Response to 'Response to Doctors for Life on Assisted Suicide'

To the Editor: We express our gratitude to the author of 'Response to Doctors for Life on assisted suicide' for participating in this important debate.

Advocates aim to include South Africa (SA) in the number of nations (only 11 in total) that have either partially or fully legalised assisted suicide over the past two decades, out of a total of 195 nations that have maintained their stance against legalisation.

In all debates it is essential to standardise terminology to clearly communicate. Physician-assisted suicide (PAS) and physician-administered euthanasia (PAE) are the most widely used terms for the intentional termination of life with the assistance of or by a healthcare professional.. Alternative terms include 'right to die,' 'death with dignity,' 'end-of-life choice,' 'medical aid in dying,' and now, 'assisted dying'. All these terms are just euphemisms for medicalised suicide.[1]

The viewpoints on PAE and PAS (PAS/E) are rooted in differing ethical frameworks.

The advocates of PAS/E believe in the right of individuals to have complete control over their own lives, including the decision to end them. For them, the dignity of death and end-of-life care is paramount, aiming to eliminate or significantly reduce all suffering (silver bullet). Their approach aims to be dignified and compassionate. The right to dignity is its absolute cornerstone. This assigns a relative value to the sanctity of life, and is grounded in humanitarian concerns. In their opinion, physicians should therefore direct their focus towards ending the patient's life in an attempt to end suffering and preserve dignity.

We recognise the 'natural law' principle of ethics, which emphasises utmost respect for the intrinsic sanctity of human life. Without human life, there cannot be dignity, and without dignity, human life is substantially devalued. Therefore, human life and dignity are intensely intertwined. The SA Bill of Rights affirms this by bestowing the right to life and the right to dignity upon everyone. The right to life is more than mere existence: it the right of all humans to live in dignity. The right to life and the right to dignity are not mutually exclusive when it comes to end-of-life-care. Given the finality of the outcome, PAS/E cannot be considered to be a medical procedure. Medicine traditionally has not involved itself in active termination of life, going right back to the Hippocratic Oath. It declares that doctors 'will neither give a deadly drug to anybody if asked for it, nor will [they] make a suggestion to this effect.'

There are many stringent requirements for informed consent for procedures. This is because all procedures carry a greater or lesser risk of morbidity and mortality. This does not entitle planned fatal outcomes. Therefore PAS/E cannot be considered a medical procedure, making informed consent a moot point for PAS/E.

Mental disorders increase the risk of suicide, and are rife in pre-terminal conditions. They must always be addressed. Doing so sufficiently often obviates the desire to die. Lewis Walpert, a British biology professor, as a former sufferer of depression, said that he had thought of suicide repeatedly and, if the option to die at Dignitas had been available, he would have considered it.[2]

Adv. Stransham-Ford was the plaintiff in the previous effort to legalise PAS/E in SA. DignitySA vigorously supported and promoted this application in the media. However, he died before judgment was passed.

Afterwards, his physician, Dr Bruce, commented that, with the assistance of community nurses from St. Luke's Hospice, he had been able to provide palliative care to Mr Stransham-Ford at his ex-wife's home. This setting allowed estranged family members to reunite in a deeply meaningful way. His symptoms were managed effectively, enabling him to die in a homely atmosphere surrounded by family and friends who cared for him. The impact of palliative care surpassed his expectations, defying his own predictions of a frightening, impersonal and undignified death.[3]

Instead of encouraging suicide, we promote compassionate, multifaceted care and robust support for those with terminal illnesses. This includes promoting optimal pain and mental health management, ensuring proper diagnosis and treatment of depression. Professional accessible palliative care should be a mainstay of management. This should include integrating psychiatric, social and pastoral support into end-of-life care. Our approach respects patient autonomy, informing them of their options, emphasising compassionate active engagement. This ensures ideal and comprehensive symptom management. We wish to empower patients to maintain control over their care, promoting dignity and comfort in their final stages of life, fully mobilising support networks.

The life of every human being possesses dignity. The purpose of palliative care is to augment dignity in dying patients because of the caring people and environment surrounding the patient.[4] The basis of palliative care, unlike PAS/E, has always been sound medical practice, ethically, morally and legally. The practice the world over includes family, friends and community.[5]

Within the severe constraints on SA healthcare facilities and the totally inadequate resource allocation for highly effective medical treatments, there is a real risk of PAS/E substituting proper care for the terminally ill and other patients in dire medical straits.[6]

The difference of approach between the 'slippery slope' of PAS/E and extending indications is purely semantic. This is because both describe increasing access to euthanasia for indications previously not included. This invariably leads to an increase in voluntary, involuntary and non-voluntary euthanasia.

Belgium faced criticism in 2021 for its radical PAS/E law, during a United Nations Human Rights Council meeting in Geneva. Since legalising euthanasia in 2002, registered PAS/E has increased hundredfold. Belgium's PAS/E practice has increased exponentially over time. Moreover, as another example, in 2014 the law was expanded to include children of any age.[7]

Oregon state (USA) is cited as an example of active utilisation of palliative care in cases of PAS/E. It needs to be noted that the quoted literature in the reply to our article is on average 20 years or more out of date. There has been a dramatic increase in PAS/E from 16 in 1998 to 278 in 2022. Simultaneously, the proportion referred for psychiatric evaluation prior to PAS/E has dropped from 31.3% to 1.1%.[8] The most common reasons given for seeking assisted death were the fear of being a burden, and financial concerns.[9]

The World Medical Association (WMA) represents 114 national medical associations and maintains a longstanding opposition to PAS/E. It reaffirmed this standpoint in its Declaration on Euthanasia and Physician-Assisted Suicide[10] of December 2022 in the preamble to the WMA Declaration of Venice on End of Life Medical Care.[11]

The spirit of *Ubuntu* is empathetic, with dignity, survival and compassion being root values.[12] *Ubuntu* values include group solidarity, survival, compassion, respect and dignity.[13] It recognises the intrinsic worth of every individual, including infants and the dying, because 'the life of another is as valuable as one's own'.[14] Everyone, whether young, disabled, elderly or terminally ill, has a role to play in ensuring the quality of the community life.[15] A person can only be a person because of other people if he or she lives.

Respect for patient autonomy is important in medical ethics, but should acknowledge the sanctity of life. It must, however, also be understood within comprehensive ethical frameworks, including beneficence (acting in the patient's best interest) and non-maleficence (do no harm).[16] Simply adhering to patient wishes without considering these principles, as well as professional duties such as maintaining the integrity of medical practice and upholding societal trust in healthcare professionals, risks ethical quandaries and potential harm.[17]

Legalising PAS/E also leads to an overall increase in 'non-assisted' suicide rates.[18] In Oregon, the 'non-assisted' suicide rate has risen by 32% since PAS/E was legalised.[19] In Europe this has been extensively investigated and controlled against neighbouring countries. It confirms a rising 'not-assisted' suicide rate in countries permitting PAS/E. Indeed, Belgium now has the highest female 'non-assisted' suicide rate in Europe.[20]

The subtleties of coercion relating to PAS/E is illustrated in this interview by the *Santa Rosa Press Democrat* (a California newspaper) with an 84-year-old woman: 'When I started losing my hearing about 3 years ago, it irritated my daughter. She began to question me about financial matters and apparently feels I won't leave much of an estate to her … She became very rude … Then one evening (she said) she thought it was okay for older people to commit suicide … So, I sit, day after day, knowing what I am expected to do.'[21]

Active participation of the healing professions leading to termination of the lives of human beings is an unacceptable final solution. This viewpoint is derived from a steadfast commitment to the sanctity and dignity of the lives of all human beings. We do not want the need to return to a second Nuremberg trial.

As reported by Dr Leo Alexander on the Nuremberg war crime trials in the *New England Journal of Medicine*, 1949:[22]

> '… it became evident to all who investigated that they (the crimes) had started from small beginnings. The beginnings at first were merely a subtle shift of emphasis in the attitudes of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived.'

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