

Decriminalising and legalising medical assistance in dying

We, the undersigned South African (SA) medical doctors, support DignitySA in their court challenge to decriminalise medical assistance/aid in dying (medically assisted dying) in SA.

We understand that DignitySA is pleading with the High Court (i) to declare the general common-law prohibition of medically assisted dying unconstitutional and invalid, thus *decriminalising* it in the light of our constitutional rights (among others, bodily autonomy and dignity); and (ii) to advise Parliament to write a law *legalising* and *regulating* assisted dying.

Our medical ethics commitments

We do not seek to give opinions on constitutional or other legal matters in this document. Since our sole concern is to enable responsible practice of medicine, we are professionally committed to the four fundamental guiding principles of medical ethics for doctors' treatment of their patients, namely: refraining from doing harm (non-maleficence); promoting their best interests (beneficence); respecting their self-determination (autonomy); and treating them fairly (justice).

We support medically assisted dying

We hold that medically assisted dying, responsibly practised, conforms to all four of these principles.

We understand that medically assisted dying means ending one's own life with the means supplied by someone else (physician-assisted suicide) (PAS), or having the means supplied and administered by someone else (physician-administered euthanasia) (PAE).

Medically assisted dying hastens death to spare the patient suffering from a condition with no prospect of further beneficial treatment. It should only be a response to an *initiative* of and *request* by the patient, following free and unencumbered deliberation and choice. As such, medically assisted dying is patient-initiated and patient-driven.

Medically assisted dying in other countries

We have studied extensive submissions by experts from six countries with legalised assisted dying – the USA, Canada, Colombia, the Netherlands, Belgium and Australia.

Their approaches to medically assisted dying, including protocols and safeguards, range from conservative to permissive. Some countries have become more permissive following citizens' initiatives (through court challenges or referenda) on behalf of excluded groups, while other jurisdictions have remained unchanged (such as Oregon, for 30 years). The measured, responsible way in which these countries approach assistance in dying is striking.

Each country adopted a model that best suits its conditions. The USA has a more conservative approach and only PAS for terminally ill patients is legal. Canada has a more inclusive approach, having also legalised PAE for terminally ill patients and mentally ill patients who are not terminally ill, provided entry criteria are met, and protocols and safeguards are observed.

The feasibility of medically assisted dying and doing what is right

Decriminalising and legalising medically assisted dying raise questions about the *feasibility* of implementing and sustaining such a clinical practice. An approach must be formulated that best reflects our conditions, including the end-of-life care capacity of our healthcare system.

We believe that, in principle, assisted dying is no different from other end-of-life treatment options. These include terminal pain management that hastens death, such as palliative sedation, withholding and withdrawal of life-sustaining treatment, or respecting advance directives involving life-and-death decisions.

For medical doctors, the primary question about assisted dying is whether it is morally and ethically right and does not concern feasibility. Institutional or administrative adjustments to accommodate legalised assisted dying are secondary to doing the right thing.

In this regard, universal factual truths about human life and death inform ethical judgment about end-of-life decisions. For all humans, death is the inevitable end of life. However, there are different routes to reach that end. Some die peacefully of natural causes and with little suffering. Others have quick deaths from natural causes, injury, or accident, with no suffering. Some die with suffering brought on by pain and/or distress from natural causes, or of injury or accident, which may be unbearable and intractable.

Suffering and palliative care

We affirm our belief that no one should die with unbearable and intractable suffering. In life, we never give up on mitigating suffering, which should be no different in dying. However, this should only be done with means that are legal and appropriate to the needs and preferences of the dying.

Palliative care, offered by members of the Association of Palliative Care Centres (APCCs) (previously the Hospice Palliative Care Association of SA) makes a significant contribution towards alleviating the pain and suffering of many patients diagnosed with a terminal illness. However, for some patients, pain and suffering may nevertheless become unbearable and intractable, thus facing a choice between stepping up palliative sedation that may end with terminal sedation, or assisted dying.

Palliative care and assisted dying are not mutually exclusive. Both recognise that there are times when the moral and professional duties of doctors should no longer be to heal and extend life. A person with the best possible palliative care management of their symptoms may nevertheless decide to request assisted dying. Insistence by others on not acceding to this request, against the patients' wishes, becomes morally indefensible.

Therefore, we support this quest for dying that is compassionate, peaceful, liberating and dignified.

Current law and medical practice

Under our current law, acting on a request for medical assistance in dying puts a doctor at risk of being charged with performing a criminal act, namely murder.

However, we know that there are doctors who medically assist their patients to die. Despite being unlawful, we consider this a moral act.

We believe that doctors who have rendered medical assistance in dying have an enduring and stable professional relationship with their patients. Given the legal risks, it cannot be spoken about in public. Prof. Christiaan Barnard was a rare voice in public support of medical assistance in dying.

Adequately mitigating pain and suffering may, in the circumstances, require administering a lethal dose of a drug that has the secondary, inevitable and foreseen consequence of hastening death. Death as a secondary consequence of palliative care is sometimes referred to as 'double effect'.

Such terminal pain management can be distinguished from medical assistance in dying *only* in terms of how one *describes* the act and

intention at issue – either as eliminating pain in a manner that *also* hastens death (terminal pain management), or as causing death *to* eliminate pain (assistance in dying). Either way, there is a legal risk regarding professional, medical treatment of dying patients, which partly explains under-treatment of the pain and suffering of some terminally ill or dying patients.

A gentle and peaceful death

As medical practitioners, we should assist patients to have as gentle and peaceful a death as possible. Therefore, medically assisted dying should be allowed as an end-of-life medical treatment option, together with others, such as palliative sedation, terminal sedation, and withdrawal or withholding of life-sustaining treatment.

A general legal prohibition of medical assistance in dying in the appropriate circumstances means abandoning patients in their final and dire need. The time has come for medical assistance in dying to be recognised as a compassionate, humane and caring end-of-life medical treatment option.

Public debate

In SA, public debate about assisted dying started in earnest more than 25 years ago – after the advent of our democracy and the adoption of the 1996 Constitution – with the release of the SA Law Commission (SALC)'s report and draft legislation on end-of-life treatment options, commissioned by President Nelson Mandela, but never debated by Parliament.

Since then, we have observed significantly increased public support, in professional, mainstream and social media, for decriminalising and legalising assisted dying. This public debate is consistent with debates in several other countries over this time – the USA, Canada, Colombia, the Netherlands, Belgium, Switzerland, Spain, Portugal, Australia, New Zealand, the UK and others.

Countries that have decriminalised or legalised assisted dying have done so responsibly and with great application to monitoring and avenues for improvement.

Once assisted dying is implemented, it may reveal shortcomings that must be addressed, which applies to *all* human endeavours and practices.

The courts and the Hippocratic Oath

It is instructive that our courts have not regarded assisted dying as being on a par with murder with evil intent. In 1975, Dr Alby Hartman, a general practitioner in Ceres, was found guilty on a charge of murder for assisting his octogenarian father to die. He was not required to serve time in prison. Several subsequent court cases involving assisted dying, until as recently as 2019 and well after the imposition of minimum sentences, likewise resulted in non-custodial sentences following guilty verdicts on charges of murder.

Because of its many shortcomings, the ancient Hippocratic Oath was replaced by modern versions of the Oath and global codes. Thus, the World Medical Association (WMA)'s 1948 Declaration of Geneva (2017 version), which the WMA refers to as 'the Modern Hippocratic Oath', contains no moral prohibition of assisted dying. It states, among other options, that 'I will respect the autonomy and dignity of my patient'.

As is the case with the termination of pregnancy, doctors would be free to act according to their conscience, with no obligation to assist medically with dying.

Medical professionals' role in legal change

We understand that this court challenge by DignitySA is part of an anticipated extended legal process, with a court phase

(decriminalisation) followed by a legislative or parliamentary phase (legalisation), but the latter only if the court advises or instructs Parliament to write assisted dying legislation.

If this challenge proceeds to a legislative stage, the medical profession should make a significant contribution towards drafting enabling legislation for the implementation of a responsible clinical practice of medically assisted dying. This would include protocols, safeguards, monitoring, oversight and review. Should this legislative stage include a call for submissions from the public, consultations, or public hearings, the medical community would play a significant role.

We favour an approach free from unnecessary, intrusive, burdensome, or overbearing administrative oversight. With modern medicine, the dying process has become increasingly complex. In addition, for some, it is an intensely private matter, and for others it involves more inclusive cultural beliefs. Consequently, it should not be made more difficult than it already is.

Safeguards to protect the vulnerable have been successfully introduced in other countries and are constantly reviewed, based on compulsory data gathering and analysis.

Because of these considerations, we support medically assisted dying practised with responsibility, compassion, protection of the vulnerable, and respect for patients' preferences regarding their bodily freedom and dignity.

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