Expert Report - Dignity SA's Constitutional Challenge to the Prohibition on Medical Assistance in Dying

1. Introduction and Expert Credentials

Purpose of the Report

This report is prepared, on instruction of Adams & Adams on behalf of DignitySA, to assist the Court in determining whether the South African healthcare system and its practitioners are equipped to implement a safe, regulated regimen for medical assistance in dying ("**MAiD**").

This report has been prepared by me, Prof Keymanthri Moodley, in my personal capacity. Views expressed do not reflect perspectives of any institutions or organisations with which the author is affiliated.

The report reflects my opinion on the practical, ethical and professional capacity of South African medical practitioners to assess and implement MAiD, as well as the feasibility of introducing appropriate safeguards.

Expert's Qualifications and Experience

I practiced as a clinician for approximately 20 years and worked as a bioethicist since 1999. During the 2 decades as a practicing doctor in the public sector and in the private sector, I encountered many patients with terminal illness from various diagnoses.

For the past 25 years, I taught bioethics to health sciences students at undergraduate level and to healthcare professionals at various postgraduate levels. In 2009, I was involved in re-establishing the Clinical Ethics Committee (CEC) at Tygerberg Hospital, an academic tertiary hospital in Cape Town. In terms of ethics dilemmas referred to this CEC, a significant proportion of cases involve end-of-life issues – in particular, matters involving withdrawal of treatment or withholding of treatment in situations of futility. Between 2009 and 2021, 63 cases were referred to the Tygerberg CEC. Of these, 25/63 (39,7%) were related to end-of-life care. Consequently, core concepts that are discussed are futility and decision-making capacity. There are no requests for MAiD as it is currently illegal in South Africa.

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I have previously provided expert ethics reports for the Health Professions Council of South Africa (HPCSA) and other legal firms involved in various different medico-legal cases. Please see attached as "KM1", a recent article on medical assistance in dying published in the South African Medical Journal in which I was a co-author: "*View of Decriminalising and legalising medical assistance in dying*".[1]

As editor of "*Bioethics, Medical Law and Human Rights: a South African perspective*", 3rd edition (2023), I authored a chapter on "*Ethics at the End of Life*". Various forms of euthanasia are described with case illustrations. However, in that chapter, I do not express an opinion as that text was intended to serve as teaching material for undergraduate students in health sciences – hence I preferred a balanced approach identifying all perspectives to allow students to form their own opinions.

In general, the combination of having worked as a clinician and a bioethicist has resulted in my ethics deliberations being grounded in the reality of the South African healthcare system. A detailed CV is attached.

2. Assessment of South African Medical Practitioners' Capacity to Implement MAiD

Assessing Patient Capacity and Consent

Training and experience of South African doctors in assessing patient competence

All qualified South African doctors should have adequate training and experience in assessing the capacity of patients to provide consent in a wide range of clinical scenarios. Such training and experience would be regarded as being particularly important in high-stakes life-and-death decisions. However, the training and experience may be variable across the 8 medical schools in South Africa at undergraduate level and varies across different medical specialties. Rotations via psychiatry may emphasize capacity to consent assessments more than other disciplines. However, medical students and interns are not responsible for obtaining consent from patients. This is documented in the Intern Handbook[2]. Consequently, the HPCSA does not expect interns

[1] Accessible at: https://samajournals.co.za/index.php/samj/article/view/1857/797
[2] Health Professions Council of South Africa, Medical and Dental Professions Board, Handbook on Internship Training, Guidelines for Interns, Accredited Facilities and Health Authorities, Pretoria, 2024.

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to be trained in assessing patient competence. However, this training should occur under supervision of qualified doctors.

South African doctors would have variable levels of training and experience in assessing patient competence depending on their postgraduate discipline. Less experienced doctors would probably consult with experts (such as psychiatrists) or with a Clinical Ethics Committee (CEC) or Clinical Ethics Consultation Service (CECS) where needed. There are, however, few formal CECs in South Africa – approximately 4 - in some public hospitals.

Standard procedures for determining informed consent and voluntariness in practice

Informed consent is a process comprising various elements – threshold, information and authorization elements (Beauchamp & Childress, 2019). Threshold elements include capacity to consent and voluntariness. If these two requirements are not met, it is not possible to obtain informed consent. Assessing capacity to consent is therefore an important skill for health professionals to possess, especially when high stakes life and death decisions need to be made. Some undergraduate curricula expose medical students to the Appelbaum and Grisso method of assessing decision-making capacity.

One needs to assess if the patient has:

1. consistent preference for a choice
2. understanding of all relevant information
3. appreciation of the situation and its consequences
4. rational reasoning about treatment options

The frequency of and context in which such assessments need to be made cannot be quantified with accuracy as these decisions are not documented routinely.

Healthcare professionals also need to assess how voluntary the consent is. This requires the ability on the part of the professional to detect coercion or undue influence, with reference to current protocols and professional standards. The HPCSA Booklet 4 on Informed Consent includes a requirement to ensure that consent is free of undue influence.[3] Voluntariness of

[3] Accessible at: https://www.hpcsa.co.za/6ab3d85a-7bf7-4871-a23b-e3e2b99755ae

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consent is particularly important in end-of-life decision-making as outlined in the examples below.

Once the threshold criteria have been met – namely, the patient has capacity to consent and it is voluntary – the consent process can proceed via the other steps that lead to decision-making and ultimately authorisation of the decision.

Experience with End-of-Life Decisions

Currently, end-of-life decisions are routinely made in South African healthcare in various scenarios (e.g., withdrawal of treatment, palliative sedation, refusal of care, organ transplants, catastrophic trauma, strokes etc.). I have been involved in such decision making as a clinician and as a founding member of the Tygerberg CEC.

End-of-life decision-making occurs more frequently in ICUs, trauma/emergency units, oncology units, cardiac or surgical units. Consequently, there are several safeguards already in place to ensure patient autonomy and protection. The National Health Act 61 of 2003 places an obligation on all health professionals to ensure that robust consent processes are followed. Some patients have their end-of-life choices documented in patient notes or living wills. Others have a durable power of attorney in place. In situations where patients are unable to consent themselves or lack decision-making capacity, surrogate decision-making occurs. The National Health Act specifies a hierarchy for decision-making in the following order: spouse or partner, parent, grandparent, adult child, sibling.

For organ donors the hierarchy of surrogate decision-making differs in the National Health Act: spouse, partner, adult child, parent, guardian, adult brother or sister. Even if a patient has registered as an organ donor, in practice, this is regarded as an expression of interest to donate and surrogate consent from the family is obtained in addition. Two doctors, independent of the transplant team, with one qualified for more than 5 years, ensure that brain death has occurred. So, there are several guardrails in place for organ donation in South Africa.

Consent regarding all end-of-life decisions is documented in writing. Where there is uncertainty around end-of-life decisions, usually involving withdrawal or withholding of treatment, the matter may be referred to a Clinical Ethics Committee (CEC) or Clinical Ethics

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Consultation Service – where these services exist. Most cases referred to a CEC involve withholding or withdrawal of treatment. Most institutions without a formal CEC or CECS, have an informal consultation process with colleagues in the healthcare team where end-of-life issues are concerned.

Most of my experience with end-of-life issues has been as a clinician and as a member of a CEC where only passive euthanasia (withholding or withdrawing treatment) is discussed. Likewise, as a clinician, I have been involved in healthcare team decisions involving withdrawal or withholding treatment in the context of futility.

3. Comparison with International Practice

While MAiD is currently illegal in South Africa, it is legal in several international jurisdictions – the Netherlands, Belgium, Luxembourg, Spain, Austria, Switzerland, Colombia, Canada, New Zealand, some states in the USA and most states in Australia.

The summary that follows is based on the foreign expert reports provided to me from Adams and Adams:

The type of MAiD permitted across the globe varies, to some extent, but most countries require a patient to be seriously ill and experiencing unbearable and irreversible suffering. The specific terminology includes "grievous and irremediable" medical conditions causing suffering that is "intolerable" to the person. Some countries specify eligibility based on terminal illness only – where death is expected in 6-12 months. This creates a dilemma for patients with long term neurodegenerative conditions where there is irreversible suffering but where death may not occur within 6-12 months. Dementia is consequently excluded as death may occur many years after the diagnosis and usually when the patient lacks capacity to consent. So, stating a wish for MAiD as an advance directive may be difficult. In general, strict criteria must be met for people to be eligible to access such services.

There is a requirement for voluntary informed consent and hence capacity assessments are an important pre-requisite in all countries where MAiD has been legalised. There is also a detailed process in which the request for MAiD must be operationalised. The legality of MAiD usually applies to physical illnesses, but some countries permit MAiD for serious mental health

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conditions that are causing unbearable suffering (Canada, Colombia). There is controversy around extension on MAiD to mature minors (under the age of 18 years) who have decisional capacity. There is also controversy around people with disabilities and access to MAiD. Many of these controversies contribute to arguments around "slippery slope" concerns with MAiD. Fears are expressed that MAiD will be implemented without voluntary informed consent or will negatively impact poor or vulnerable individuals, and those with mental health diagnoses or those with disabilities. However, as strict eligibility criteria and guardrails are in place in most international jurisdictions where MAiD is legal, deviations from standard practice are rare.

Almost all countries permit MAiD for their own citizens except for Switzerland where foreigners may access MAiD as well.

Like South Africa, medical training in all these countries is regulated and follows specific curricula approved by professional bodies like the HPCSA. Likewise, professional bodies maintain similar ethics standards, and capacity assessments are similar.

4. Ethics and medical assistance in dying

Ethics principles and MAiD

The foundational principle of patient autonomy in healthcare

Respect for patient autonomy is a foundational ethics principle in healthcare (Taylor, 2018). It creates the obligations of informed consent, confidentiality and truth-telling in all aspects of the doctor-patient relationship (Beauchamp & Childress, 2019). All healthcare decision-making is premised on the concept of choice to accept or decline a medical intervention or treatment option.

Booklet 1 of the HPCSA guidelines supports the principle of autonomy in healthcare:
2.3.4 Autonomy: Healthcare practitioners must honour the right of patients to self-determination, which allows them to make their own informed choices, and to live their lives by their own beliefs, values and preferences.[4]

[4] https://www.hpcsa.co.za/eaff527f-36a9-4fbe-8681-5bb1983ee75e

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Likewise, all persons have an autonomous right to choose to end their lives in the context of irreversible and untreatable pain and suffering (Dugdale et al, 2019). Respecting the autonomy of patients includes respecting their right to dignity in life and during death. Consequently, all competent patients ought to exercise choice in end-of-life decision-making. Obstructing this autonomous choice via legislation and professional body guidelines (such as the current HPCSA guidelines) would be regarded as paternalistic. However, in South Africa some conservative communities support a broader notion of autonomy that includes family members in decision-making processes. This will need to be considered in MAiD requests, although legally, the final decision rests with individuals.

The principle of autonomy also extends to healthcare providers who may exercise choice to be involved in MAiD or not. This is important in multicultural communities like we have in South Africa where worldviews on end-of-life issues differ considerably. This would need to be taken into consideration in any legislation related to MAiD. Conscientious objection to active participation in the process ought to be included in the legislation with an option to refer patients to other colleagues. Special considerations will be important in communities with few healthcare providers where options for referral may be limited. This challenge has been encountered in termination of pregnancy ("**TOP**") requests. Some public sector employment opportunities in such areas have had to specify job requirements which included a willingness to offer TOP. So, only those doctors who are willing to provide TOP services would be eligible to apply to some positions. With MAiD, conscientious objection can be accommodated by limiting the service to secondary and tertiary hospitals where the healthcare staff component is large and diverse making referral to other colleagues possible. Another option is to ensure that any facility that is approved for the provision of MAiD has healthcare personnel who are willing to assist patients or participate in MAiD themselves.

Balancing the principles of beneficence and non-maleficence

Decision-making in healthcare usually involves careful balancing of the principles of beneficence (doing good) and non-maleficence (do no harm) – see Beauchamp and Childress, 2019.[5]

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55 blob:https://www.hpcsa.co.za/eaff527f-36a9-4fbc-8681-5bb1983ec75e

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In terms of Booklet 1 of the HPCSA guidelines:

2.3.2.1 Beneficence: Healthcare practitioners must act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest.

2.3.2.2 Non-maleficence: Healthcare practitioners must not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.

Likewise, decision-making around MAiD requires a careful balancing of minimizing risks and promoting benefits.

There is a conceptual difference between assisting a patient to die in the context of intractable pain and suffering versus "killing". It helps to understand that killing is usually involuntary and not requested while assistance in dying is requested and voluntary (Matthew et al, 2025).

Alleviation of intractable pain and suffering is a core obligation to reduce harm. Opinions on the role of health practitioners in assisted dying are divided. Some health practitioners argue that intervening to prolong life is acceptable and an act of beneficence but interventions to hasten death are maleficent. Others argue that intervening to prolong life and intervening to end suffering via medical assistance in dying are both acts of beneficence and morally equivalent.

The principle of justice

Finally, justice requires the fair treatment of all patients and equitable access to MAiD for all patients in the private and public healthcare systems. In the event that MAiD services are a limited resource, due to a smaller group of practitioners agreeing to provide such services, policies must be established to ensure fair access similar to what happens with renal dialysis, organ transplants and ICU services. Access to renal dialysis services are limited due to the small number of dialysis machines available. Subsequently, strict criteria are in place to allow access to this limited resource. These criteria ensure that a limited resource is distributed fairly. This principle is referred to as distributive justice (see prioritization policy page 80-82 in Moodley K. Bioethics, Medical Law and Human Rights, 2023).

In general, the above principles support MAiD. However, slippery slope arguments based on fears of extension of MAiD to vulnerable populations – adolescents, the mentally ill and disabled – are used against MAiD. Such arguments are contended by MAiD supporters (see

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international expert reports).. The other argument frequently used against MAiD includes doctors "playing God" (Landman, 1997). However, a counterargument is that doctors "play God" when prolonging life or preventing natural death.

Ethical considerations that would guide participation of healthcare professionals

In the context of a doctor-patient relationship, all healthcare professionals have a duty of care towards their patients.

The HPCSA in Booklet 1 outlines the duties of healthcare practitioners:

4.6 Healthcare practitioners fulfil multiple roles and duties:

4.6.1 As human beings they have "natural duties", for example the natural duties to refrain from doing harm, to promote the good, or to be fair and just. As is the case with everyone, healthcare professionals owe these duties to all other people, whether they are patients or not, and quite independent of our professional qualifications.

4.6.2 As qualified and licensed professionals they have "moral obligations", for example, to provide healthcare, relieve pain, gain informed consent, respect confidentiality, and to be truthful.

This duty of care exists during life including during the dying process. Healthcare professionals also have a duty to relieve suffering and pain. Providing MAiD is therefore consistent with my understanding of the role and duties of a healthcare professional in South Africa. It should form an essential part of end-of-life discussions and planning and should routinely be integrated into a compassionate, patient-centred approach to healthcare. However, this can only occur if SA has a legal framework that allows healthcare providers to have these discussions safely, respond appropriately to requests from patients and have options to discuss. Palliative care options should be offered to all patients with terminal illnesses and MAiD should be viewed as a component of any palliative care service. The Belgian expert report highlights this approach.

5. Feasibility of Implementing a Regulated MAiD Framework in South Africa

Eligibility Criteria and Safeguards

A hallmark of MAiD frameworks in other jurisdictions globally is the list of strict eligibility criteria that are specified legally. These include the severity of the underlying medical

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condition in terms of futility. Only terminal or irremediable conditions with unbearable suffering are eligible. Capacity to consent must be formally assessed and documented to ensure that the person requesting MAiD is competent to consent. Most importantly, the request must be voluntary. More than one medical practitioner is involved and these practitioners, in some countries must be explicitly trained in end-of-life care (see the Australian expert report). In South Africa, strict eligibility criteria are well documented and routinely applied for organ transplantations, termination of pregnancy, and access to ICU or renal dialysis.

Procedural Safeguards

A wide range of procedural safeguards are also in place globally where MAiD has been legalized. This includes assessment by more than one healthcare practitioner, seniority of such practitioners, training of such practitioners, a requirement for repeated requests, mandatory counselling and offering of all alternatives (including palliative care). An additional safeguard is implemented by ensuring that a committee or board of independent experts from diverse disciplines reviews and authorizes requests, provided all eligibility criteria are met. There is a requirement of a specific time frame from the date of the request to the date of implementation to ensure that eligibility criteria are correct, procedures are followed and to allow the patient making the request to carefully reconsider their request. Patients are free to change their minds and withdrawal of requests is permissible. Only enduring requests are included in authorization decisions.

There are also standard operating procedures for how the medications used for MAiD are governed. The Australian expert report highlights this aspect.

Post-death reporting and annual review mechanisms are also in place to monitor and evaluate the process. The Australian expert report describes the operationalization of the MAiD request in considerable detail. Accurate and transparent data collection around MAiD enables deviation from legal requirements to be detected and managed early.

Having procedural safeguards for MAiD is non-negotiable and must be robust. However, this must be accompanied by administrative efficiency. The Stransham-Ford case, which involved a request for assistance in dying, highlighted that a delay in decision-making can result in mootness.

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Feasibility of implementing similar eligibility criteria and safeguards in South Africa

The legal system in South Africa has already put in place eligibility criteria and several safeguards for other high-stake situations in healthcare. The judiciary ensures that the laws are interpreted correctly and implemented to protect human rights. Examples include organ transplantation, renal dialysis and termination of pregnancy.

Organ Transplantation – Chapter 8 of the National Health Act 61 of 2003 and the associated regulations establish eligibility criteria for living and cadaveric donors and recipients. Several guardrails are in place including the requirement of two doctors who must certify brain death, neither of whom must be part of the transplant team and one of whom must be in practice for a minimum of 5 years. Transplant institutions are also regulated and must meet specific criteria. Although the Act allows for either an expression of interest via a potential organ donor being on the registry or surrogate consent, some transplant centres require both.

Renal Dialysis –within renal dialysis units, a committee usually decides if patients meet eligibility criteria for dialysis. The criteria are detailed in the Western Cape Provincial Guidelines and the "Accountability for Reasonableness Framework" is followed for allocation of scarce resources[6].

Termination of Pregnancy – in accordance with the Choice on Termination of Pregnancy Act 92 of 1996, specific criteria are described for termination at various gestational ages and there are regulations regarding institutions where such procedures may be conducted as per the Act. Likewise, for MAiD, specific eligibility criteria and guardrails should be implemented to ensure that human rights are protected, and to ensure safety, equity and fairness.

The above-mentioned examples illustrate that South Africa has set a precedent by instituting legal frameworks for other important health scenarios where high stakes decisions must be made. The draft bill on the Rights of the Terminally Ill compiled by the South African Law Commission almost two decades ago lays out strict eligibility criteria. However, this draft bill has not proceeded any further in the legal system.

[6] Accessible at: https://pubmed.ncbi.nlm.nih.gov/11090498/

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Potential for Abuse and Mitigation Measures

Each new health related option has benefits and potential risks or challenges. Despite best intentions in the implementation of laws and policies, there is always the potential for deviation or abuse. The slippery slope fear is central to this concern about potential abuse. As explained above, there is a concern that eligibility criteria could be relaxed to include less serious health reasons in MAiD requests, although as highlighted in some of the foreign expert reports, it does not qualify as a slippery slope if that extension remains within constitutional bounds, and despite the slippery slope fear routinely being raised, the foreign experts have emphasized that this has not occurred. There is also the possibility that capacity assessments may not be conducted robustly or accurately or that consent may not be fully informed. Concerns exist around coercion or less voluntary decisions. Occasionally, patients who initially request MAiD, may change their minds. In other countries where MAiD is legalized, it appears from reports and the literature that such abuse is by far the exception rather than the rule. The Australian expert report highlights that administrative non-compliance could occur in a complex bureaucratic process. However, there are no documented cases of MAiD being performed without consent or ineligible patients being authorized for MAiD in that country. In high stakes decision-making in healthcare such as MAiD, it is critical that the benefits and potential risks are carefully balanced and that measures are implemented to optimize the risk-benefit ratio.

In most cases, carefully designed safeguards are in place to minimise or eliminate risks and enhance patient protection. This is evident in the MAiD policies implemented in other countries but also in other domains of healthcare in South Africa. Organ transplantation, termination of pregnancy and access to limited resources are legislated and implemented in South Africa with due consideration to harm reduction and patient protection. It should be no different with MAiD policies.

Addressing the Upper Middle-Income Country Context

Most countries in the world where MAiD is legal are high income countries. Colombia is an example of an upper middle-income country, similar to South Africa, where MAiD has been implemented since 1997. Strict eligibility criteria are in place and various safeguards have been implemented. There is a strong emphasis on informed consent. Of note is the requirement for

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an interdisciplinary committee comprising a doctor, a lawyer and a psychologist/psychiatrist at minimum to review and authorize requests for medical assistance in dying. Despite the long-standing implementation of medical assistance in dying in Colombia, there are still challenges in terms of operationalization, administrative hurdles and interpretation of eligibility criteria. South Africa could potentially face similar challenges and these need to be managed proactively.

Currently, the South African healthcare system is poised for transition from a dual healthcare system to a national health system. Given various legal challenges, it is uncertain when the national system based on National Health Insurance (NHI) will be fully implemented.

Given the current dual healthcare system (public and private healthcare) with services located asymmetrically in urban and rural areas, my suggested South African-specific safeguards to ensure safety and equity, are as follows:

1. Access to MAiD would need to be available in the public sector and in the private sector to ensure equity.
2. Institutions (both private and public) would need to meet specific criteria that are embedded within operational frameworks in order to be accredited to offer MAiD – for example, requests must be referred to secondary and tertiary hospitals with specialist services and a multidisciplinary committee to ensure that strict criteria are met before MAiD is implemented. Competency assessment expertise, robust consent processes, continuity of care and accurate evaluation of prognosis are all critical requirements.
3. While health service access is much better in urban and suburban areas, primary and secondary level services in rural areas would need telehealth expert support from tertiary hospitals to provide MAiD to patients closer to their homes.
4. All tertiary hospitals certified for MAiD provision, should have a Clinical Ethics Committee in place to resolve disputes or to discuss complex cases.
5. Specific curated training courses in MAiD for healthcare professionals should be developed to facilitate capacity development of healthcare professionals.
6. Engagement with various role players would be important and necessary to include diverse perspectives from multicultural views into legislation and policies.

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7. Healthcare providers who participate in MAiD would need access to debriefing and psychological support as required.[7]

6. Conclusion

The healthcare system in South Africa is generally efficient but disparate due to differential standards between the private and public healthcare sectors. Although the public healthcare system is currently facing several challenges in terms of human, infrastructural and financial resource constraints, there is potential for improvement. Consequently, a phased approach to implementation of MAiD may be necessary to develop the diverse expertise required to establish multidisciplinary committees to review and authorize MAiD requests at some secondary and tertiary hospitals.

Capacity development to implement such services is urgent. Public engagement and participation should be accelerated. All healthcare professionals have a duty to establish and document the end-of-life wishes of their patients. Likewise, patients should be encouraged to draft living wills and grant durable power of attorney rights to nominated family members.

In my opinion, it is a constitutional necessity to establish a legal framework that permits MAiD. I further believe implementation is feasible, and that the South African healthcare system and medical training can ensure patient protection and guard against risks if MAiD is implemented. However, it is important that capacity development and resources are simultaneously directed to the implementing facilities to optimize this process.

I am currently not in active medical practice, so unable to provide MAiD, but I would certainly exercise my constitutional right to receive MAiD once it is legal in South Africa. As a founding member of the Clinical Ethics Committee at Tygerberg Hospital and a leading bioethicist in South Africa, I would participate actively in capacity development around the ethics of MAiD to ensure that the service is offered to all South Africans who require it via a robust ethico-legal process with all safeguards in place for safety and equity.

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[7] See: "*Emotional impact on healthcare providers involved in medical assistance in dying (MAiD): a systematic review and qualitative meta-synthesis*" accessible at https://bmjopen.bmj.com/content/12/7/e058523.citation-tools

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7. Declaration and Signature

Statement of Independence

I hereby attest that the report reflects an independent, unbiased expert opinion.

Signature and Date

Keymanthri Moodley 30 March 2026

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"KM1"

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

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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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