unopposed use of the concept of autonomous individuality as a basis for decision-making in end of life decisions. It is essential that we also

fully embrace the ethical principle of doing no harm to other family members.

Every decision for voluntary euthanasia will inevitably draw others into it. Spouses, siblings, children, grandchildren, friends must be free to grieve a death without having their grief subverted by a decision for doctor-assisted suicide, if they are to grieve freely and healthily.

Assisted suicide will seriously interfere with the grieving process of very many people, especially teens and young adults. Subverted grief will manifest as denial, diffuse anger, self-contempt and depression – emotions which can be destructive of others and of self.

The incidence of suicide amongst teens especially, is already a significant public health issue in our country.

With active euthanasia, we will be adding deaths by a well researched process of “suicide contagion” – later suicides which follow one which has occurred in a family or peer group. This is all very well documented in relation to abortion.

It will happen with doctor-assisted suicide as well, because young people especially have an intuitive, God-given sense of the sanctity for human life.

All this evidence suggests that the introduction of doctor-assisted suicides, even in “havens”, will add to other suicides, adding grief to grief for the families concerned.

One argument advanced for the introduction of doctor-assisted suicide is that suicides are common amongst patients who are terminally ill. In fact the incidence of suicide amongst terminally ill people is low, making up only 2-4% of cases of suicide in a number of large studies from the US, UK, Sweden and Australia. And good hospice care is an excellent medical intervention to prevent such suicides. In a major study, 97% of terminally ill patients who were suicidal, had changed their minds about ending their lives within a couple of weeks, when they were given such care and support. There are few medical interventions which are as good as that.

Finally, it is essential that medical staff be protected from ambivalence in their work, so that they can always concentrate on the tasks of saving life, and providing excellent care for those needing it.

Ambivalence in medical care is a serious issue for the patient!! If euthanasia is legalized, it will be a whole lot easier for a doctor to learn that you do not need to try too hard to save life in difficult and exhausting clinical situations - that it is OK to give up.

The author of a report in a major American Medical Journal concluded: “Most patients expressing a desire to die want to know whether they are still worthwhile. So often, the suicide request is really asking the question, “Does anyone care?” The worst thing doctors can say in such a situation is to agree that physician-assisted suicide is a ‘good’ option.”

Death with dignity is only possible if the relational, existential and spiritual issues at the end of life are addressed – such things as offering and receiving forgiveness, or having time for a family to gather around a dying member to celebrate their lives and affirm their worth. Encouraging a rapid escape from facing these issues by doctor-assisted suicide implies defeat, not dignity.

The objective of good hospice care is death with integrity. That allows the patient to reach for wholeness. That brings dignity, and it is greatly to be preferred.

I consider the introduction of doctor assisted suicide in RSA would be a disastrous mistake.

We should not try to give to doctors the power our society refuses to give to judges and courts.

Dr Jon Larsen September 2011