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The right to live: Legal aspects

INTRODUCTION

The law has the function of regulating society. It is also expected of the law to define exact moments in time, such as the beginning and end of human life. The precise moment of birth and death may have important consequences, not only for a lawyer giving effect to a will or a surgeon performing an organ transplant, but also for family members and friends.

Whilst the philosopher is concerned with the question of when life begins, it is more important for the lawyer to determine the stage at which the law commences, or should commence, to protect the human foetus or embryo, or even to regulate the use of sperm and oocytes which have the potential of becoming human beings.

The abortion debate, which has raged in many countries and reached its peak in South Africa in the late sixties and early seventies sparked renewed interest in the moment human life is initiated. (For a discussion of the common law position, and case law prior to the *Abortion and Sterilisation Act 2 of 1975*, see Strauss 1984:207-245). As much has been said on the topic of abortion and the sanctity of human life, it is not my intention to repeat all the arguments which have been feverishly debated over the years. Instead, a few specific cases of childbirth, involving moral, legal, ethical and religious dilemmas are examined. Advances in medicine and modern birth technology have created problems which have caught legal systems unawares, have initiated large-scale debates and have promoted many dissenting

arguments - not only amongst those directly involved, such as doctors, lawyers, and ethicists, but also amongst church groups, women's organisations, policy makers and the public in general.

1 CLAIMS OF 'WRONGFUL LIFE'

In a recent article (Schedler 1986:357-358), a professor in philosophy at the Southern Illinois University, U S A discussed the following incident:

Mrs A contracted rubella (German measles) in the first trimester of her pregnancy. A child with severe abnormalities was born. She alleged that her doctor had failed to inform her of the potential effect of the disease on an embryo, in which case she would have preferred to have had an abortion. She instituted a malpractice action against the doctor for compensation for pain and suffering, as well as for the recovery of general expenses. The attorney, acting on behalf of the child, also instituted an action against the doctor for so-called 'wrongful life' claiming medical expenses as well as damages for pain and suffering as a result of the child's defective existence.

I do not intend dealing with the question of informed consent and the general requirements for delictual liability of doctors, as much has been said and written on the subject. The wrongful life claim should, however, be considered in more depth. The term 'wrongful life', which is the subject of the present discussion, refers to the claim of a child - generally instituted by the parents - against a doctor or genetic counsellor for failing in his/her duty to inform the patient adequately of the possibility that the child may be born with abnormalities. It is averred that, had the mother known about such a possibility, she would have elected to have had an abortion, which is available in some countries on request, and in others if continuation of the pregnancy poses a serious threat to the health of the child or mother. (In terms of S 8 of the *Abortion and Sterilisation Act*, abortion is permissible if a serious risk exists that the child to be born will suffer from a physical or mental defect of such a nature that he will be irreparably seriously handicapped). The doctor is considered to have breached his duty towards the child, whose birth (and in some instances even conception) he should have prevented. It is therefore alleged that there was an omission or failure to act on the part of the doctor who, according to the plaintiff, was responsible for placing the child in a worse position than if he/she had not been born at all.

What we are dealing with here is the question of whether one has a right to be born as 'a whole and functional human being' (as mentioned in the Appellate Division of the Supreme Court of New York in the case of *Park v Chessin* 60 A D 2d 80.400 N Y S 2d 110 [1977] discussed by Schedler 1986:361) and whether nonexistence is, in certain instances, preferable to an impaired existence.

The first wrongful life claim of the kind discussed here, was heard and rejected by the New Jersey court in *Gleitman v Cosgrove* (49 N J 20 227 A.2d 689 [1976]). A decade later, a wrongful life claim was awarded by the New York supreme court in *Park v Chessin* (referred to above) in which the court recognised the right to be born whole and functional. This decision was, however, later rejected by the New York Court of Appeals in *Becker v Schwartz* (46 N Y 2d 401 413 N Y S 2d 895.386 N E 2d 807, 812 [1978]) on the ground that there was no precedent for the recognition of such a right. Cases followed in California,¹ Washington,² Illinois³ and New Jersey,⁴ where wrongful life actions were allowed, but in most cases, only extraordinary medical expenses were recovered and compensation for pain and suffering for a life burdened by birth defects was not allowed.⁵ In most instances the courts have avoided awarding compensation in the form of general damages, as they would then have had to compare an impaired childhood with a state of nonexistence - a comparison involving philosophical considerations which most courts would rather avoid.

In Britain embryos in utero are protected under the *Congenital Disability (Civil Liability) Act* of 1976. Section 4 of this Act provides that a child who has survived for 48 hours after birth has the right, under certain circumstances, to be awarded damages for injury done to it in utero. Wrongful life actions are not permitted under the Act (Puxton 1986:191). A wrongful life action was, nevertheless, instituted in the 1982 case of *Mc Kay v Essex Health Authority*. (1982 2 WLR 890. For a discussion of the case see Brownlie, S 1985:22; Louw, P F 1987:204-205). The British court rejected the claim and stated that the child has an action only if he/she would have been born normal but for the action of a third party and not if he/she would have preferred nonexistence to a handicapped life. Two of the judges also touched on the 'sanctity of life' argument. Stephenson J stated: 'It could not be suggested that the quality of her life is such that she is certainly better dead, or would herself wish that she had not been born ...' and Griffiths J stated: '... there should be rejoicing that the hospital's mistake bestowed a gift of life upon the child.'

In South African law the general rule is that legal subjectivity commences when a child is born alive. At that moment the child attains the capacity and status of a person and becomes the bearer of juridical competencies, rights and legal obligations (Boberg 1977:8-9; Van der Vyver 1980:92-93). There is, however, one exception to this rule by virtue of the so-called *nasciturus* fiction (*Nasciturus pro iam nato habetur quotiens de commodo eius agitur* - Digesta 1.5.7: Digesta 1.5.26), in terms of which legal protection can be backdated to conception when to do so would be to the benefit of the child, on the condition that the child is born alive (Barnard, Cronje & Olivier 1986:13). In terms of the *nasciturus* fiction, the court will allow a child who suffered injuries in utero, and is born handicapped as a result of the negligence of a third party, the right to sue for damages, provided negligence and causality can be proved (*Pinchin NO v Santam Insurance Co Ltd* 1963 [2] SA 254 [W]).

The South African courts have so far not had the opportunity to consider a wrongful life claim, although several South African writers have speculated on the possibility of success should one be instituted (Brownlie 1985:33; Louw 1987:202; Lupton 1982: 149-157; Strauss 1980:67-68; 1984:199; 1987:5). In the light of the manifest reluctance of our courts to encourage and broaden the liability of doctors, it seems unlikely that such an action will be successful in South Africa. Apart from the difficulty of establishing causality, failure to inform a patient adequately does not *per se* constitute negligence (Strauss 1984:324-325). Above all, sensitive policy issues are involved in calculating damages, for example, the comparison of a handicapped life with nonexistence. Our courts would most likely favour the attitude of the English court in denying that an unborn child has the right to be *born whole and functional*, and in refraining from burdening a doctor with the duty of preventing the birth of a handicapped child or compelling him/her to make a decision on the 'worth' of a human life.

Viewing wrongful life actions from a different perspective, the question may rightly be asked whether the human race, in striving for excellence, has become so consumer-orientated that it is applying to pregnancies standards similar to those it applies to consumer goods - accepting only the best and having little tolerance for any defects (Schaeffer & Koop 1980:55).

2 POSTHUMOUS ARTIFICIAL INSEMINATION

In the second example, the case of the Parpalaix couple, (discussed by Atherton 1986:380-383; Deutsch 1985:299; Current Topics 1984:627-628) dealing with posthumous artificial insemi-

nation or insemination after the death of the donor, a young French couple fell in love, only to discover soon afterwards that the male partner had cancer of the testicles. He was warned that the prescribed chemotherapy could result in his sterility. To ensure that they would still be able to have children, Mr P deposited sperm in a Government-run sperm bank. Soon after the treatment his health deteriorated rapidly and three days before his death the couple were married in a bedside ceremony in hospital. When Mrs P claimed the frozen sperm for artificial insemination, the sperm bank refused, on the grounds that sperm should not be considered an object returnable under a normal deposit arrangement to the next of kin of a dead depositor. Mrs P sued the sperm bank for the release of the sperm, but her claim was denied in the district court as the frozen sperm had not been specifically mentioned by the husband in his will. This decision was later overruled by three judges in a suburban court in Creteil, (Tribunal de Grande Instance de Creteil, Aug 1 1984 225/84) which ordered the release of the sperm. Mrs P was subsequently inseminated but apparently failed to conceive.

In 1984 there were no clear laws in France governing the legal and ethical problems raised by the case. Under Napoleonic law, however, a child born to a woman more than 300 days after her husband's death is considered illegitimate.

The most important questions raised by the case are the following:

- * Can one claim ownership to sperm and ova?
- * Should posthumous fertilisation (fertilisation after the death of a donor) be allowed?
- * Should there be a time limit on the freezing of genetic material?
- * Is a posthumously conceived child legitimate?

Although there have been no reported cases of posthumous artificial insemination in South Africa, such a case was reported in England in 1977⁶ and it would be interesting to consider the possible approach of South African law to the problems mentioned.

Gametes differ from other human tissue which may be donated or transplanted in the important respect that they contain readily utilisable genetic information - a gamete has the potential of becoming a human being (Jansen 1985:123-126). Although South African law does not recognise proprietary rights in a human body as such (Van der Merwe 1982:20; Strauss 1984:163-166), a person has the right to decide what to do with his/her body, tissues, organs or gametes after death, or once they have been removed from the body as long as it is not against public policy or

contra bonos mores and not in conflict with the provisions of the *Human Tissue Act* (No 65 of 1983). The donor's consent remains an absolute prerequisite for utilisation of human tissue or gametes (Strauss 1984:180). Utilising the frozen sperm of a man without his consent, either for the creation of an embryo or the fertilisation of a woman other than his wife - when that was the purpose of the storage - is reprehensible and should not be even contemplated by a responsible institution.

Artificial insemination and *in vitro* fertilisation are lawful procedures in South African law, provided they are performed in compliance with the *Human Tissue Act* (No 65 of 1983) as amended and the Supplementary Regulations (R 1182 GG 10283 20-06-86). The Regulations do not, however, address storage of sperm or embryos at present. Artificial insemination may only be performed by a medical doctor or someone acting under his/her supervision at approved premises and the recipient must be a married woman, whose husband has consented to the procedure (Reg 8[1]). If the husband dies before the artificial insemination, it is submitted that the widow is not a *married woman* in terms of the Act, as marriage is dissolved by the death of one of the spouses.

Another aspect which has to be taken into account is that the *Human Tissue Act* permits artificial insemination for *medical purposes* (S 19) only. Can artificial insemination, performed for sentimental reasons on a widow who is otherwise perfectly healthy and capable of producing children, be considered as insemination for medical purposes? The act itself provides no clear indication in this regard. Schutte (1986:76-77) believes that such insemination is not permitted by the Act, as the inability to procreate in the normal way is terminated by the death of an infertile husband. There is therefore no medical purpose in performing the artificial insemination. A doctor doing so can - theoretically, at least - incur criminal liability under the Act and the Regulations (S 34 and Reg 14).

A third aspect which must be taken into account is that the South African Medical Research Council (1987:32) has stated that the long-term freezing of gametes and embryos is not recommended - in any event for not longer than the expected reproductive life of the donors.

Although posthumous artificial insemination is not addressed directly in our law, it seems clear that the performance of artificial insemination is limited to *married women* and for *medical purposes* only. As a widow is not a married person in terms of the Act, she is precluded from being artificially inseminated with the frozen sperm of her deceased husband. For the same reason, artificial insemination of one partner in a

lesbian relationship is also prohibited. Furthermore, children born as a result of posthumous artificial insemination are illegitimate in our law, as the child's natural parents were not married to one another at the time of the child's conception or birth, or at any time between conception and birth (Van der Vyver 1980:102; Van der Vyver & Joubert 1985:203). The recently adopted *Children's Status Act*, No 82 of 1987, (GG 10974 published on October 14 1987) aimed at improving the status of illegitimate children in general - does not address the legitimacy of posthumous artificially created children and they are therefore still illegitimate. Section 5 of the Act provides for the legitimacy of children born by artificial insemination with donor sperm if the husband of the woman giving birth has consented to the procedure.

The present position of our law may adversely affect a woman requesting to be inseminated with her deceased husband's sperm. Society in general, however, is concerned that children should not be born long after the death of one of the spouses. Such births are as a rule actively discouraged, primarily as they may create immense problems in the field of inheritance and succession, as pointed out by the Warnock Commission (1984:par 10.9) in England, which investigated the social, legal and ethical implications of Human Fertilisation and Embryology.⁷ With the advances in modern birth technology and the possibility of freezing not only sperm and ova, but also embryos, new solutions must be found. In the rare cases of posthumous artificial insemination, a possible solution would be to permit it *only* if a specific request for the release of the frozen genetic material is made by the deceased in a valid will, and only within a limited time after the death of the spouse.

3 SURROGATE MOTHERHOOD

Since the birth of South Africa's first known surrogate babies - the Ferreira-Jorge triplets - in October 1987, surrogacy has become an increasingly controversial issue debated on moral, legal, ethical and religious grounds.

Surrogate motherhood as a new reproductive method - used in conjunction with artificial insemination or in vitro fertilisation - is utilised to alleviate the problem of infertility - a problem as old as civilisation itself. The despair often associated with infertility is captured in the desperate plea of Rachel to Jacob in the Old Testament of the Bible: 'Give me sons or I shall die!' (Gn 30:1). In our society children are often seen as a gift from God and it is therefore not surprising that the inability to have children is sometimes experienced as

punishment. Confirmation of infertility can be emotionally devastating for a couple and responses may vary from denial, isolation, anger, guilt and feelings of unworthiness, depression and grief, to acceptance (De Jongh van Arkel 1982:25-26; Wood & Westmore 1983:35-38).

The biotechnological revolution and the discovery of new and improved techniques for artificial reproduction have created hope for childless couples who, previously, could consider adoption as the only alternative method of obtaining a baby. In recent years, however, there has been a vast increase in the number of childless couples. According to a recent estimate, approximately 15% of all married couples experience infertility in some form (Andrews 1984:2; Cappucio 1985:93). A marriage is normally classified as infertile if pregnancy does not occur within a year of persistent trying. Infertility can be attributed to various factors such as genetic, physical or psychological defects, certain diseases, or as a result of surgery or environmental factors. Some forms of infertility can be cured, but unfortunately there are some couples for whom no cure exists.

With extremely long waiting periods for adoption and too few babies available, it is not surprising that alternative methods of conception are continuously being explored. Technological advances in reproductive techniques have contributed to making artificial insemination and in vitro fertilisation household words. Although the first artificial insemination was successfully performed as long ago as 1799 in England by John Hunter, and in 1866 by Marion Sims in the United States (Smith & Iraola 1984:263), in vitro fertilisation and paid surrogate motherhood are less than a decade old. The birth of Louise Brown in 1978 in England - the world's first test-tube baby - sparked renewed interest in modern reproductive technology. In vitro fertilisation and embryo transfer are increasingly performed in South African infertility clinics (Kruger 1986:593; Van der Merwe et al 1984:641), and in October 1987 the first known surrogate babies - the Ferreira-Jorge triplets - were born by utilising in vitro fertilisation and embryo transfer.

In a standard surrogacy agreement the surrogate mother agrees to be inseminated with the semen of the 'commissioning' or genetic father and undertakes to carry the baby to term and hand it over to the 'commissioning' couple at birth. This is sometimes referred to as partial surrogacy or surrogacy in its original form, which must be distinguished from complete or gestational surrogacy, where fertilisation takes place in vitro when oocytes (egg cells) of the 'commissioning' mother are fertilised with

semen of her husband or a donor in a glass dish in a laboratory. The fertilised egg is then transferred to the surrogate or host mother who undertakes to carry the baby to term and hand it over to the 'commissioning' couple at birth.

With all these modern technological advances, it is now possible for a child to have as many as five 'parents': the egg donor, the sperm donor, the surrogate who bears the child and the couple who raise it (Dalgety & Pryor 1986:25). It is even possible for a grandmother to bear a child for her daughter, as in the Ferreira-Jorge/Anthony case. In a recent American article by Lori Andrews (1985:29-31), a well-known Chicago attorney, journalist and author of a book on modern birth technology (Andrews 1984), the case of a 46-year-old divorced woman who married a 49-year-old childless widower was discussed. The couple wanted a family of their own and approached a University in vitro fertilisation programme with the suggestion that the divorced woman's 25-year-old daughter donate oocytes to be utilised in vitro with the sperm of her stepfather (the widower). As she herself was not prepared to act as a surrogate mother, the suggestion was that the embryo be implanted in a surrogate mother who would carry the baby to term. In this way it is possible for the child to be approximately 25% genetically related to the mother, although she herself was no longer fertile. She would then be both 'mother' and 'grandmother' to the child and her daughter would be both its 'mother' and 'sister'.

These examples merely illustrate that we have reached a stage where the traditional definitions of 'mother' and 'father', whether in the legal, medical, or sociological context, are no longer accurate (Wadlington 1983:465-514; Stumpf 1986:187-207).

The advantage of surrogate motherhood is that the waiting period is a normal pregnancy term - approximately nine months - as opposed to the long waiting period for adoption. The child is also genetically related to at least one of the 'commissioning' parents. Surrogacy may also be the only alternative for women who are completely sterile and who may be emotionally devastated by the discovery of their infertility. Many childless couples may have also completed a series of exhaustive infertility tests over a long period of time and request surrogacy as a final alternative to adoption.

It is difficult to ascertain the number of children born by utilising surrogate motherhood, but according to a recent estimate, the number is put at approximately 500 (Katz 1986:1). (Statistics obtained from Gelman & Shapiro, *Infertility: Babies by contract*. *Newsweek* 04-11-1985.) As with most technological advances, the law lags behind and at present we face the situa-

tion where surrogate babies may be born in a legal vacuum. Legislation directly addressing surrogacy exists in only a few countries and is in most cases unsatisfactory (Pretorius 1987b: 275-293 for an evaluation of British and Australian legislation). An example is the *British Surrogacy Arrangements Act* of 1985, aimed at prohibiting commercial surrogacy and the *Australian Infertility (Medical Procedures) Act* 1984 in Victoria which prohibits all forms of surrogacy. Since the much publicised 'Baby M' case in New Jersey, USA, approximately 26 American states have proposed legislation for the regulation of surrogacy (Andrews 1987:31-40; Donovan 1986:57-61; Katz 1986:41-53). These proposed bills range from a blank authorisation of the procedure to careful regulation or, in some instances, prohibition.

Common law principles do not provide sufficient answers to the problems surrounding surrogate motherhood and doctors, lawyers, theologians and other professionals, faced with queries regarding surrogacy, find it increasingly difficult to provide satisfactory answers to desperate childless couples. There is certainly no unanimity in professional circles about the future of surrogate motherhood and whether it should be considered a viable option to adoption.

Amongst the most important questions lawyers are asked are whether such contracts are legal and enforceable. What about the legitimacy of the child? What happens if the surrogate mother changes her mind and refuses to hand over the baby at birth? Can the 'commissioning'/biological father be held liable for child support? What happens if the baby is born with an abnormality? What happens if any of the parties dies or gets divorced before completion of the contract, and should the surrogate mother be compensated for her services? These are only a few of the many questions surrounding surrogacy.

Because of the limited scope of the paper, only the most important problems will be addressed.

First and foremost, it is important to alert the parties to the difficulties which may be encountered when entering into a surrogacy agreement. At this stage there is no guarantee that a surrogacy agreement will be enforceable in a court of law. Although the agreement may not in itself be regarded as 'unlawful' in the sense that it does not violate any existing legislative provision, it could, depending on its content, be regarded as conflicting with morality and be unenforceable, either in its entirety or in part (Tager 1986:395). Breach of contract may occur in various ways. The most probable form is refusal by the surrogate mother to deliver the child to the commissioning couple

at birth. The bitter custody battle in the much-publicised 'Baby M' case, when the surrogate mother refused to hand over the child, is adequate proof of the bitterness and heartache which both the surrogate and the 'commissioning' couple may experience if things go awry. A court faced with such a situation relies primarily on the criterion of the *best interest of the child* in deciding who should have custody. (In Re a Baby ['Baby Cotton' case] in England 1985 NLR Rep 106; Baby M case in the United States of America.) Breach by the commissioning couple will be relatively rare, particularly when one considers the risks for such a couple attendant upon the agreement. This view is strengthened by the fact that the child is genetically related to at least one of the parents. Such cases are, however, conceivable where the child is born with an abnormality. This is what happened in the contentious, and as far as could be determined, unreported American case of Mahlahoff/Streiver in 1983, where the child was born microcephalic. In this case neither of the contractual parties was prepared to have the child. Blood tests determined that the child was that of the surrogate mother and her husband. (For a discussion see Mandler 1985:1286-1287; Cappucio: 1985:104-105).

For a contract to be enforceable it should not contravene public policy or the so-called *boni mores*. Public policy is a difficult concept to define accurately. It denotes the ethical, social and moral convictions of a society. It may therefore have different meanings at different times and in different places. What was considered science fiction only a few years ago has now, through technological advancement, become part of our everyday reality. As a general rule, an agreement to transfer or delegate parental power permanently, such as an agreement to hand over a child at birth, is considered contrary to public policy in South Africa (Spiro 1985:43-45) and may therefore be invalid and unenforceable. Under certain circumstances, such as divorce or adoption, a court may grant an order for the transfer of all or some aspects of parental power (Spiro 1985:265; *Ex Parte Van Dam* 1973(2) SA 182 W; *Baseti v Louw* 1979(4) 225). This common law rule that one may not agree to relinquish parental power voluntarily - without interference by a court - became part of our law long before anyone could have anticipated that procreation technology would become so advanced that as many as five people could claim parental rights to one child. It is consequently submitted that, in the light of the tremendous advances recent years have seen in this field, this rule should no longer automatically be accepted as valid. An agreement to transfer parental powers in cases of surrogate motherhood should be statutorily recognised, and be enforceable.

One of the most controversial aspects is compensation of the surrogate for her services as this may be considered 'baby jartering' and exploitation of a human being. In Britain, the *Surrogacy Arrangement Act* 1985, prohibits commercial surrogacy. This followed the recommendations of the Warnock Commission. In the United States of America, however, many commercial agencies are flourishing. Generally it seems that altruistic surrogacy, where no compensation is involved and the profit motive is wholly lacking, is more acceptable in South African society than commercial surrogacy (Strauss 1983:22; Lupton 1982:354; Tager 1986: 400-404; Pretorius 1987a:273). It is, however, submitted that the surrogate should be compensated for her basic expenses such as maternity wear, transport and medical expenses, as it cannot be expected of a woman to face the risks inherent in pregnancy without at least covering her basic expenses. Furthermore, donors of semen may be compensated for reasonable expenses in terms of the *Human Tissue Act Regulations* (Reg 7).

It is the contention of the author that, in the absence of a profit motive, surrogate motherhood should not be branded as immoral, provided it is fully controlled and regulated. It is therefore submitted that the entire process of surrogacy be carefully regulated in a manner analogous to adoption. The parties to such an agreement should be carefully screened and it should only be made available to those couples for whom no other alternative exists. Merely to prohibit all forms of surrogate motherhood will drive it underground and couples will be denied the help of professionals in the medical, legal and related fields. Criminal sanctions are also inadvisable, as they would make criminals of desperate childless couples, and indirectly punish the child for the acts of the parents. Furthermore, no law could prevent a couple from travelling to a country where surrogacy was legal and bringing the baby back to South Africa, a situation which would be totally unacceptable and which would not solve the problem.

ENDNOTES

- 1 *Curlender v Bio-Science Laboratories* 106 Cal App 3d 811, 165 Cal Rptr 477 (1980), where both special damages and medical expenses were allowed and later in *Turpin v Sortini* 31 Cal 3d 220, 643 P 2d 954, 182 Cal Rptr 337 (1982), where general damages were denied but extraordinary expenses allowed. Wrongful life suits were barred by the California Legislature in 1982 Cal Civ Code 43.6(a) (West 1982).
- 2 *Harbeson v Parke-Davis* 98 Wash. 2d 460 656 P.2d 483 (1983)
- 3 *Siemieniec v Lutheran Gen. Hosp.*, 134 Ill, App. 3d 823, 480 N.E. 2d 1227 (1985).
- 4 *Procanik v Cillo* 97 N.J. 339, 478 A.2d 755 (1984).
- 5 *Turpin v Sortini* n 7 supra; *Siemieniec v Lutheran Gen Hosp* n 9 supra; *Harbeson v Parke-Davis* n 2 supra and *Procanik v Cillo* n 4 supra.
- 6 Kim Casali who is best known for the creation of the 'love is...' drawings had a child 17 months after her husband died from a terminal disease. In this case frozen semen was also kept in storage for her subsequent use. This case is discussed by Van der Vyver 1980:88.
- 7 Cmnd 9314. The Committee consisted of sixteen appointed members under the leadership of Dame Mary Warnock and their task was: '...to consider recent and potential developments in medicine and science relating to human fertilisation and embryology; to consider what policies and safeguards should be applied, including consideration of the social, ethical and legal implications of these developments; and to make recommendations.'

WORKS CONSULTED:

- Andrews, L B 1984. *New conceptions: A consumer's guide to the newest infertility treatments*. New York: St Martin's Press.
- Andrews, L B 1985. When baby's mother is also Grandma and Sister. *Hastings Center Report* 15(5), 29-31.
- Andrews, L B 1987. The aftermath of Baby M: Proposed state laws on surrogate motherhood. *Hastings Center Report* 15(5), 31-40.

- Atherton, R 1986. Artificially conceived children and inheritance in New South Wales. *Australian Law Journal* 60, 374-383.
- Barnard, A H, Cronje, D S P & Olivier, P J J 1986. *Die Suid-Afrikaanse persone -en familiereg*. Durban: Butterworth.
- Boberg, P Q R 1977. *The law of persons and the family*. Cape Town: Juta.
- Brownlie, S 1985. Wrongful life: Is it a viable cause of action in South Africa? *Responsa Meridiana* 5(1), 18-35.
- Cappucio, M S 1985. Surrogate motherhood in Ohio: A dangerous game of baby roulette. *Capital University Law Review* 15(59), 93-110.
- Current Topics 1984. *Australian Law Journal* 58(11), 627-632.
- Dalgety, D J & Pryor, M 1986. Law and the biological revolution: Changes in attitudes, behavior, medical standards and technology. *New Zealand Law Journal* (Jan), 25-28.
- De Jongh van Arkel, J T 1982. Die pastorale perspektief, in Pieterse 1982:24-30.
- Deutsch, E 1985. 'Parpalaix et al v C E C O S'. *Medicine and Law* 4, 299.
- Donovan, P 1986. New reproductive technologies: Some legal dilemmas. *Family Planning Perspectives* 18(2), 57-60.
- Jansen, R P S 1985. Sperm and ova as property. *Journal of Medical Ethics* 11, 123-126.
- Katz, A 1986. Surrogate motherhood and the baby-selling laws. *Columbia Journal of Law and Society Problems* 20, 1-53.
- Kruger, T 1986. Die etiese aspekte van in vitro bevrugting. *Suid Afrikaanse Mediese Tydskrif* 69(10), 593-594.
- Lockwood, M (ed) 1985. *Moral dilemmas in modern medicine*. Oxford: Oxford University Press.
- Louw, P F 1987. 'Wrongful life': 'n Aksie gebaseer op die onregmatige veroorsaking van lewe. *Tydskrif vir Suid-Afrikaanse Reg* 2, 199-213.

- Lupton M L, 1982. The legal consequences of artificial insemination and embryo transplantation. D Phil thesis (School of Law), University of Natal, Pietermaritzburg.
- Lupton M L, 1985. The status of children born by artificial insemination in South African law. *Journal of South African Law* 3, 277-295.
- Lupton M L 1986. Surrogate parenting: The advantages and disadvantages. *Tydskrif vir Regswetenskap* 2, 148-157.
- Mallory, T E & Rich, K E 1986. Human reproductive technologies: An appeal for brave new legislation in a brave new world. *Washburn Law Journal* 25, 458-504.
- Mandler, J J 1985. Developing a concept of the modern 'family': A proposed uniform surrogate parenthood act. *The Georgetown Law Journal* 73, 1283-1329.
- Oosthuizen, G C, Shapiro, H A & Strauss S A (eds) 1980. *Genetics and society*. Cape Town: Oxford University Press.
- Pieterse, H J C. ed) 1982. *Die proefbuisbaba: Toekomsskok of nuwe burger?* Pretoria: N G Kerkboekhandel.
- Pretorius, R 1987a. Surrogaat-moederskap: Implikasies in die Suid-Afrikaanse regstelsel. *De Rebus* 234, 270-278.
- Pretorius, R 1987b. A comparative overview and analysis of a proposed surrogate mother agreement model. *The Comparative and International Law Journal of Southern Africa (CILSA)* 20 (3), 275-293.
- Puxton, M 1986. In vitro fertilisation: The legal situation, in Fishel, S & Symonds, E M, *In vitro fertilisation: Past, present and future*. Oxford: IRL Press.
- Schaeffer, F A & Koop, C E 1980. *Whatever happened to the human race?* 2nd ed. London: Marshall Morgan & Scott.
- Schedler, G 1986. Women's reproductive rights: Is there a conflict with a child's right to be born free from defects? *The Journal of Legal Medicine* 7(3), 357-384.
- Schutte, M 1986. Die hervorming van die regsposisie van buite-egtelike kinders met besondere verwysing na die status van kinders deur kunsmatige bevrugting verwek. LLD tesis. Universiteit van Suid-Afrika, Pretoria.

- Smith, G P & Iraola, R 1984. Sexuality, privacy and the new biology. *Marquette Law Review* 67(2), 263-291.
- South African Medical Research Council 1987. *Ethical considerations in medical research*. Rev. ed. Parow: MRC Publications Unit.
- Spiro, E. 1985. *Law of parent and child*. 4th ed. Cape Town: Juta.
- Strauss, S A 1980. Genetic manipulation: The legal liability of the practitioner in Oosthuizen, Shapiro & Strauss 1987:59-73.
- Strauss, S A 1983. Die regspektief, in Pieterse H J C 1983: 11-23.
- Strauss, S A 1984. *Doctor, patient and the law: A selection of practical issues*. 2nd ed. Pretoria: Van Schaik.
- Strauss, S A 1987. Geneesheer, pasiënt en die reg: 'n Delikate driehoek. *Tydskrif vir die Suid-Afrikaanse Reg* 1, 1-12.
- Stumpf, A E 1986. Redefining mother: A legal matrix for new reproductive technologies. *The Yale Law Journal* 96, 187-207.
- Tager, L 1986. Surrogate motherhood: Legal dilemma. *South African Law Journal* 103(3), 381-404.
- Van der Merwe, C G 1982. *Sakereg*. 2nd ed. Durban: Butterworth.
- Van der Merwe, J V, Irsigler, U M, De Milander, C, Wimmers, M S E, Botes, A D E, Snyman, E, Von Prince, M S, Koch, Z & Hurter, P 1984. In vitro fertilization and embryo transfer in Pretoria. *South African Medical Journal* 66, 641-644.
- Van der Vyver, J D 1980. The legal status of the homo novus, in Oosthuizen, Shapiro & Strauss 1980:88-112.
- Van der Vyver, J D & Joubert, J D 1985. *Persone-en Familiereg*. 2nd ed. Kaapstad: Juta.
- Wadlington, W 1983. Artificial conception: The challenge for family law. *Virginia Law Review* 69, 465-514.
- Warnock Report 1984. Report of the Committee of Inquiry into Human Fertilisation and Embryology, Cmnd 9314 London: Her Majesty's Stationery Office.
- Wood, C & Westmore, A 1983. *Test-tube conception*. London: Allen & Unwin.

L D HULLEY

The right to end life

1 INTRODUCTION

When an ethicist is asked to discuss an issue like 'the right to end life', it immediately tends to become a normative question. I succumbed to that temptation and the statement began to function as a question 'is it right that we have a right to end life?', and I shall respond to the issue in that form. I shall therefore discuss moral questions which seem to me to be related to the issue of whether you have the right to end life, your own - with or without assistance - or someone else's. Merely stating the matter in this way has no doubt already raised many moral questions. Indeed the topic simply bristles with ethical problems; each move you make creates a host of side issues - each important in their own right. It is impossible to give each of them the attention they deserve. You are therefore faced with the unsatisfactory position of having loose ends as you pursue the main argument. I shall therefore soldier on fully aware that I will be raising many questions which perforce must be left unanswered. In any discussion I shall, however, try to consistently use clearly identifiable principles.

2 NARROWING THE PARAMETERS

It is necessary to reduce the area of discussion by excluding certain aspects of the topic. Friedrich Nietzsche argues that: 'freedom to live is identical with freedom to die when I choose, so that death does not just happen to me, thus bringing life into bondage to it. I commend my death as a free death that comes when I choose' (Thielicke 1983:69).

Jean Améry takes this argument further and sees suicide as that act which belongs to the 'original core of what is human' (Thielicke 1983:73), and distinguishes human beings from animals. According to these two thinkers the right to take your life is inherent. I shall return to that question in a moment. What concerns me for the moment is how a person goes about exercising this 'right'. In February 1988 a vagrant testified in a court of law that he had been paid a sum of money by a businessman to shoot him. Initially I was not concerned here with the reportedly related financial matters, or are they indeed relevant? Can financial straits be regarded as sufficient cause for one to exercise the 'right' to die? Are such problems to be regarded as the moral equivalent of a terminal illness, accompanied by severe discomfort, which is held by some as a good enough reason for a person's life to be ended? Intuitively most people would feel that the two cases cannot be equated, and I believe that intuition to be correct. I will not take this point much further other than to say that I reject Nietzsche's point of view primarily because of my view of what human life is, more about which presently. A second reason for my rejection of Nietzsche and Améry's approach is that it is dependent on the idea that human beings as individuals are responsible to themselves and for themselves only. In his *The Responsible Self* H Richard Niebuhr has argued cogently that at least part of the idea of responsibility is that it has an element of social interaction. As human beings we are not merely responsible to and for ourselves but need also to take other people into account. We are accountable to them, especially to those for whom we are responsible. This is quite apart from the question of whether we are accountable to God for our present behaviour. I find the extreme individualism implied in Nietzsche and Améry's position unacceptable. In the light of these considerations I shall therefore confine myself to discussing the right to die of those suffering from terminal illness.

3 TERMINAL ILLNESS A GROWING PROBLEM

At this point I want to return to something just mentioned previously, the question of the right to end life where you are faced with terminal illness, your own or another person's. I understand terminal illness to mean:

... a state of disease characterised by progressive, irreversible deterioration, with impairment of function and survival limited in time.

(Crispell and Gomez 1987:74)

Such a state could be brought about by a variety of causes, both in the young and in geriatric cases. A British doctor foresees that the extent of the problem as regards geriatric cases will increase markedly. Writing about his own country he says:

Between now and the year 2000, although the total number of people over the age of 65 will decline, it is predicted that there will be an increase of over 50 per cent in the number of people over the age of 85 and a substantial increase in those aged 75-84.

(Robertson 1982:173)

It must be acknowledged that this forecast refers to a highly developed country with a sophisticated medical care system but you can expect the same tendency to present itself in this country. The growing need for old age homes in all sections of our heterogeneous population is evidence of this. The increase in the number of people of advanced age means the number of geriatric patients who may be faced with terminal illness is likely to increase. Medical science has also developed tremendously in recent years, both in respect of surgical intervention and other forms of treatment. The equipment for monitoring the condition of a patient has reached high levels of sophistication. The sight of intravenous and nasogastric tubes providing hydration and nutrition is not all that uncommon a sight in most hospitals. It is therefore possible to hydrate and feed a patient who is not able to take in liquids and food in the normal way. Conditions which would have ended in death, and still do where only less sophisticated medical facilities are available, no longer do so. In terms of the utilitarian, or consequentialist, theory of ethics the positive effect of modern medicine in society must be approved. One can only applaud these advances in medicine; the good which society derives from them is wellnigh incalculable. It is now possible to keep people alive, and hopefully help them to recover, in many cases in which the prognosis would previously have been very poor. But here lies the crux of the problem. Are there not also cases where people should not be kept alive? It is in this context that the question of the right to end life is forcefully raised. Should everybody be kept alive at all costs? Should people's lives be prolonged as long as humanly possible?

4 THE SIGNIFICANCE OF HUMAN LIFE

These questions penetrate to the heart of the matter, from the other end as it were. Why are these questions regarded as significant by many people? Behind the discussion is the ques-

tion of the meaning and significance of human life. Unless we have a sneaking suspicion, or may be strongly convinced, that human life is significant the question of death or the right to die would hardly warrant a second thought in circles such as this conference. We are not prepared to regard human life and death as matters of purely biological interest thereby removing the discussion from the moral realm. This is generally an intuition for most people, but once again an important intuition for it touches on the value of human life, sometimes discussed in terms of the concept, the sanctity of life. Jacques Thiroux, a philosopher, makes this point as follows:

[The Value of Life Principle] ... is empirically prior to any other because without human life there can be no goodness or badness, justice or injustice, honesty or dishonesty, freedom or lack of it. Life is a basic possession, the main possession of each individual human being. It is the one thing that all human beings have in common, yet each individual experiences life uniquely - no one else can truly share or live another's life. Therefore individuals (as Kant correctly maintained) should never be treated merely as means, but rather as unique and individual ends in themselves.

(Thiroux 1986:131f)

Human life is the precondition for all human goods, any questions of value or ethical considerations. Depriving someone of life means depriving them of that without which all other issues are meaningless. Small wonder then that human life has been regarded as *sui generis*, accorded a unique status and valued for its own sake. It is appropriate therefore that at this point I note some other theological and philosophical views on the value of human life, a fortiori because the theological views in particular play an important role in this discussion.

In Judaeo-Christian thought there is a strong tradition regarding the sanctity and inviolability of human life. In most cases the foundation of the conviction is traced back to the concept of the *imago Dei* contained in the creation story.

God created man in his own image, in the image of God he created him; male and female he created them. And God blessed them, and God said to them, Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the sea and over the birds of the air and over every living thing that moves upon the earth.

(Gn 1:27-28)

The special status accorded humankind as creatures created in the divine image has prompted Thielicke to speak of an *alien dignity* with which human beings are endowed. Any activity which threatens that dignity must be called into question. I have quoted both verses from Scripture because in the passage it is clear that human life is not equated with other forms of biological life. Human beings are directed to have dominion over other forms of life. The implications of being created in the divine image and the injunctions regarding the rest of creation is that human life is a special case with a special worth. Taken together with the prohibition against killing in the decalogue, it has prompted some ethicists so to exalt the idea of the sanctity of life that life should be saved at all costs. I shall return to that below. Just in passing we should note that in the early medieval period when the influence of Augustine's dualism was at its height, the *imago Dei* was believed to be in the human soul, the body being of lesser value. In the early Renaissance the idea that the human species was somehow unique began to develop. With the Reformation came another important change. The concept of dignity was not attached merely to the human species, but to each individual member of the species. Our sense of individualism has developed to such an extent that we find it hard to conceptualise anything other than the dignity of individuals.

Both Greek and Latin philosophers touched on the special status of the human species but did not influence modern thought to any marked degree. Among the philosophers, Immanuel Kant's ideas had the greatest influence on modern thinking about human beings. Kant argued for an ideal society which he called the kingdom of ends. He insisted that human beings should never be treated merely as means to an end but always be regarded as ends in themselves at the same time. In *The doctrine of virtue* he argues as follows:

Man in the system of nature is a being of slight importance. Although man has, in his reason, something more than they (other animals) and can set his own ends, even this gives him only an *extrinsic* value in terms of his usefulness.

But man regarded as a person - that is, the subject of morally practical reason - is exalted above any price; for as such he is not to be valued as a mere means to the end of others or even to his own ends, but as an end in himself. He possesses in other words, a *dignity* (an absolute inner worth) by which he exacts *respect* for himself from all other rational beings in the world: He

can measure himself with every other being of this kind and value himself on a footing of equality with them ... Autonomy is the basis of dignity of human and of every rational creature.

(Gaylin 1984:18f)

It is easy to see how Kant's views found ready acceptance in this debate. The concept of dignity found a ready resonance in the long held Christian understanding of dignity, derived from the *imago Dei*. This combination may well have contributed to Thielicke's concept of alien dignity which belongs to human beings. The growing western individualism could happily embrace the idea that autonomy, which embodies the power to reason and make moral decisions, is the foundation upon which human dignity is built. The idea of autonomy also found ready acceptance among the growing band of theologians who argued that individuals had a freedom of choice in religious and moral matters. This set of interrelated ideas - human beings as ends in themselves, human dignity and autonomy - is often used in the debate on the right to die. I too find them important. They reflect a deep conviction that human life is of great value, and that it is an indispensable precondition for any valuing whatever, as Thiroux argues. The question arises whether you are to regard human life to be an absolute value, one which must be preserved at all costs.

In his book *A Christian method of moral judgement* Philip Wogaman (1976) argues for what he calls methodological presumptions. These presumptions are regarded as primary values which you assume to be valid in your ethical decision-making; any deviations from the primary values have to be justified. From the foregoing argument you can readily conclude that human life is to be regarded as a primary value and the burden of proof is on those who choose to end it. Gustafson argues in similar vein, but he qualifies the value placed on human life.

Human physical life is not of absolute value. But it is the indispensable condition for human values and valuing, and for its own sake it is to be valued. Thus the burden of proof is always on those who would take it. The delicacy of discerning what value is to be given to human physical life under particular circumstances when it is not valued absolutely presents one of the principal practical moral problems men have to face.

(Gustafson 1971:140)

Before commencing the discussion on the last point made by Gustafson, I want to mention one other argument sometimes used in this debate in addition to the theological and philosophical arguments already noted. It is sometimes referred to as the pragmatic argument for the preservation of human life, at other times spoken of as the slippery slope argument. Trianosky (1978:414) summarises it as follows:

It is sometimes said that permitting some form of euthanasia would gradually erode moral motivations and behavioral inhibitions that support a moral code. It is said, for instance, that permitting voluntary euthanasia would lead to erosion of inhibitions on killing in general to the point where we would wink at euthanasia for those who are a nuisance to society: idiots, recidivist criminals, defective newborns, and the insane for example.

An implication of this argument is that once you have allowed the sanctity of life principle to be disregarded in respect of one identifiable group it would be easier to do the same for others. Herein lies a great danger. For us the implication is that the putative advantages of allowing voluntary euthanasia would be more than wiped out by a growing disregard for the related moral values. What happened in Germany under Hitler, when first one category of people then another was exterminated is usually cited as an example of the slippery slope.

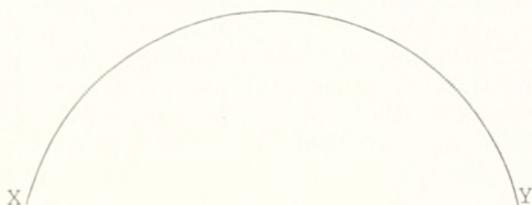
Holding human life to be a relative rather than an absolute value requires some justification. On the theological level I hold that God alone is absolute or ultimate, all human ideas - even truths held to be revealed - are at best penultimate. This includes such things as the prohibitions in the commandments. This does not mean that they can lightly be disregarded, but it means that circumstances may arise in which the strict application of the concept of the sanctity of life does not seem appropriate. One would then have to justify departure from the norm. For example, many people regard war, or a threat to national security, as sufficient reason for departing from the prohibition on killing or from regarding human life as sacrosanct.

5 WHEN DYING BEGINS

Having reduced the area of discussion to persons suffering from terminal illness one is faced with a situation where the condition of the person is inexorably getting progressively worse, resulting in the deterioration of functions and a limited lifespan. In the terms used above one could speak of limitations in respect of both the quality and quantity of life.

At this point Young's distinction between prolonging life and prolonging death is relevant. Young holds that some people would regard life as depicted in the following diagram.

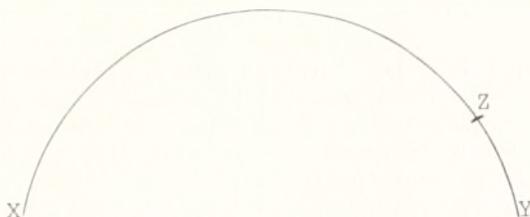
Figure 1



In figure 1 birth is represented by X and death by Y. Medical treatment and nursing care would be aimed at postponing Y at all costs. Those who hold the extreme view of the sanctity of life would fall in this category. They would regard it as necessary to continue with the aggressive medical treatment of a person irrespective of the effects the treatment may have on the quality of life of the person, or whether such treatment denies the person any vestige of human dignity or may even be against the wishes of the person.

Young introduces another diagram into the discussion.

Figure 2



In figure 2 X and Y represent respectively birth and death as they do in figure 1. Point Z represents the point at which physicians notice discernable evidence that the dying process has begun. Even for highly skilled medical people this point is often an educated guess. Nevertheless, you may then be faced with a situation where both the quality and quantity of life are limited. Those who are most closely related to the person by kinship ties would sense a progressive loss of dignity and even perhaps such a loss of personal human attributes that to speak of

personhood becomes a distortion. Towards the end there is little or no response, no self-awareness. Autonomy - which Kant regarded as the foundation of dignity - has all but disappeared or even disappeared completely, the person having little or no control of either voluntary or involuntary movement. It is in the ZY phase of life that the problem of the right to die becomes most acute. This is highlighted in an investigation carried out in New York into suicides in 1985. The suicide rates of men in the age group 20-59 diagnosed as having AIDS was more than 73 times as high as that of the general population and more than 36 times as high as men in that age group in general. It is clearly evident that these men exercised their right to die.

Two questions arise here: in what sense have we a right to die and, if it is a qualified right, in what circumstances may it be exercised?

5.1 A right to die?

Rights have been defined as moral entitlements. In this sense they give the holders moral claims upon society, both upon individuals and institutions, to assist them to receive that to which they are entitled, or at least to do nothing which will prevent them from receiving their due. In this discussion it would mean so structuring the availability of medical resources and expertise that people's wishes are fulfilled, assuming for the moment that they are rights, or that people are not prevented from carrying out their wishes.

Rights are generally of two classes, those regarded as inherent rights or those which are created by negotiation and societal agreement. In the writings of some ethicists inherent rights are regarded as divinely ordained or natural rights, whereas the second is seen as part of the social contract theory. An example of the former is the statement in the American Declaration of Independence that '... all men are endowed by their Creator with certain unalienable rights; that among these are life, liberty, and the pursuit of happiness' (Borchert and Stewart 1986:336). The acceptance that people have a right to life is well-nigh universally accepted. It is held by some that individuals may forfeit that right by for instance committing murder. Somewhat hesitantly I wish to add here another group, badly deformed infants. In some circles it is held that they have no right to life, or this is the implication of the decision to let them die. This is a highly emotive issue and I do not wish to take it further, although I shall touch on it again below.

There is much less acceptance of the idea that we have a right to die. If it indeed is a right, is it to be regarded as an inherent right, in the manner of Nietzsche and Améry, or a negotiated right? The widespread discussion surrounding the issue suggests that at present, at any rate, the matter is being negotiated. We should note, however, that in certain American states persons may express a desire, either in writing or verbally, not to be kept alive should they find themselves in the last stages of a terminal illness for example. Here we are faced with persons in the ZY stage of life and this I have already suggested differs materially from persons faced with a different set of problems.

5.2 Active and passive treatment

In this discussion of the right to die I have tried to limit it to a discussion in which both the quantity and quality of life are significant factors. Even within this limited discussion there remain at least two variables, these are the physician's intention and the person's will. In the first instance one may speak of the direct treatment by the physician or nontreatment by the physician. These are sometimes referred to as active intervention and passive behaviour. In the case of active intervention the physician may engage in aggressive treatment of the disease; administer palliative treatment with drugs which may have the indirect result of shortening the person's life; engage in activity which is designed to put an end to life such as administering a drug intended to be lethal. In the case of passive behaviour, treatment is withheld so that the disease may take its course. Here one has to add the possibility that treatment previously commenced is stopped with the purpose that the person should die sooner rather than later. In each of these possible courses of action the person may be a willing or unwilling party to the course of action taken. In some cases such as comatose accident victims who have not previously expressed a preference, the family in consultation with the physicians may make a decision based on what they think the person would have decided had the opportunity been available. I once again wish to mention the case of badly malformed infants; they are sometimes placed in this category.

At the outset I must exclude the possibility of acting directly to end an unwilling person's life; that would be murder. It would also be regarded as the blatant disregarding of the right to life which is well-nigh universally regarded as inherent. Disregarding this right places all other human rights and values in jeopardy as I noted above.

I do not intend going into arguments surrounding the question of whether there is any moral difference between the active and passive approaches to this issue in any depth. Some philosophers would argue like Landman that there is no inherent or intrinsic moral difference between acts of active euthanasia and omissions of passive euthanasia (Landman 1982:5). To this point I have deliberately refrained from using the term euthanasia in favour of the more neutral phrase the right to die because euthanasia evokes in many minds a set of presumptions which I have been trying to avoid. In this essay I shall regard them as equivalents.

I shall attempt a short explanation of why I do not regard active and passive euthanasia as morally equivalent. Some years ago there was the notorious incident in New York where a young woman, Kitty Genovese, was stabbed to death while a number of apartment dwellers watched. Both the assailant's action and the lack of action by those watching were necessary conditions for her death. You cannot, however, argue that both the attacker and the onlookers were equally culpable. Had the latter not been there to witness the event it would still have happened, whereas had the attacker been elsewhere she would not have been killed. You may argue that the cases are not quite similar and propose a different scenario. Say someone was drowning in a pool and two people were watching, the one an onlooker not able to swim and the other the lifesaver on duty. The former would not be regarded as having an obligation to save the swimmer's life while the latter would have. It is then argued that the lack of intervention by the lifesaver could be regarded as the moral equivalent of deliberately drowning the swimmer. While the lifesaver was not the cause of the swimmer's drowning, you may nonetheless hold such a person to be responsible for the other's death. Here the crux of the matter is whether the person who refrains from action may be regarded as having an obligation to prevent the death of the other. In the case of the lifesaver, you would answer in the affirmative.

In terms of the above argument one would have to hold that the physician likewise always has the obligation to prevent the death of the person being attended to. This assertion, however remains part of the debate. I have consciously used the phrase prevent the death rather than save the life of the person being attended to because this raises another important aspect of the discussion. Is the physician merely preventing the person from reaching point Y on the ZY segment of the line or are we talking of further human activity on the XZ segment? People who advocate continuing aggressive medical intervention to sustain life, even when a person is in the ZY phase, usually function with an extreme view of the sanctity of life. The question must now be

asked whether conditions may arise in which the physician may depart from the prima facie obligation to prevent death, or - to use Wogaman's concepts - to depart from the presumption that life ought to be sustained.

5.3 The quality and quantity of life

At this point in the discussion I want to introduce two concepts which have a significant bearing on the debate, that is the quality and quantity of life. If you accept their relevance, as I do, it raises questions such as the following: Will any proposed treatment not only provide an extension of life, but will that life be of such a quality that the person can exercise such human behaviour as: engaging in interpersonal relationships; communicating with other people; be consciously able to take decisions about the future? Will the continued treatment be of such a nature that the negative side-effects outweigh any hoped for advantages in either the short or the long term? A closely related question is whether the nature of the treatment itself will be so uncomfortable that the person being treated would find the discomfort from the disease easier to bear. Another important consideration is whether treatment would be manifestly futile (Callaghan 1982:397). Behind all these questions there is the following basic consideration: Would the advantages that could reasonably be expected, either in the short or longer term, outweigh the disadvantages of the treatment? An example of short-term advantage would be double effect drugs administered to a terminal cancer sufferer to control pain and allow the person to communicate at the interpersonal level, although these drugs may shorten the person's lifespan. An example of long-term advantage would be where the treatment may entail even severe discomfort in the short-term but promises a significant extension of the quantity of life with a concomitant reasonable quality of life.

Should you grant that the foregoing are significant considerations in the decision-making process you have agreed in principal that consequentialist arguments are a valid contribution to the debate. Unhappily the sanctity of life principle, which is seen as deontological, or a legalist approach is often regarded as the alternative to the consequentialist, or situational approach. Wogaman's methodological presumptions combine aspects of the two approaches. I also want to argue that if one regards human life as sacred, that which is holy is more than mere biological existence but includes that which we regard as human life. Human life seems to imply a level of personhood in which people are able to perform certain functions which reflect their personalities. In other words they ought to be able to engage in

significant relationships involving their emotions, among other things. I am aware that I have used various 'definitions' of what constitutes being human but basic to them all are the ideas that human beings are sentient beings who can enter into significant relationships with other human beings.

5.4 Expressing human care

I now wish to explain why I have pedantically continued to use the term person rather than patient. It seems to me that if we are engaged in a holistic approach to life, and the nature of this seminar suggests that at least the organisers and perhaps the speakers regard it as a multifaceted affair, then the idea of personhood must be regarded as important. In the context of this discussion the following statement by James B Nelson, an American ethicist, is apposite.

Our first responsibility is not to save a physical life and then only later to worry about the whole person. Our first responsibility is to take into consideration the person's wholeness - involving emotions and significant relationships - at each step of the way. Our first responsibility is to care. This is even more basic than curing, and acts of care will center principally upon the person rather than principally upon the disease.

(quoted in Young 1977:53)

5.4.1 *Switching off the machine*

In this quotation Nelson makes the very important claim that our first responsibility is to care. Most people would grant that whereas medical treatment may be seen as evidence of care, for the ordinary person it is shown principally in providing nutrition and hydration, or, to put it plainly, giving food and drink. Before discussing nutrition and hydration I want to discuss the discontinuing of medical treatment. To stop treatment once it has started seems to be more difficult than not to start treatment at all. It seems to suggest a callous and deliberate attempt to end another's life. Under treatment I would here include both life-support systems and the use of drugs and other medical procedures. Furthermore to switch off a life-support system seems to engender a great deal more conflict than a team of surgeons deciding that further surgical intervention in the case of widespread cancer would be futile. In both cases there is a decision to stop treatment because it no longer serves any useful purpose. It is reasoned that the person

being treated could not expect any benefit from continued treatment. Although these two situations seem very similar there seem to be important differences. In the case of the operation neither the person nor any family members are likely to be consulted prior to the decision being taken, yet strangely this is accepted without question. In contrast to this there is usually wide consultation with family members, also taking into account any preferences the person may have previously expressed, before the decision is taken to switch off life-support systems. As I noted above the incidence of geriatric cases in this category is likely to increase, apart from the growing number of other people who may be treated in this way merely because these facilities are becoming more readily available. This can lead to problems. In America for example a prominent physician who was taken to court in a malpractice suit for switching off a life-support system won the case but appeared thereafter to be reluctant to connect people to such a system. Should such an attitude become common many people who may benefit from the treatment may be denied the opportunity. Where the concept of the sanctity of life is taken to such extreme positions that the machine may never be switched off physicians would likewise become reluctant to use them. Not only would physicians be reluctant to employ life-support systems, but you can envisage that where they are used and the decision to switch them off is excluded in principle you would eventually have whole hospital wards full of people connected to life-support systems. I submit that far from this being a recognition of the sanctity of life, it is in fact a denial of it. I have already made it clear that the mere continuation of biological life cannot be considered to be a human life; dignity, autonomy and personhood are absent. To speak of the dignity and quality of life of such people is to do violence to those concepts, they can only be referred to in terms of their negation. In this situation one can argue that such a person has probably entered the ZY segment of life and should be allowed to die. One could even argue that such a person has the right to be allowed to die. Far from playing God by allowing the person to die, as is sometimes suggested, it seems to me that Fletcher is right when he argues that those who prevent death in such circumstances are guilty of playing God (Gill 1985:483) By arguing in this way, that is, considering the results of a course of action, I have once again used consequentialist reasoning.

5.4.2 Suspending nutrition and hydration

I now wish to raise perhaps one of the most difficult aspects of this debate: the continued provision of nutrition and hydration to patients in the ZY phase of life. Surprisingly enough this is

not a new problem. Already in 1587 the Dominican theologian Francisco de Vitoria argued that 'if death is imminent, the relative benefit of sustaining nutrition may objectively be outweighed by the burden of force-feeding a dying patient' (Sparks 1987:173). In this respect we are faced with the problem that on occasions people themselves have requested that nasogastric tubes be removed in the knowledge that they would die slowly of starvation. (See *Hastings Center Report* 1987:23; Lynn & Childress 1983:17). In the case study contained in the Special Supplement to the *Hastings Center Report* the views of the commentators from the Federal Republic of Germany and the People's Republic of China substantially agreed with that of the English commentator R H Nicholson, who commented on the legal and medical aspects as follows:

If a court were ever to decide, it would do so under English common law according to whatever practice a responsible body of medical opinion felt to be appropriate. In other words, if Mrs Randall refused the tube, the court would uphold that decision, since the majority of experienced doctors in this field would not wish to feed her.

(*Hastings Center Report* 1987:24)

The German commentator added that even if the request was acceded to, other medical and nursing care should be continued. This is a generally held position. The Chinese commentator holds that acceding to the person's request would reflect a further humanisation of medicine, and that no one has the right to reject the person's wishes. Rather than an easier death, suspension of nutrition and hydration could lead to an agonising end. It remains perhaps the most difficult facet of this debate, one which has no simple solution. The decision is usually made on the basis that to continue life on the level being experienced is not worth while.

Having considered the person's wishes we turn to the medical point of view. In Nicholson's statement above reference was made to treatment which medical opinion held to be appropriate in the circumstances. This is a most significant concept. The issue is not whether one should treat, refrain from or suspend treatment but to decide what in the circumstances of each individual would be the most appropriate treatment. What may be appropriate in the case of an acutely ill person where there are hopes of recovery may not be appropriate for one who is terminally ill.

Cardiac resuscitation, artificial respiration, intravenous infusions, nasogastric tubes, and antibiotics are all primary supportive measures for use in acute or acute-on-chronic illnesses to assist a patient through the initial period towards recovery of health. To use such measures in the terminally ill, with no expectancy of a return to health, is generally inappropriate and is therefore, by definition bad medicine.

(Twycross 1982:87)

What Twycross is arguing for is that the course of treatment should be decided upon after considering the advantages and disadvantages which might accrue to the person being treated. The treatment which offers the greatest balance of advantages over disadvantages is deemed to be the most appropriate. This is in line with the consequentialist argument used above. Where there is a reasonable expectation of advantage on the level of both the quality and quantity of life the measures mentioned above, cardiac resuscitation and others appear to be appropriate. Where there is little to be gained from such procedures in terms of the quality and quantity of life of the person being treated one may regard the treatment as serving little or no purpose. It is at this point that the person being treated and the physician may find common ground. Both may regard further curative medical treatment to be futile - this holds true whether the person is able to express an opinion, or earlier expressed the wish to be allowed to die rather than to be subjected to such treatment; in the case of a comatose person the family considers that the person would have so wished had the opportunity been there.

5.5 The quality of dying

I shall now introduce a concept which I believe is given too little attention in this debate. In my argument I raised the issue of the dignity belonging to human beings as human beings; I spoke of the quality of life as being an important corollary of the idea of dignity. I now wish to introduce what to me is an equally important corollary, that of the quality of dying. The way we treat people during the ZY period of life largely determines how they die.

In Tolstoy's novel *Anna Karenina* Levin and his wife Kitty go to visit his brother Nicholas who is dying from tuberculosis and is living in rather sorry circumstances. Levin is horrified by the plight of his brother and is powerless to do anything. Kitty immediately takes in the situation, rolls up her sleeves and washes the dying man, dresses him in fresh clothes, makes him

comfortable and feeds him. Her actions will not cure but they bring a measure of dignity to Nicholas's last moments and, most importantly, are an expression of love and care. I quoted earlier from Nelson's statement in which he held that caring is more basic than curing. The widespread acceptance of this maxim would explain the veneration accorded Mother Theresa of Calcutta by people of all faiths and none. She enables people to experience some dignity and loving care in their last moments thereby enhancing the quality of dying. The hospice movement functions in a similar way. There is no question of providing curative treatment, people are merely treated with the love and respect proper to those who have an inherent dignity. People are not prevented from dying, other than by the sort of care provided, but the quality of their dying is improved a great deal.

Inherent in the concept 'quality of dying' is an acceptance of human finitude, an acceptance that death is part of life - if I may be allowed to coin a phrase. But, having accepted death it attempts to humanise it. In this context I believe one can say that people have a right to die, but it is necessary to add that the quality of that dying should be such as befits a respect for life. Allowing someone to die when the quality of life is very poor is as much a respect for life as the aggressive treatment of an illness when there is hope for an improved quality of life and an increased quantity of that life. Whereas when aggressive treatment is maintained even when the prognosis is poor and there is little or no prospect of a return to a reasonable quality of life it reflects a disrespect for human life or at least a distorted view thereof. One would enhance the quality of dying by: providing such treatment and nursing care as would make the person comfortable; enabling the family and friends of the person who is ill to show loving care and concern. Such humane treatment, rather than treating people by using the technological extensions of human skill and ingenuity is more likely to have what I consider to be the desired result.

6 CONCLUDING REMARKS

In my concluding remarks I shall summarise the ethical arguments which I have employed in my discussion. Human life is not to be equated with mere biological life, it implies a certain measure of dignity as well as the ability to relate to other human beings. Human life is also to be regarded as having an attribute usually spoken of as the sanctity of life. These attributes when taken together explain in some measure why human life is regarded

as a primary value, indeed that the right to life may be regarded as inherent. The life to which we have a right must also be enjoyed at an acceptable level, there must be a good quality of life.

In the previous paragraph both deontological and value statements are included. The value statements are given substance in the goods which persons experience, they are in other words, judged in consequentialist terms. I believe that Wogaman's methodological presumptions enable us most adequately to combine these two aspects of ethical decision-making. In terms of this discussion, because of the implications of the concept of the sanctity of life, we are prima facie obligated to save life and not take it. Circumstances may however arise which negate the dignity and sanctity of life. Such circumstances do not justify the direct taking of life but rather mean that accepting death is the proper means of showing respect for life. Persons should then be assisted to die in a manner proper to those who carry the divine image. What I have therefore done is to combine the deontological sanctity of life principle with consequentialist arguments such as the quality and quantity of life as well as the quality of death.

WORKS CONSULTED

- Anderson, J K 1987. Euthanasia: A biblical appraisal. *Bibliotheca Sacra* 144(574), 208-217.
- Battin, M P 1983. The least worst death. *The Hastings Center Report* 13, 13-16.
- Battin, M P 1987. Age rationing and the just distribution of health care: Is there a duty to die. *Ethics* 97, 317-340.
- Borchert, D M & Stewart, D 1986. *Exploring ethics*. New York: Macmillan.
- Brandt, R B 1983. The real and alleged problems of utilitarianism. *The Hastings Center Report* 13, 37-43.
- Brock, D W 1985. Taking human life. *Ethics* 95, 851-865.

- Brodeur, D 1987. Deciding who's in charge. *New Catholic World*, 148-153.
- Callaghan, B 1982. Euthanasia and clinical practice. *The Tablet* 236(7398), 397-398.
- Crispell, K R & Gomez, C F 1987. Proper care for the dying: A critical public issue. *Journal of Medical Ethics* 13, 74-80.
- English, D C 1986. Intensive care: The crucifixion of the dying? *The Christian Century* 103(17), 489-490.
- Gaylin, W 1984. In defense of the dignity of being human. *The Hastings Centre Report* 14, 18-22.
- Gill, R 1985. *A textbook of Christian ethics*. Edinburgh: T & T Clark.
- Green, O H 1980. Killing and let die. *American Philosophical Quarterly* 17(3), 195-204.
- Gustafson, J M 1971. *Christian ethics and the community*. Philadelphia: Pilgrim.
- Haldane, J J 1985. The ethics of life and death. *The Scottish Journal of Theology* 38, 603-611.
- Haldane, J J 1987. Biomedical ethics: A multinational view. *Hastings Center Report: Special Supplement* 17(3), 1-36.
- The Hastings Center Report: Special Supplement* 1987. 17(3).
- Heins, D 1982. The last passage: Re-visioning dying, death and funeral. *The Christian Century* 99(1), 21-23.
- Huyskens, P 1982. De milde dood een wreed probleem. *Elseviers Magazine* 38(39), 58-70.
- Landman, W 1982. The moral equivalence of active and passive euthanasia. *S A Journal of Philosophy* 1(1), 5-10.
- Leiser, B M 1986. *Liberty, justice and morals*. New York: Macmillan.
- Lynn, J & Childress, J F 1983. Must patients always be given food and water? *The Hastings Center Report* 13(5), 17-21.

- Macquarrie, J 1967. *A dictionary of Christian ethics*. London: SCM.
- Nicholson, R H 1987. No feeding tubes for me: Commentary. *The Hastings Center Report: Special supplement* 17(3), 23-24.
- Niebuhr, H R 1963. *The responsible self*. New York: Harper & Row.
- Pretoria News 7 Mar 1988. Aids victims opt out.
- Robertson, G S 1982. Dealing with the brain-damaged old: Dignity before sanctity. *Journal of Medical Ethics* 8(4), 173-179.
- Sparks, R C 1987. To treat or not to treat? *New Catholic World*, 168-173.
- Steinbock, B 1983. The removal of Mr Herbert's feeding tube. *The Hastings Center Report* 13, 13-21.
- Thielicke, H 1983. *Living with death*. Grand Rapids: Eerdmans.
- Thiroux, J P 1986. *Ethics: Theory and practice*. New York: Macmillan.
- Tillich, P (1957) 1964. *Systematic Theology*, vol 2. Nisbet: Welwyn.
- Trianosky, G W 1978. Rule utilitarianism and the slippery slope. *The Journal of Philosophy* 75, 414-424.
- Twycross, R G 1982. Debate: Euthanasia - a physicians viewpoint. *Journal of Medical Ethics* 8(2), 86-95.
- Van Overeem, E 1982. Barmhartig. *Elseviers Magazine* 38(39), 51.
- Verhey, A 1982. The death of infant Doe. *The Reformed Journal* 32(6), 10-15.
- Wogaman, P 1976. *A Christian method of moral judgement*. London: SCM.
- Young, E D W 1977. Reflections on life and death. *Journal of Theology for Southern Africa* 18, 48-55.



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