Cancer Association of South Africa (CANSA)

Research • Educate • Support

Fact Sheet and Position Statement on Assisted Suicide

Introduction

Suicide (Latin *suicidium*, from *sui caedere*, "to kill oneself") is the act of intentionally causing one's own death. Suicide is often carried out as a result of despair, the cause of which is frequently attributed to one or other mental disorder, such as depression, bipolar disorder, schizophrenia, borderline personality disorder, alcoholism, or drug abuse.

[Picture Credit: Help!]

Stress factors such as a serious illness, financial difficulties or troubles with interpersonal relationships often also play a role.

Efforts to prevent suicide include limiting access to methods of suicide such as firearms and poisons, treating mental illness and drug misuse, and improving economic circumstances. Although crisis hotlines are common, there is little evidence for their effectiveness.

The most commonly used methods of suicide vary by country and is partly related to availability. Common methods include: hanging, pesticide poisoning, and firearms. Non-fatal suicide attempts may lead to injury and long term disabilities. Attempts are more common in young people and females.

Caring for the dying patient is among the most challenging clinical tasks a physician faces. Physicians take great pains to alleviate suffering and are trained to prolong life - especially when a satisfactory quality of life can be maintained. Therefore, when a patient with a terminal illness asks to hasten his or her own death, conflict often arises. To a physician, this request can be confusing, anxiety provoking, and infuriating. However, requests to hasten death generally signal the presence of physical, psychological, or social stressors that can frequently be ameliorated. Understanding the nature of such requests allows physicians to ease suffering and reduce the desire for death in such patients.

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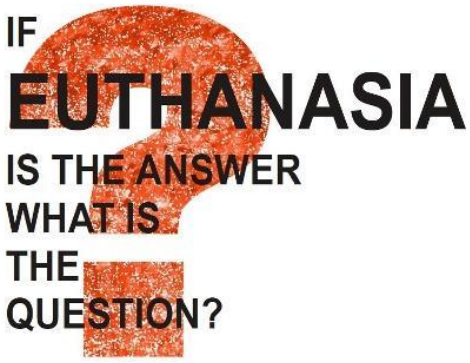
Description of Terminology

The following descriptions of terminology used in the document are provided to enhance the mutual understanding of certain concepts:

Euthanasia - also known as assisted suicide, physician-assisted suicide (dying) , doctor-assisted dying (suicide) , and more loosely termed mercy killing, basically means to take a deliberate action with the express intention of ending a life to relieve intractable (persistent, unstoppable) suffering. Some interpret euthanasia as the practice of ending a life in a painless manner. Many disagree with this interpretation, because it needs to include a reference to intractable suffering.



[Picture Credit: Euthanasia]

In the majority of countries euthanasia or assisted suicide is against the law.

There are two main classifications of euthanasia:

- Voluntary euthanasia - this is euthanasia conducted with consent. Since 2009 voluntary euthanasia has been legal in Belgium, Luxembourg, The Netherlands, Switzerland, and the states of Oregon (USA) and Washington (USA).
- Involuntary euthanasia - euthanasia is conducted without consent. The decision is made by another person because the patient is incapable to doing so himself/herself.

There are two procedural classifications of euthanasia:

- Passive euthanasia - this is when life-sustaining treatments are withheld. The definition of passive euthanasia is often not clear cut. For example, if a doctor prescribes increasing doses of opioid analgesia (strong painkilling medications) which may eventually be toxic for the patient, some may argue whether passive euthanasia is taking place - in most cases, the doctor's measure is seen as a passive one. Many claim that the term is wrong, because euthanasia has not taken place, because there is no intention to take life.
- Active euthanasia - lethal substances or forces are used to end the patient's life. Active euthanasia includes life-ending actions conducted by the patient or somebody else.

Active euthanasia is a much more controversial subject than passive euthanasia. Individuals are torn by religious, moral, ethical and compassionate arguments surrounding the issue. Euthanasia has been a very controversial and emotive topic for a long time.

The term *assisted suicide* has several different interpretations. Perhaps the most widely used and accepted is "the intentional hastening of death by a terminally ill patient with assistance from a doctor, relative, or another person". Some people will insist that something along the lines of "in order to relieve intractable (persistent, unstoppable) suffering" needs to be added to the meaning, while others insist that "terminally ill patient" already includes that meaning.

Palliative Care - is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by

means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative Care for Children

Palliative care for children represents a special, albeit closely related field to adult palliative care. The World Health Organization's definition of palliative care appropriate for children and their families is as follows; the principles apply to other paediatric chronic disorders (WHO; 1998a):

- Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family.
- It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease.
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centres and even in children's homes.

(World Health Organization).

Euthanasia and Assisted Suicide Laws Around the World

The Netherlands - In April 2002, the Netherlands became the first country to legalise euthanasia and assisted suicide. It imposed a strict set of conditions: the patient must be suffering unbearable pain, their illness must be incurable, and the demand must be made in "full consciousness" by the patient. It has been recorded that during 2010, a total number of 3 136 people were given a lethal cocktail under medical supervision.

So-called palliative sedation has also become a widespread practice in hospitals throughout the Netherlands, with 15 000 cases a year since 2005, according to the Royal Dutch Medical Association.

Patients with a life expectancy of two weeks or less are put in a medically induced coma, and all nutrition and hydration is withdrawn.

Penders, G.E.M., van Nispen Tot Pannerden, A., van Loenen, G., van de Vathorst, S. & van der Heijden, F.M.M.A. 2019.

"In the Netherlands there is an increasing amount of euthanasia and physician-assisted suicide (eas) for patients with psychiatric illnesses. However, in recent years, psychiatrists have become more reluctant to assist with or apply eas. In 1995, 47% of psychiatrists were prepared to grant a request for eas, compared with 37% in 2016. In the literature various personal, medical and ethical arguments are mentioned for reluctance or willingness regarding eas."

AIM: To determine the point of view of residents in psychiatry about requests for eas, to gain insight into their arguments for being reluctant or willing regarding eas, and to determine their opinion on attention paid to eas during the medical training of a psychiatrist.

METHOD: A survey on eas was developed based on a literature study. Residents in psychiatry from the consortium Zuid-Nederland-Noord (znn) (n=78) were asked to complete this survey online.

RESULTS: A total of 37 residents (47%) responded. Of these, most residents (73%) found it conceivable that they would grant a request for eas from a patient with psychiatric illness. Residents did not agree with the classical arguments for reluctance. The training of psychiatrists paid insufficient structural attention to eas.

CONCLUSION: This study shows that a majority of Dutch residents in psychiatry find it conceivable that they would grant a request for eas. According to these residents, more attention is warranted on eas in the medical training to psychiatrist."

Roest, B., Trappenburg, M. & Leget, C. 2019.

BACKGROUND: Family members do not have an official position in the practice of euthanasia and physician assisted suicide (EAS) in the Netherlands according to statutory regulations and related guidelines. However, recent empirical findings on the influence of family members on EAS decision-making raise practical and ethical questions. Therefore, the aim of this review is to explore how family members are involved in the Dutch practice of EAS according to empirical research, and to map out themes that could serve as a starting point for further empirical and ethical inquiry.

METHODS: A systematic mixed studies review was performed. The databases Pubmed, Embase, PsycInfo, and Emcare were searched to identify empirical studies describing any aspect of the involvement of family members before, during and after EAS in the Netherlands from 1980 till 2018. Thematic analysis was chosen as method to synthesize the quantitative and qualitative studies.

RESULTS: Sixty-six studies were identified. Only 14 studies had family members themselves as study participants. Four themes emerged from the thematic analysis. 1) Family-related reasons (not) to request EAS. 2) Roles and responsibilities of family members during EAS decision-making and performance. 3) Families' experiences and grief after EAS. 4) Family and 'the good euthanasia death' according to Dutch physicians.

CONCLUSION: Family members seem to be active participants in EAS decision-making, which goes hand in hand with ambivalent feelings and experiences. Considerations about family members and the social context appear to be very important for patients and physicians when they request or grant a request for EAS. Although further empirical research is needed to assess the depth and generalizability of the results, this review provides a new perspective on EAS decision-making and challenges the Dutch ethical-legal framework of EAS. Euthanasia decision-making is typically framed in the patient-physician dyad, while a patient-physician-family triad seems more appropriate to describe what happens in clinical practice. This perspective raises questions about the interpretation

of autonomy, the origins of suffering underlying requests for EAS, and the responsibilities of physicians during EAS decision-making.

France - Euthanasia and assisted suicide are against the law. The president, François Hollande, promised to look at the "right to die with dignity" but has always denied any intention of legalising euthanasia or assisted suicide.

In 2005 the Léonetti law introduced the concept of the right to be "left to die". Under strict conditions it allowed doctors to decide to "limit or stop any treatment that is not useful, is disproportionate or has no other object than to artificially prolong life" and to use pain-killing drugs that might "as a side effect, shorten life".

United States - Doctors are allowed to prescribe lethal doses of medicine to terminally ill patients in five US states. Euthanasia, however, is illegal. In recent years, the "aid in dying" movement has made incremental gains, but the issue remains controversial.

Oregon was the first US state to legalise assisted suicide. The law took effect in 1997, and allows for terminally ill, mentally competent patients with less than six months to live to request a prescription for life-ending medication. More than a decade later, Washington state approved a measure that was modelled on Oregon's law. And last year, the Vermont legislature passed a similar law. Court decisions rendered the practice legal in Montana and, most recently, in New Mexico.

In 2013, roughly 300 terminally ill Americans were prescribed lethal medications, and around 230 people died as a result of taking them. Some patients choose not to take the medication.

Emanuel, E.J., Onwuteaka-Philipsen, B.D., Urwin, J.W. & Cohen, J. 2016.
IMPORTANCE: The increasing legalization of euthanasia and physician-assisted suicide worldwide makes it important to understand related attitudes and practices.
OBJECTIVE: To review the legal status of euthanasia and physician-assisted suicide and the available data on attitudes and practices.
EVIDENCE REVIEW: Polling data and published surveys of the public and physicians, official state and country databases, interview studies with physicians, and death certificate studies (the Netherlands and Belgium) were reviewed for the period 1947 to 2016.
FINDINGS: Currently, euthanasia or physician-assisted suicide can be legally practiced in the Netherlands, Belgium, Luxembourg, Colombia, and Canada (Quebec since 2014, nationally as of June 2016). Physician-assisted suicide, excluding euthanasia, is legal in 5 US states (Oregon, Washington, Montana, Vermont, and California) and Switzerland. Public support for euthanasia and physician-assisted suicide in the United States has plateaued since the 1990s (range, 47%-69%). In Western Europe, an increasing and strong public support for euthanasia and physician-assisted suicide has been reported; in Central and Eastern Europe, support is decreasing. In the United States, less than 20% of physicians report having received requests for euthanasia or physician-assisted suicide, and 5% or less have complied. In Oregon and Washington state, less than 1% of licensed physicians write prescriptions for physician-assisted suicide per year. In the Netherlands and Belgium, about half or more of physicians reported ever having received a request; 60% of Dutch physicians have ever granted such requests. Between 0.3% to 4.6% of all deaths are reported as euthanasia or physician-assisted suicide in jurisdictions where they are legal. The frequency of these deaths increased after legalization. More than 70% of cases involved patients with cancer. Typical patients are older, white,

and well-educated. Pain is mostly not reported as the primary motivation. A large portion of patients receiving physician-assisted suicide in Oregon and Washington reported being enrolled in hospice or palliative care, as did patients in Belgium. In no jurisdiction was there evidence that vulnerable patients have been receiving euthanasia or physician-assisted suicide at rates higher than those in the general population.
CONCLUSIONS AND RELEVANCE: Euthanasia and physician-assisted suicide are increasingly being legalized, remain relatively rare, and primarily involve patients with cancer. Existing data do not indicate widespread abuse of these practices.

Germany and Switzerland - In German-speaking countries, the term "euthanasia" is generally avoided because of its association with the eugenicist policies of the Nazi era. The law therefore tends to distinguish between assisted suicide (*beihilfe zum suizid*) and "active assisted suicide" (*aktive sterbehilfe*).

In Germany and Switzerland, active assisted suicide – i.e. a doctor prescribing and handing over a lethal drug – is illegal. But German and Swiss law does allow assisted suicide within certain circumstances. In Germany, assisted suicide is legal as long as the lethal drug is taken without any help, such as someone guiding or supporting the patient's hand. In Switzerland, the law is more relaxed: it allows assisted suicide as long as there are no "self-seeking motives" involved.

Switzerland has tolerated the creation of organisations such as *Dignitas* and *Exit*, which provide assisted dying services for a fee.

Reiter-Theil, S. Wetterauer, C. & Frei, I.A. 2018.
“In Switzerland, the practice of lay right-to-die societies (RTDS) organizing assisted suicide (AS) is tolerated by the state. Patient counseling and accompaniment into the dying process is overtaken by RTDS lay members, while the role of physicians may be restricted to prescribing the mortal dose after a more or less rigorous exploration of the patient’s decisional capacity. However, Swiss health care facilities and professionals are committed to providing suicide prevention. Despite the liberal attitude in society, the legitimacy of organized AS is ethically questioned. How can health professionals be supported in their moral uncertainty when confronted with patient wishes for suicide? As an approach towards reaching this objective, two ethics policies were developed at the Basel University Hospital to offer orientation in addressing twofold and divergent duties: handling requests for AS and caring for patients with suicidal thoughts or after a suicide attempt. According to the Swiss tradition of “consultation” (“Vernehmlassung”), controversial views were acknowledged in the interdisciplinary policy development processes. Both institutional policies mirror the clash of values and suggest consistent ways to meet the challenges: respect and tolerance regarding a patient’s wish for AS on the one hand, and the determination to offer help and prevent harm by practicing suicide prevention on the other. Given the legal framework lacking specific norms for the practice of RTDS, orientation is sought in ethical guidelines. The comparison between the previous and newly revised guideline of the Swiss Academy of Medical Sciences reveals, in regard to AS, a shift from the medical criterion, end of life is near, to a patient rights focus, i.e., decisional capacity, consistent with the law. Future experience will show whether and how this change will be integrated into clinical practice. In this process, institutional ethics policies may— in addition to the law, national guidelines, or medical standards— be helpful in addressing conflicting duties at the bedside. The article offers an interdisciplinary theoretical reflection with practical illustration.”

Belgium – Belgium passed a law in 2002 legalising euthanasia, becoming the second country in the world to do so. The law says doctors can help patients to end their lives when they freely express a wish to die because they are suffering intractable and unbearable pain. Patients can also receive euthanasia if they have clearly stated it before entering a coma or similar vegetative state. Assisted suicide is not mentioned in the law, which does not specify a method of euthanasia.

Belgian euthanasia cases rose to 1 807 in 2013, compared with 1 432 in 2012, 708 in 2008 and 235 in 2003. Just over half of cases last year were aged 70 or over, and 80% of the applications were made by Dutch-speakers.

Belgium also became the first country to legalise euthanasia for children. There is no age limit for minors seeking a lethal injection, but they must be conscious of their decision, terminally ill, close to death and suffering beyond any medical help. They also need the assent of their parents to end their lives. So far, no such cases have yet been reported to authorities.

Canada - "In February 2015, the Supreme Court of Canada ruled that it was unconstitutional to prohibit physicians from assisting in a patient's consensual death, thereby setting the groundwork for the legalization of medical assistance in dying (MAiD). Much of the research on this topic has focused on physicians, although other health care professionals will be involved in the process, including pharmacists, pharmacy technicians, and pharmacy assistants. In many provinces, the medications required for MAiD will be dispensed from hospital pharmacies, which will result in direct involvement of hospital pharmacy staff." (Gallagher, *et al.,* 2019)

Althagafi, A., Ekong, C., Wheelock, B.W., Moulton, R., Gorman, P., Reddy, K., Christie, S., Fleetwood, I., Barry, S. 2019.
BACKGROUND: The Supreme Court of Canada removed the prohibition on physicians assisting in patients dying on 6 February 2015. Bill C-14, legalising medical assistance in dying (MAID) in Canada, was subsequently passed by the House of Commons and the Senate on 17 June 2016. As this remains a divisive issue for physicians, the Canadian Neurosurgical Society (CNSS) has recently published a position statement on MAID.
METHODS: We conducted a cross-sectional survey to understand the views and perceptions among CNSS members regarding MAID to inform its position statement on the issue. Data was collected from May to June 2016.
RESULTS: Of the 300 active members of the CNSS who received the survey, 89 respondents completed the survey, 71% of whom were attending neurosurgeons and 29% were neurosurgery residents. Most respondents,74.2%, supported the right of physicians to participate in MAID with 7.8% opposing. 37% had current patients in their practice fitting the criteria for MAID. 23.6% had been asked by patients to assist with MAID, but only 11% would consider personally providing it. 84% of neurosurgeons surveyed supported the physicians' right to conscientious objection to MAID while 21% thought attending surgeons should be removed from the inquiry and decision-making process. 43.8% agreed that the requirement to refer a patient to a MAID service should be mandatory. Glioblastoma multiforme (65%), quadriplegia/quadriparesis secondary to spinal tumour/trauma (54%) and Parkinson's disease (24%) were the most common suggested potential indications for MAID among the neurosurgical population.
CONCLUSIONS: Our results demonstrate that most neurosurgeons in Canada are generally supportive of MAID in select patients. However, they also strongly support the physicians' right to conscientious objection.

South Africa – The Supreme Court of Appeal on 6 December 2016 found it was wrong for a high court to issue an order allowing a terminally ill cancer patient to commit suicide with a doctor's help.

"It was wrong to hold that the common law crimes of murder and culpable homicide needed to be or should be developed to accommodate physician-assisted euthanasia and physician-assisted suicide", the written judgment stated.

It found the court did not fully consider the principles and ambit of changing common law to encompass consent as a defence to a charge of murder.

The court believed it was desirable for issues that raised "profound moral questions" to be decided by representatives of the country's citizens as a whole.

"It is of course possible that Parliament will, as has occurred in other countries, intervene and pass legislation on the topic."

The court would welcome such a move in the light of separation of powers.

On April 30 2015, the High Court in Pretoria ruled that terminally-ill Cape Town advocate Robin Stransham-Ford, 65, had the right to commit suicide with a doctor's help.

Judge Hans Fabricius said at the time: "The applicant is entitled to be assisted by a medical practitioner either by the administration of a lethal agent or by providing the applicant with the necessary lethal agent to administer himself."

He was of the view that the Constitutional Court and Parliament should reconsider the issue of legalising assisted suicide.

Stransham-Ford died two hours before the order was granted, as a result of his cancer.

The Supreme Court of Appeal (SCA)upheld an appeal by the ministers of justice and health, the National Director of Public Prosecutions, and the Health Professions Council of SA.

It found that the lower court's order was tailored to deal only with Stransham-Ford's case. When he died, the relief was no longer necessary.

It said there was evidence to suggest he had changed his mind about wanting an assisted death.

The high court judge was not told about the change in his condition or his doubts.

According to the SCA, the high court's notion of a dignified death was not informed by a rounded view of society.
"It [a court] needs to consider the impact of its decision beyond our affluent suburbs into our crowded townships, our informal settlements, and in the vast rural areas that make up South Africa."

Should assisted suicide ever be allowed in the country, there would need to be a proper regulatory framework.

Jacobs, R.K. & Hendricks, M. 2018.

BACKGROUND: Euthanasia/physician-assisted suicide have been a controversial and sometimes taboo topic for a long time, not only in South Africa (SA) but also internationally. A recent (SA) judicial case has seen the topic debated again. Consensus on accepting or abolishing these practices in SA has yet to be reached. All relevant role players need to be adequately engaged before policy can be informed.

OBJECTIVES: To determine the views of future doctors (medical students) regarding euthanasia and physician-assisted suicide (PAS) and to ascertain their stance on its legalisation in South Africa (SA).

METHODS: A paper-based, semi-quantitative descriptive study design consisting of 16 questions, using convenience sampling of third- to fifth-year medical students at Stellenbosch University, was used.

RESULTS: The overall response rate was 69.3% (N=277). In total, 52.7% of participants (n=146) felt that the practices of euthanasia/PAS should be legalised in SA. Responses varied depending on patient morbidities. If a patient had terminal disease with intractable suffering, 41.9% of participants would terminate the patient's life upon request. A further 36.1% of participants stated that they would have no part in ending a patient's life, while 35.0% said that they would be comfortable with providing the patient with the correct means to end their life (PAS). The majority (80.1%) of participants indicated that they would prefer a dedicated ethics committee to decide who receives euthanasia/PAS. Many factors influenced participants' responses, but differences in opinion between and within the various religious groups were particularly evident in the responses received.

CONCLUSIONS: More than half the respondents in this study were open to legalising euthanasia/PAS, substantially more than in previous studies. However, only 41.9% of respondents would consider actually performing euthanasia/PAS, for certain patients. Views of other healthcare workers as well as the public are required before policy can be informed.

South Africa Law on Murder, Suicide and Assisted Suicide

South Africa utilises specific definitions to classify cases that are under investigation where someone died of unnatural causes like murder. Some of the definitions stem from the common law such as murder and others are defined in terms of the Criminal Procedure Act, 1977 (Act 51 of 1977).

- Murder consists in the unlawful and intentional killing of another human being.
- Attempted Murder consists in the commission of an unlawful act with the intention of killing another human being but which does not result in the death of that human being.
- Culpable Homicide consists of the unlawful, negligent causing of death of another human being.

(ISS Crime Hub).

According to a psychiatry publication, Mental Health Daily, reporting on suicide worldwide, committing suicide or attempting suicide is not considered a crime in South Africa. From 1886 to 1968 it was illegal, however, this legislation no longer stands. According to the publication assisted suicide is still illegal in South Africa.

Professor Pierre De Vos, Constitutional Lawyer, Faculty of Law, University of Cape Town (2015), writes: "As a general principle, a person who assists another to end his or her life, is guilty of murder and can

be successfully charged and prosecuted. Where a doctor or family member knowingly administers a lethal dose of a painkiller to end the suffering of the terminally ill patient or a patient who is in a permanent vegetative state, he or she will potentially be guilty of murder and could be prosecuted". (Constitutionally Speaking).

CANSA's Position on Assisted Suicide

- The Cancer Association of South Africa (CANSA) reaffirms its Purpose and Mission:
  - PURPOSE – Our purpose is to lead the fight against cancer in South Africa
  - MISSION – Our mission is to be the preferred non-profit organisation that enables research, educates the public and provides support to all people affected by cancer.

- CANSA cannot support assisted suicide in any form (passive or active) as it is illegal in South Africa.
- CANSA further supports the World Health Organization (WHO) in its guidelines for the control of cancer pain. To this end CANSA believes that there are medicines available for the adequate control of pain, if administered correctly. Morphine is one of the drugs of choice for the control of cancer pain and is also available at a reasonable cost. Please refer to the WHO Guidelines on Cancer Pain Relief below.

- CANSA wishes to affirm its commitment to the laws applicable in South Africa. Should the Constitutional Court of South Africa deliberate on the legality or otherwise of assisted suicide and issue a ruling in that regard, CANSA may reconsider its position on assisted suicide.

The World Health Organization's Guidelines on Cancer Pain Relief

The following is quoted from the WHO Guideline on Cancer Pain Relief, with a guide to opioid availability, Second Edition, WHO, Geneva, 1996. The document is now somewhat dated but the section on oral morphine is still relevant:

> Morphine can be given as: a simple aqueous solution of the sulphate or hydrochloride salt every four hours (an antimicrobial preservative may be added); tablets, every 4 hours; slow-release tablets, every 12 hours. (also 24 hr formulation) The effective analgesic dose of morphine varies considerably and ranges from as little as 5 mg to more than 1000 mg every four hours. In most patients, pain is controlled with doses of 10-30mg every four hours. The effective dose varies partly because of individual variations in systemic bioavailability. The correct dose is the dose that works. The drug must be given "by the clock" and not merely when the patient complains of pain. The use of morphine should be dictated by intensity of pain, not by life expectancy. If the patient has a sudden attack of severe pain, a rescue dose of morphine should be given promptly (as immediate release PW) and repeated after one hour if necessary. After the pain has been relieved, the regular dose should be reviewed, and increased if necessary. Slow-release morphine tablets are available in some countries in strengths varying from 10 mg to 200 mg. These tablets usually need be given only every 12 hours.

(World Health Organization).

Medical Disclaimer

This Fact Sheet and Position Statement is intended to provide general information only and, as such, should not be considered as a substitute for advice, medically or otherwise, covering any specific situation. Users should seek appropriate advice before taking or refraining from taking any action in reliance on any information contained in this Fact Sheet and Position Statement. So far as permissible by law, the Cancer Association of South Africa (CANSA) does not accept any liability to any person (or his/her dependants/estate/heirs) relating to the use of any information contained in this Fact Sheet and Position Statement.

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EMERGENCY LINES

Dr Reddy's Help Line
0800 21 22 23

Pharmadynamics Police &Trauma Line
0800 20 50 26

Adcock Ingram Depression and Anxiety Helpline
0800 70 80 90

Destiny Helpline for Youth & Students
0800 41 42 43

ADHD Helpline
0800 55 44 33

Department of Social Development Substance Abuse Line 24hr helpline
0800 12 13 14
SMS 32312

Suicide Crisis Line
0800 567 567
SMS 31393

SADAG Mental Health Line
011 234 4837

Akeso Psychiatric Response Unit 24 Hour
0861 435 787

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