the old students of St Peter's Roman Catholic seminary, and in the very blunt reactions by the same group to the remarks reported to have been made by Cardinal McCann of Cape Town in a somewhat unfortunate press interview he had in Australia on the occasion of the Pope's visit there in December 1970.

These seem to me to be the three factors that will govern political developments in South Africa in the seventies. I will try to analyse them, and examine some possibilities of development in a subsequent article.

The 'Good Death' versus 'Euthanasia"

by Hugh Trowell

We pray for a good death and a perfect end in every service of Compline. When is death (*thanatos*) good (*eu-*)? Every man must answer this according to his definition of goodness. Does goodness depend merely on the absence of pain in the sufferer or of grief in the spectators? Death is such a negative subject that to make it good one must see some positive content of love, compassion, even bravery and perhaps immortality set around it, within it and beyond it. Only then is death *euthanatos* (the good death).

Dictionaries define euthanasia as 'gentle easy death', but euthanasia is a euphemism which like a shroud hides the reality. When the sprightly old lady died in her sleep no one would call it euthanasia, but it is. If a man had a stroke and sank slowly and gently without pain to death in a couple of days and the doctor gave only one brandy, no one would accuse him of assisting euthanasia. But the dictionary would.

All dictionaries proceed to give a second meaning to euthanasia, which has killed the first meaning by 'gentle and easy death'. Hence some of the muddle. Euthanasia, we are told, may mean 'bringing about death, especially in painful and incurable disease' (Concise Oxford Dictionary). It must be emphasized that euthanasia means bringing about a death. It is the killing of a person. It should never be called murder, which is too emotive a term, while manslaughter is too cold and implies an accident and a lack of intent. There is however an intention to kill in every euthanasia.

Voluntary euthanasia implies that an adult person has requested to be killed. Involuntary euthanasia implies that the person made no such request—as occurred to millions under Hitler. The (British) Voluntary Euthanasia Society has never supported involuntary

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euthanasia; it has supported only voluntary euthanasia among adults. People sometimes argue that a dog owner mercifully takes his dog to be put down, so why treat a human being differently? Two points emerge: firstly, human beings do not have an owner, they must decide for themselves; secondly, my own dog never ran down the road to the vet wagging his tail! For dogs the argument must be about involuntary euthanasia.

There are at least four different categories of persons for whom voluntary euthanasia could be contemplated. Most people envisage only the first category.

(*A*) *Terminal stage of incurable painful physical illness.* Some feel that voluntary euthanasia might be permissible in the terminal stages of severe physical illness. Death is then inevitable and appears near.

Doctors then give large doses of sedatives and analgesics so that the patient is often asleep much of the time. It is permissible to give a dose of sedative sufficiently high to control the pain, even if this does slightly shorten life—something that no one could ever prove. It is not permissible to give an enormous dose, deliberately set very high, because here there would be a decision to terminate life. This would require a dose very many times the normal dose; it would be euthanasia.

As patients may be heavily sedated in the terminal stage doctors see no reason then to terminate life.

(*B*) *Earlier stage of serious physical illness.* The Voluntary Euthanasia Bill (1969) would have permitted euthanasia at an earlier stage of serious physical illness, if two doctors, one being of consultant status, certified that a person had a serious physical illness, reasonably thought in the patient's case to be incurable and expected to cause him severe distress. Let us consider one example. A man feels he is fit but develops several mysterious bruises, he consults his doctor and is referred to a consultant from whom he learns that he has a severe variety of leukaemia. With modern treatment he may live say two to five years; he will probably suffer little severe pain. The consultant says it is incurable, the patient is very distressed at the prospect of dying early in life with declining powers. This person would have, under the Voluntary Euthanasia Bill, a right to ask at once for euthanasia.

(*C*) *Non-fatal physical disease.* The Bill allowed people who suffered great distress from an incurable physical complaint to request voluntary euthanasia. There was no need for the complaint to be progressive or fatal, although these points would, of course, be borne in mind by the consultant and the doctor who assessed the man's illness. An amazing number of chronic complaints fall into this category; chronic neurological disease, such as a stroke, and certain chronic skin diseases are obvious examples.

(*D*) *Those whose mental faculties are seriously impaired.* The 'advance declaration' of the Voluntary Euthanasia Bill was designed to cover persons whose mental faculties were so impaired that they could no

longer volunteer as new applicants for voluntary euthanasia. If an application for euthanasia had been signed and re-executed within twelve months, during which time the person had all his mental faculties, then it remained in force (unless revoked) during his lifetime. This document expressly provided for the contingency that the person might develop a mental illness which might prove incurable and distressing and that he might lose his rational faculties and be unable to request the doctors to perform euthanasia. A consultant psychiatrist could then advise the physician in charge of the patient that the mental impairment was irremediable and distressing; the physician in charge could then administer euthanasia, if he too agreed.

It should be clearly recognized that the Bill respected the conscientious objections of doctors; no one would be under any compulsion.

There were thus at least four fairly distinct categories of patients who might have qualified for voluntary euthanasia under this Bill. In the House of Lords, where it was debated, forty votes were cast for the Bill and sixty-one against. Most of the discussion concerned those in category (A), the terminal stage of severe, incurable, painful physical illness. *Most doctors think that voluntary euthanasia refers only to this category.* Thus some years ago two national opinion polls found that about one third of the doctors said they would administer voluntary euthanasia if it were legalized. In my opinion they were never asked to envisage categories (B), (C) and (D).

Against this assessment of medical opinion must be set the results of asking some fifty-six London teaching hospital consultants in 1970 whether they favoured voluntary euthanasia. Only four favoured it. It seems likely that even they envisaged only category (A). Even the four who answered Yes were, like all the others, given the impression that there would be 'a special euthanasia referee who checks the proposal personally, the relatives being duly informed and given the time and opportunity to object'. It can be stated with the greatest clarity that the Voluntary Euthanasia Bill (1969), submitted one year before this questionnaire, has not one word at all about a special euthanasia referee, or about relatives being informed and given time and opportunity to object. There have been the most misleading statements about whether doctors would co-operate with voluntary euthanasia legislation.

A great deal of the agitation about voluntary euthanasia stems not only from great compassion, which is worthy of respect, but from a vague concept called the 'right to die'. There is even more muddled thinking about this cliché than about the whole matter of euthanasia. A cynic might say that it was apparently the only human right that was on no statute book yet was never denied. All men die.

Like the term 'euthanasia', the term 'the right to die' means different things to different people. It could form a charter between patient and doctor stipulating that the person hopes to die naturally

but does not wish the process of dying unnecessarily prolonged by medical means, especially by heroic, costly and difficult procedures. Doctors have recognized, especially in the past few decades, when their powers have been increased, that they should not prolong biological life indefinitely. It is the quality of personal life that is all important.

But to some, the right to die means the right to choose death as soon as it is known that an incurable complaint is present, or even when life appears insupportable and a misery. This euphemism, 'the right to die', covers another grim possibility. It means the right to be killed and for some other person, preferably a doctor, to do it.

It is sometimes asserted, incorrectly, that the Suicide Bill (1961) recognized the right of an individual to determine when life was insupportable. Previous to this Bill it had been a crime to commit suicide. Slowly it had been recognized that most persons who commit suicide were mentally ill with depression and were not fully responsible for their actions. It cannot be argued that the absence of legal sanctions against suicide is to be interpreted as supporting a right to suicide. Fornication is not illegal and a schoolboy might argue that he had a right to fornicate and facilities should be provided. It is not illegal for me to tell lies to my wife; woe betide me if I say I have a right!

The Suicide Bill (1961) recognized that the desire for death is usually a sign of mental disease and that the person should see a psychiatrist, who is often able to cure the depression and all desire for suicide. It is probable that the signing of a declaration in favour of euthanasia would, in certain persons, be one of the first signs of mental illness. Would it then be a valid petition of a fully rational person? One thing seems certain: if there is ever legislation in favour of voluntary euthanasia this argument will be produced by lawyers who will contest a certain euthanasia, possibly after it has occurred. Wills provide many legal battles; in this case the chief actor will be absent. Perhaps he made a mistake; in any case it proved to be a fatal mistake.

Possibly there are a few doctors who would co-operate with a request for euthanasia by a patient in the terminal stages of incurable painful disease. It would be the doctor who would prescribe the 'treatment', as the Voluntary Euthanasia Bill euphemistically called it. The initiative would remain with the doctor, just as it does in undertaking any other major treatment or surgical operation. Once concede as a fundamental or even a legal human right that a person may decide that he should be killed, however early in the illness, then the initiative has passed to the patient. The doctor then should co-operate, or, if his conscience forbids that, he is under an obligation to give the patient the name of some doctor who will collaborate. This procedure has been established in the working of the abortion law; a doctor who does not agree, by reason of conscience, should, many say, hand over the patient to one who does.

Those who advocate voluntary euthanasia are on the horns of a dilemma with regards to safeguards. Either they must make the safeguards so onerous (referees, documents, witnesses, consent of relatives, etc.) that they are impossibly heavy, as in the first Euthanasia Bill (1936), or they must make the safeguards so light, as in the Voluntary Euthanasia Bill (1969), as to lay the way open to serious abuse. Under this Bill there were no public referees to scrutinize documents, visit the applicant and confirm his request, no witnesses perhaps when the euthanasia was administered, it was not specified that the death certificate should be clearly marked, there was no provision that relatives must be informed or consulted or could appeal. If there were any appeal after the event would there be a post-mortem examination?

It must be accepted that those who support voluntary euthanasia have genuine cause for complaint. Many persons die slowly, far more slowly than they or their relatives can bear. Pain may be only partially alleviated, especially where resources of personnel are limited. Nausea can be very distressing, breathing may be very difficult. The community as a whole has devoted too little of its resources to this problem.

Those who support voluntary euthanasia are full of praise for a few institutions which care specially for those dying in great pain and distress, for much can be done if special efforts are made and the latest drugs are employed. Some of these institutions have a strong religious tradition and remain outside the National Health Service. It is important that they should be centres of teaching and research, for they contain patients who can seldom stay long in any of the teaching hospitals. What can be achieved in a few institutions could be multiplied. It is along lines such as these, rather than euthanasia, that the solution will be found.

Persons differ and every death is different from other deaths. Most adults recognize the fact that they are dying unless their faculties are dulled by disease, old age or drugs. Many do not seem to recognize the true state of affairs until a short period before death. Most seldom discuss the matter in any detail, but a deep understanding of the truth exists; it is deeper than words. A few persons of mature character insist on knowing all the facts well beforehand and sense any efforts at deception. Others definitely do not want to know, but some of these show eventually that they realized it but could never discuss it with those they love. Perhaps at an early stage the doctor was by no means certain, and the patient was hopefully or perversely blind. Some doctors evade a patient's question; perhaps the relatives are told but sworn to secrecy. This can lead to an unreal atmosphere around the death bed.

Most come to accept dying as a fact, even if they never speak about it. Relatives at all stages play a fundamental role and can offer great support. The patient and the relatives come to accept death as a reality, set within the hands of God. He gave life and he gives

death. It is all good; it can all be redeemed. There is a growing body of opinion in the Anglican Church that we should be thinking again about the Last Sacraments. This is an occasion when as a sacrament the Church unites its members to him who died the good death, *euthanos*, and with him we are one in the Eucharist. Thanks be to God.

Most religions have set their faces against any practice of voluntary euthanasia. This is true not only of Christians but also of Jews and Muslims. There have been, of course, some notable exceptions. Among Protestants individual churchmen have spoken in favour of a swift ending of the suffering in terminal cases of physical illness. Their number has been but few.

What can be said to those who own no religious allegiance? It is here that the concept of natural law appears so valuable. This article has deliberately omitted reference to religious objections; it has argued the case in terms of a consideration of compassion for the dying person. Those who support voluntary euthanasia appear to have little understanding of the complexities that surround fatal illness. Consideration is also due to the relatives, but they are locked in an impossible position of wanting the loved one and yet praying for a swift release. Few relatives would be equal to the task of assisting his suicide or even killing the loved one. Doctors find it abhorrent.

The Case for Voluntary Euthanasia

A Reply to Dr Hugh Trowell

by Benjamin Downing

Chairman of the Voluntary Euthanasia Society

Dr Trowell, with his usual kindness and wisdom, is keen to be fair to the supporters of voluntary euthanasia. Not for nothing is he an experienced physician as well as an Anglican clergyman. All the same some confusion, mixed with medical prejudice, does creep in. It is neither intellectually nor morally adequate to write, as he does, that 'there is . . . an intention to kill in every euthanasia'. That is about as adequate as asserting that death is always an unmitigated evil. Voluntary euthanasia situations are obviously complex, involving rights, judgments, duties and attitudes. They are not to be described in facile phrases.

Dr Trowell is concerned that there is much muddle over 'the right to die', but he does not really do much to clear it up. Since life obviously involves death there can be no conflict between 'the right to live' and 'the right to die', *pace* the British Medical Association in its recent pamphlet (January 1971) *The Problem of Euthanasia*, which

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