

The previous version of this letter was incomplete and mistakenly published in *SAMJ* 2024;114(5). Therefore, we are publishing this updated version with contributions from additional authors.

## Assisted suicide: Ethical considerations and the South African debate

**To the Editor:** We, the undersigned medical doctors, stand with Doctors for Life International as they go to court to oppose DignitySA's legal challenge seeking to decriminalise physician-assisted suicide (PAS) and physician-administered euthanasia (PAE).<sup>[1]</sup>

PAS raises serious questions about the value any society attaches to human life, and serious questions about the role and responsibilities of healthcare professionals. Those who are answerable for caring for individuals nearing death bear special responsibilities. When euphemisms such as 'death with dignity' are used to normalise acts of PAS, it creates a risk of substituting and eventually replacing proper care for terminally ill patients.

We believe it would be nearly impossible to ensure that all acts of PAS are genuinely voluntary and free from coercion. Also, in too many circumstances, vulnerable people – the elderly, lonely, sick, distressed or financially struggling – would feel pressure, whether real or imagined, to request early death.<sup>[2]</sup> In such cases there is 'an illusion of autonomy' as the person 'may truly want to die, but this desire is not the fruit of his freedom alone, it may be – and most often is – the translation of the attitude of those around him, if not of society as a whole which no longer believes in the value of his life and signals this to him in all sorts of ways.'<sup>[3]</sup> This goes against the African ethic of *ubuntu* where a 'person is regarded as a person, because of other people', which is in contrast to the Western concept of autonomy as self-determination.<sup>[4]</sup>

The 'slippery slope' of euthanasia is evident in all countries where it has been legalised in any form. In the Netherlands, euthanasia was legalised in 2002 with strict criteria centred on unbearable suffering due to incurable conditions, and only at the request of the patients. However, these criteria have steadily broadened over time: the Groningen Protocol (2004) has now legalised non-voluntary infant euthanasia, and later extensions included patients 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 such as dementia or those who are simply 'tired of life'. Canada legalised euthanasia, termed 'medical assistance in dying' (MAID), in 2016. Initially restricted, eligibility was expanded in 2021 to those with serious and incurable illnesses that are not terminal. MAID extended regulations allow nurses to administer lethal injections to induce dying in patients. From March 2024, access to MAID extends 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.

Furthermore, there is evidence in these countries that the safeguards and controls put in place to prevent involuntary or non-voluntary euthanasia (without consent) have not been effective, with few consequences for contravening these. In addition, palliative care consultations are not mandatory in some of the jurisdictions that allow euthanasia or assisted suicide, even though uncontrolled pain and symptoms remain among the reasons for requesting euthanasia.<sup>[5]</sup> Contrary to van Niekerk *et al's* assertion (*SAMJ*, February 2024), these

countries have not 'done so responsibly and with great application to monitoring and avenues for improvement'.

Our stance is supported by the World Medical Association's latest Declaration on Euthanasia and Physician-Assisted Suicide. The declaration affirms that a strong commitment has to be maintained to the principles of medical ethics and to the utmost respect for human life by remaining firmly opposed to euthanasia and PAS.<sup>[6]</sup>

There should be no change in the law on intentional killing, which is regarded as 'the cornerstone of law and social relationships',<sup>[7]</sup> even in circumstances where the person concerned is terminally ill and has requested such action. At present, we have a clear ethical boundary that does not allow us to actively kill people even at the end of life. A medical practitioner who administers a lethal agent to a patient at the latter's request will currently face a charge of murder.<sup>[8]</sup>

When suicide is legalised in any form, it poses a significant risk of suicide contagion. Numerous studies support the existence of this phenomenon.<sup>[9]</sup>

When caring for terminally ill patients, the decision to cease treatment is made with the aim of halting the prolonged dying process. The agent causing death is the disease. The attitude of the physician is one of humility and acceptance, allowing the terminally ill patient to die. When euthanasia is practised, the intent is the death of the patient. The attitude of the doctor is an attitude of taking control, and the agent of death is the physician.

We believe that it is right that no constitutional instrument embodies a right to determine the time and manner of one's death, or to have assistance in hastening the arrival of death. We respect the right of a person to refuse treatment, but reject the notion that personal autonomy can be justly extended to requiring others to perform acts that assist a patient to commit suicide. This would be 'autocracy' – rule of the self over others.<sup>[10]</sup>

In principle, we cannot accept simply obeying patients' wishes as the overriding ethical imperative in medical practice. Of course, it is important, but it cannot be accepted as a paramount consideration. If it were, the unethical consequence would be that, for instance, many unnecessary and harmful procedures might be routinely done.

Requests for euthanasia can be classified into five categories: (summarised by the abbreviation ABCDE): being **A**fraid of what the future may hold, experiencing **B**urnout from unrelenting disease, having the wish and need for **C**ontrol, experiencing **D**epression and experiencing **E**xtrêmes of suffering, including refractory pain and other symptoms.<sup>[11]</sup> Understanding the nature of such requests allows physicians to ease suffering and reduce the desire for death in such patients. The increasing effectiveness of palliative care improves the quality of life of patients and their families facing challenges associated with life-threatening illnesses.

The real challenge facing society is to make quality palliative and end-of-life care available to all.<sup>[12]</sup>

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, enshrined in *ubuntu* and made possible through the practice of palliative care, rather than through the option of euthanasia.

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