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Assisted suicide: Ethical considerations and the South African debate

To the Editor: Doctors for Life International, supported by multiple doctors, oppose DignitySA in their court challenge to decriminalise medically assisted suicide in SA. We support the present ban on doctor-assisted suicide in South Africa.

The World Medical Association (WMA) has reaffirmed its long-standing policy of firm opposition to euthanasia and physician-assisted suicide. After an intensive process of consultation with physicians and non-physicians around the world, the WMA at its annual Assembly in Tbilisi, Georgia, adopted a revised Declaration on Euthanasia and Physician-Assisted Suicide as follows: 'The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.'

There should be no change in the law on intentional killing, which is regarded as the cornerstone of law and social relationships, even in circumstances where the person concerned is terminally ill and has requested such action. At the moment we have a clear line where we do not actively kill people by the ending of a life. A medical practitioner who administers a lethal agent to a patient at the latter's request commits the crime of murder.

Euthanasia is divided into two separate groups, passive euthanasia, which virtually no one objects to, and active euthanasia, the controversial form of euthanasia. Active euthanasia includes so-called physician-assisted suicide, where the doctor does not directly kill the person, but does provide the medication for the act of suicide. Passive and active euthanasia are two different concepts, although there are borderline cases where the distinction is vague. In summary, it can be said that passive euthanasia applies when the doctor, in the case of a terminally ill patient, steps back and acknowledges that he is not God. In passive euthanasia, the disease causes the patient's death. In active euthanasia, the doctor causes the patient's death. With passive euthanasia, the doctor has an attitude of humility and surrender. In active euthanasia, there is an attitude of taking control.

It would be impossible to ensure that all acts of doctor-assisted suicide were truly voluntary and free from coercion. Vulnerable people – the elderly, lonely, sick, or distressed – would feel pressure, whether real or imagined, to request early death. The message that society sends to vulnerable and disadvantaged people should not encourage them to seek death, but should assure them of our care and support in life.

No constitutional instrument embodies a right to commit suicide or to determine the time and manner of one's death, or to have assistance in hastening the arrival of death. We respect that a person may refuse treatment; however, personal autonomy cannot extend to requiring others to perform acts that assist a patient in committing suicide.

Simply obeying patients' wishes is not the overriding ethical imperative for doctors. Of course it is important, but it is not paramount. If it were, many unnecessary operations and some harmful operations might routinely be done. Autonomy over the time and mode of one's own death already exists – as committing suicide is not an offence in law.

The Netherlands, Belgium, and Canada serve as cautionary examples regarding the 'slippery slope' associated with euthanasia legislation. In the Netherlands, euthanasia was legalised in 2002 with strict criteria centred on unbearable suffering due to incurable conditions at the request of the patient. However, these criteria have steadily broadened over time: the Groningen Protocol (2004) has now legalised non-voluntary infant euthanasia, and later extensions included those with advanced dementia and mental illnesses. Belgium followed suit, legalising euthanasia in 2002 and extending it to minors in 2014. Additionally, Belgium continues to debate expansions to those with conditions like dementia or those considered 'tired of life'. Canada legalised euthanasia, termed 'Medical Assistance in Dying' (MAID), in 2016. Initially restricted, eligibility expanded in 2021 to those with serious and incurable illnesses even without foreseeable death. Further, in March 2024, access to MAID will extend to include those whose sole underlying condition is a mental disorder. These expansions underscore the concern that once euthanasia is accepted in limited circumstances, it becomes progressively difficult to contain its application, leading to situations far beyond the initial intent of the legislation.

Assisted suicide raise questions for society on the value that it attaches to human life and the role and responsibilities of healthcare professionals. Those who are responsible for caring for individuals nearing death bear special responsibilities. The increasing effectiveness of palliative care has the capacity to relieve the suffering of terminal illness in the great majority of cases. Requests to hasten death generally signal the presence of physical, psychological, or social stressors that can frequently be alleviated. Understanding the nature of such requests allows physicians to ease suffering and reduce the desire for death in such patients.

Dignity is not something conferred by the ability to end one's life prematurely; it is rooted in the intrinsic value and sanctity of every human life, regardless of health or circumstance. Dignity is best upheld through compassionate care and support, rather than through the option of euthanasia.

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