



## Response to Doctors for Life on assisted suicide

**To the Editor:** A more detailed and charitable response to Doctors for Life International (henceforth DLI)<sup>[1]</sup> and other authors<sup>[2]</sup> recent letters to the editor regarding assisted suicide is important to elucidate certain misconceptions in the assisted suicide debate.

I will not address DLI's distinction between passive and active euthanasia in this response, other than to say that this view is strongly contested within the biomedical ethics community for a variety of reasons, e.g. the killing/letting die distinction, whether acts of omission and commission are truly different morally speaking, etc.

DLI's concern whether a request for assisted dying is voluntary and enduring is an important one. However, this concern does not hold up to scrutiny. Firstly, DLI questions whether we can 'truly'<sup>[1]</sup> be certain that acts of assisted suicide are genuine and voluntary, but then fail to provide the necessary or sufficient conditions that would fulfil their criteria for a genuine, voluntary and enduring decision. As such, we are unable to assess whether assisted suicide can be defended through an argument from consistency with other medical procedures. Additionally, by not stating their conditions for a voluntary decision, DLI circumvent whether their conditions may be so strenuous as to invalidate common medical decisions that are currently well accepted within society (and by DLI themselves).

Moreover, from DLI's observation that there are *some* instances in which the desire to be aided in dying is not enduring and voluntary, we cannot preclude the possibility that there *are* instances in which the request is enduring and voluntary. Most legislation governing the practice of euthanasia has accounted for this concern by turning the act of euthanasia into a process of euthanasia. We can use Belgium as an illustrative example, since DLI refer to the country specifically in their letter. Not including previous consultations with their treating physicians, patients requesting euthanasia in Belgium underwent an average of 3.49 psychiatric consultation services during the process of having a euthanasia request evaluated.<sup>[3]</sup> The average time between a patient making a request for euthanasia and the performance of the act was 8.66 months.<sup>[3]</sup> It is my argument that an average of approximately 8 and a half months for the evaluation of a euthanasia request by doctors/psychiatrists over multiple consultations is sufficient to judge that the decision is both enduring and genuine (and is certainly more stringent than any current procedures DLI can point to in the practice of medicine today).

The principle of *ubuntu* is invoked in the additional letter to DLI's initial article as an argument against physician-assisted suicide.<sup>[2]</sup> Setting aside whether *ubuntu* ought to be the lens through which moral decisions and public policy are made, I believe that physician-assisted dying is one of the purest examples of the principle being defended. It is precisely from the recognition of interminable suffering in another human being that the empathy underlying our desire to relieve that suffering is stirred into action.

To DLI's legal point, it is a worthwhile observation that there exist equally compelling rights-based arguments in favour of assisted suicide embedded in most constitutions. This derives from the right to human dignity (among others) and is often conveniently (or deliberately) overlooked by advocates of rights-based arguments against assisted suicide. The South African (SA) Bill of Rights states that 'Everyone has inherent dignity and the right to have their dignity respected and protected.'<sup>[4]</sup>

There is little dignity in a painful, protracted death filled with suffering and a loss of self-esteem. This is particularly true in a society where the means exist to prevent this eventuality. If those positing

rights-based arguments against assisted suicide object by saying that the right to life is fundamentally different to all other rights, all the work still remains for proponents of this line of argument to demonstrate why this is the case. Moreover, not only would they have to demonstrate that the right to life is qualitatively different from other rights, but they would need to show that it carries enough moral weight to outweigh all other considerations, such as intractable pain and suffering or an undignified death.

Next, DLI states that 'simply obeying patients' wishes is not the overriding ethical imperative for doctors', and then argues that many harmful procedures are avoided because of this.<sup>[1]</sup> For a start, DLI appears to have overlooked the many arguments in favour of euthanasia that are not derived solely from a concern of respect for patient autonomy, but also out of other important ethical frameworks/principles. For example, arguments in favour of euthanasia can be found in utilitarian theories, virtue ethics and more pluralistic arguments from justice. However, an even more glaring omission is the fact that a doctor's ability to not 'simply obey'<sup>[1]</sup> the patient's wishes in certain instances is protected *precisely* out of a respect for autonomy (namely, the doctor's autonomy). Moreover, it does not follow that a country that views assisted dying as a morally permissible action would therefore need to make it a morally obligatory one for doctors to perform as well.

DLI then argue that agency over one's death is protected due to the fact that suicide is not an offence in law.<sup>[1]</sup> Setting aside the callous nature of such a suggestion, this argument overlooks several important points. Suicides are, generally speaking, traumatic and messy affairs. This applies both to those who commit suicide and those with the misfortune of discovering the deceased. Assuming that a person wishes to bring their life to an end, we can reasonably arrive at a consensus on what a 'good' death looks like. It would, at a minimum, be relatively quick, painless and accessible. By these standards, suicide outside of the setting of assisted suicide is rarely (if ever) performed well, and is certainly not a dignified death, but rather a lonely, frightening and tragic way to die.

DLI next invokes the logical slippery slope argument (henceforth SSA). SSAs can be empirical or logical in their structure. It is worth noting that the empirical SSAs against assisted dying have largely been rebutted, as evidence shows that countries that legalised assisted dying have seen a year-on-year decrease in the rate of assisted dying (contrary to the assertions of those invoking the empirical form of the SSA).<sup>[5,6]</sup>

Next, it is argued that the legalisation of voluntary euthanasia leads to an increase in involuntary and non-voluntary euthanasia.<sup>[2]</sup> This assertion is made in the article with no evidence to substantiate it.<sup>[2]</sup> Moreover, the limited data available on this phenomenon actually provide the opposite picture to the one painted in the additional article by van Eeden *et al.*<sup>[2]</sup> Dutch surveys from 1990, 1995 and 2001, respectively, show that the rate of non-voluntary euthanasia has decreased since the first survey in 1990 to the last one in 2001 from 0.8% to 0.7% (contrary to DLI's assertion).<sup>[6]</sup>

In order to demonstrate the logical SSA, DLI argues that assisted dying has expanded to include neonatal euthanasia and euthanasia of those with mental illness. However, this does not demonstrate a slippery slope. Rather, it demonstrates a consistent application of the moral principles underlying assisted dying. The hidden premise that DLI fails to mention (but is necessary for their logical SSA to be coherent) is the premise that assisted death of infants with

intractable suffering or people with severely debilitating mental illness is undesirable. This premise requires justification that DLI neglects to provide. As such, apart from invoking the SSA in name, DLI does little to actually make the argument itself. To demonstrate a logical slippery slope, DLI would need to show that the examples they raised of the SSA are not in fact consistent with the considered moral judgements of the society in which they are applied.

DLI also point to palliative care as an alternative to assisted dying. Firstly, I would like to reiterate DLI's call for an expansion of access to palliative care services to all people. There are few proponents of assisted dying who do not share this desire as well. However, while effective palliative care can provide significant relief from suffering, it is not a silver bullet for suffering in all circumstances, nor can it mitigate certain important negative aspects of dying. A key aspect of palliative care is that it intends to 'neither hasten nor postpone death.'<sup>[6]</sup> As such, it can make adjustments to the experience of the process by relieving some pain and discomfort, but cannot alter the inevitability of the process itself. Additionally, there are some palliative care interventions that may relieve the immediate problem, but come at some greater expense to the person's experience of their life. As such, while palliative care has a wide array of helpful interventions available to the treating doctor, they may not always be the desired route for the patient.

A case example from the state of Oregon in the USA sheds some light on the real-world relationship between palliative care and assisted dying. Since the inception of Oregon's Death with Dignity Act (ODDA) in 1997, 171 patients have died via physician-assisted dying.<sup>[7]</sup> Of these patients, 86% were already enrolled in hospice care.<sup>[7]</sup> Hence, we can infer that individuals who seek euthanasia are *more* likely to be enrolled in palliative care of some kind than the general population. Additionally, the introduction of euthanasia legislation in Oregon,

alongside improvements in policy implementation and training, has been positively associated with *improvements* in palliative care outcomes, such as fewer hospital admissions.<sup>[8]</sup> This empirical evidence underscores the false dichotomy drawn between these two practices by DLI – a dichotomy not shared by those who actually utilise the services – but largely by certain medical professionals and policy-makers. As such, I suggest that palliative care be reframed as an adjunct rather than an alternative to assisted dying, existing on a spectrum of interventions aimed at relieving suffering.

In conclusion, while I firmly believe that more dialogue is needed regarding assisted dying in SA, the arguments presented by DLI and others presently do not provide sufficient reason to override a long-overdue reconsideration of this practice in our country.

**C A Joseph**, MB ChB, MPhil Applied Ethics

*drcameron.joseph@gmail.com*

1. Van Eeden A. Assisted suicide: Ethical considerations and the South African debate. *S Afr Med J* 2024;114(5):6. <https://doi.org/10.7196/SAMJ.2024.v114i5.2002>
2. Van Eeden A, Nematandani S, Meiring M, et al. Assisted suicide: Ethical considerations and the South African debate. *S Afr Med J* 2024;114(6):6-7. <https://doi.org/10.7196/SAMJ.2024.v114i6.2246>
3. Thienpont L, Verhofstadt M, Van Loon T, et al. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: A retrospective, descriptive study. *BMJ Open* 2015;5(7):e007454. <https://doi.org/10.1136/bmjopen-2014-007454>
4. Constitution of the Republic of South Africa, 1996.
5. Van der Heide A, Onwuteaka-Philipsen BD, Rurup ML, et al. End-of-life practices in the Netherlands under the Euthanasia Act. *N Engl J Med* 2007;356(19):1957-1965. <https://doi.org/10.1056/NEJMsa071143>
6. Lewis P. The empirical slippery slope from voluntary to non-voluntary euthanasia. *J Law Med Ethics* 2007;35(1):197-210. <https://doi.org/10.1111/j.1748-720X.2007.00124.x>
7. Sepulveda C, Marlin A, Yoshida T, et al. Palliative care: the World Health Organization's global perspective. *J Pain Symptom Manage* 2002;24(2): 94. [https://doi.org/10.1016/S0885-3924\(02\)00440-2](https://doi.org/10.1016/S0885-3924(02)00440-2)
8. Bryant C, Simopolous N, Goy ER, et al. Oregon Hospice chaplains' experiences with patients requesting physician-assisted suicide. *J Palliat Med* 2005;8(6):1160-1166. <https://doi.org/10.1089/jpm.2005.8.1160>
9. Steinbrook R. Physician-assisted death – from Oregon to Washington State. *N Engl J Med* 2008;359(24):2514. <https://doi.org/10.1056/NEJMp0809394>

*S Afr Med J* 2024;114(7):e2241. <https://doi.org/10.7196/SAMJ.2024.v114i7.2241>