# 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.

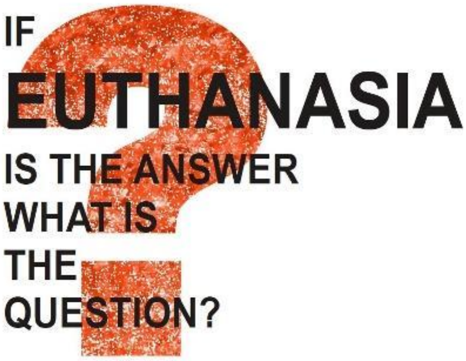
The most commonly used methods of suicide vary by country and is partly related to availability. Common methods include: hanging, pesticide poisoning, and firearms. Non-fatal suicide attempts may lead to injury and long term disabilities. Attempts are more common in young people and females.

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.

**Andriessen, K., Krysinska, K., Castelli Dransart, D.A., Dargis, L. & Mishara, B.L.** 2020.
***Background:*** Several countries have regulated euthanasia and physician-assisted suicide (PAS). Research has looked at the experiences of patients, family, and professionals. However, little is known of the effects on bereaved individuals.
***Aims:*** We aimed to assess (a) what is known about the grief and mental health of people bereaved by euthanasia or PAS and (b) the quality of the research.
***Method:*** Systematic review according to PRISMA guidelines with searches in Cinahl, Embase, PsycINFO, Pubmed, and Scopus.
***Results:*** The searches identified 10 articles (eight studies), and the study quality was fair. People bereaved by euthanasia/PAS generally had similar or lower scores on measures of disordered grief, mental health, and posttraumatic stress compared with those who died naturally. Lack of social support and secrecy may compound their grief. Being involved in the decision-making process and having the feeling of honoring the deceased's will may facilitate their grief.
***Limitations:*** Studies used self-reports from non-random self-selected participants, were retrospective, and were conducted in only three countries.
***Conclusion:*** There is little evidence of increased risk of adverse grief or mental health outcomes in people bereaved by euthanasia/PAS. As more countries legalize assisted dying, high-quality studies of the factors that may hinder or facilitate the grief process are needed.

**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.

**Gerson, S.M., Koksvik, G.H., Richards, N., Materstvedt, L.J. & Clark, D.** 2020.
**Context:** A central approach of palliative care has been to provide holistic care for people who are dying, terminally ill, or facing life-limiting illnesses while neither hastening nor postponing death. Assisted dying laws allow eligible individuals to receive medically administered or self-administered medication from a health provider to end their life. The implementation of these laws in a growing number of jurisdictions therefore poses certain challenges for palliative care.
**Objectives:** To analyze the research literature about the relationship of assisted dying with palliative care, in countries where it is lawful.
**Methods:** A five-stage scoping review process was adapted from the Joanna Briggs Institute. Data sources searched through October 2018 were MEDLINE, CINAHL, PsychINFO, SCOPUS, and ProQuest

dissertations and theses, with additional material identified through hand searching. Research studies of any design were included, but editorials or opinion articles were excluded.
**Results:** After reviewing 5778 references from searches, 105 were subject to full-text review. About 16 studies were included: from Belgium (n = 4), Canada (n = 1), Switzerland (n = 2), and the U.S. (n = 9). We found that the relationship between assisted dying and palliative care practices in these locations took varied and sometimes combined forms: supportive, neutral, coexisting, not mutually exclusive, integrated, synergistic, cooperative, collaborative, opposed, ambivalent, and conflicted.
**Conclusion:** The studies in this review cast only partial light on challenges faced by palliative care when assisted dying is legal. There is pressing need for more research on the involvement of palliative care in the developing practices of assisted dying, across a growing number of jurisdictions.

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.

**Mangino, D.R., Nicolini, M.E., De Vries, R.G. & Kim, S.Y.H.** 2020. **Objective:** To describe the characteristics of persons with dementia receiving euthanasia/assisted suicide (EAS) and how the practice is regulated in the Netherlands.
**Designs:** Qualitative directed content analysis of dementia EAS reports published by the Dutch euthanasia review committees between 2011 and October 5, 2018.

**Results:** Seventy-five cases were reviewed: 59 concurrent requests and 16 advance requests. Fifty-three percent (40/75) were women, and 48% (36/75) had Alzheimer disease. Advance request EAS patients were younger, had dementia longer, and more frequently had personal experience with dementia. Some concurrent request EAS patients were quite impaired: 15% (9/59) were deemed incompetent by at least one physician; in 24% (14/59), patients' previous statements or current body language were used to assess competence. In 39% (29/75), patients' own physicians declined to perform EAS; in 43% (32/75), the physician performing EAS was new to them. Physicians disagreed about patients' eligibility in 21% (16/75). All advance request and 14 (25%) concurrent request patients had an advance euthanasia directive but the conditions of applicability often lacked specificity. In 5 of 16 advance request EAS and 2 of 56 concurrent request EAS cases, EAS procedure was modified (e.g., premedication). Twenty-five percent (4/16) of advance request cases did not meet legal due care criteria, in particular the "unbearable suffering" criterion.
**Conclusions:** Advance and concurrent request EAS cases differ in age, duration of illness, and past experience. Advance request EAS cases were complicated by ambiguous directives, patients being unaware of the EAS procedure, and physicians' difficulty assessing "unbearable suffering." Notably, some concurrent request patients were quite impaired yet deemed competent by appeals to previous statements.

**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.

**Gerson, S.M., Preston, N.J. & Bingley, A.F.** 2020.
**Context:** Many jurisdictions around the world have passed medical aid in dying (MAID) laws allowing competent eligible individuals facing life-limiting illness to self-administer prescribed medication to control timing of death. These laws do not prevent some patients who are receiving hospice services from dying by suicide without assistance.
**Objectives:** To explore hospice professionals' experiences of patients who die by suicide or intentionally hasten death with or without legal assistance in an area where there is legalized MAID.

**Methods:** Semistructured in-depth qualitative interviews were conducted with 21 home hospice professionals (seven nurses, seven social workers, four physicians, and three chaplains). Thematic analysis was carried out to analyze the data.
**Results:** Three primary themes were identified from the interviews: 1) dealing with and differentiating between hastened death and suicide, 2) MAID access and affordability, and 3) how patients have hastened their own deaths. Analysis of these data indicates that there are some patients receiving hospice services who die by suicide because they are not eligible for, have no knowledge of, or lack access to legalized MAID. Hospice professionals do not consistently identify patients' deaths as suicide when they are self-inflicted and sometimes view these deaths as justified.
**Conclusion:** Suicide and hastened deaths continue to be an unexamined cause of death for some home hospice patients who may have requested MAID. Open communication and increased education and training is needed for palliative care professionals regarding legal options, issues of suicide, and suicide assessment.

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&rsquo;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 &ldquo;consultation&rdquo; (&ldquo;Vernehmlassung&rdquo;), 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&rsquo;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&mdash; in addition to the law, national guidelines, or medical standards&mdash; 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.

**Nanner, H.** 2020.
"Adoption of assisted dying has rapidly grown, but many groups caution that these policies can cause suicide contagions. If those urging caution are correct, jurisdictions with these policies will experience increased suicides. This study aimed to determine the changes in population suicide rates in Belgium before and after its 2002 policy using the synthetic control method (SCM) and generalized synthetic control method (GSCM). As comparisons we used additional European Union members that have not adopted these policies. GSCM showed an average annual suicide rate increase of 0.73 per 100,000 population (95% CI - 5.7 to 7.2; p = 0.80). Placebo testing based on the SCM analysis showed equal outcomes for Belgium and the comparisons. This study failed to show evidence of association between implementation of legislation legitimizing assisted dying and population suicide rates. The threat of suicide contagion has influenced policy discussions in the past, but this study suggests that there is presently no indication for policy-makers to view suicide contagions as a concerning side effect of assisted dying legislation."

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.

United Kingdom – Discussions have commenced in the United Kingdom.

**Pentaris, P. & Jacobs, L.** 2020.

"Current debates about assisted dying and assisted suicide cover a series of medical, legal, moral, ethical and religious aspects. Yet, public views on the subject remain underexplored and, therefore, not always accounted for in the formation of public policy. This paper reports on empirical data from a cross-sectional study in the UK in 2019, which examines public views about the legalisation of assisted dying and assisted suicide, by means of a self-administered Qualtrics-based survey (self-devised vignettes). A combination of simple random and convenience sampling was used. Participants (n = 297) state their preference that both assisted dying and assisted suicide should be legalised in the UK (n = 70%), while doctors should be legally allowed to support such wishes of patients with an incurable and painful illness from which they will die (n = 62.22%). The paper concludes that public opinion needs to be further accounted for in policymaking and discourses regarding patient autonomy and dignity of care."

Australia - On 19 June 2019, assisted dying became lawful in Victoria, the second most populous state in Australia.

**Willmott, L., White, B., Ko, D., Downar,, J. & Deliens, L**. 2020.

**Objectives:** On 19 June 2019, assisted dying became lawful in Victoria, the second most populous state in Australia. Section 8 of the *Voluntary Assisted Dying Act* is a legislative safeguard that is designed to ensure a patient's request for assistance to die is voluntary. This section prohibits health practitioners from initiating a conversation about assisted dying with the patient. This article explores the potential implications of this prohibition for effective communication between doctors and their patients, and the ability of doctors to provide high quality end-of-life (EOL) care in some cases.

**Method:** The authors reviewed and analysed literature on the importance of communication at the EOL including the need to understand and appropriately respond to Desire to Die or Desire to Hasten

Death statements. A legal critique of section 8 of the Victorian *Voluntary Assisted Dying Act* was also undertaken to determine the scope of this new duty and how it aligns with existing legal obligations that would otherwise require doctors to provide information about EOL options requested by a patient.

**Results:** Contemporary literature suggests that open and honest communication between doctor and patient including the provision of information about all EOL options when sought by the patient represents good clinical practice and will lead to optimal EOL care. The provision of such information also reflects professional, ethical and legal norms.

**Conclusion:** Despite (arguably) promoting an appropriate policy objective, the legislative prohibition on health professionals initiating conversations about voluntary assisted dying may, in cases where patients seek information about all EOL options, lead to less optimal patient outcomes.

**Conflict of interest statement**

Competing interests: LW has been engaged by the Victorian Government to design and provide the legislatively mandated training for doctors involved in voluntary assisted dying. LW is also a member of the board of Palliative Care Australia (but this article only represents her views not those of Palliative Care Australia). BW has been engaged by the Victorian Government to design and provide the legislatively mandated training for doctors involved in voluntary assisted dying. DK is on the Voluntary Assisted Dying Review Board (but this article represents her views only). JD is a former member of the Physicians' Advisory Committee for Dying with Dignity Canada, a group that advocated for the legalisation of voluntary assisted dying in Canada. He currently works at Bruyere Continuing Care, a Catholic healthcare facility. This article does not represent the views of either Dying with Dignity Canada or Bruyere Continuing Care. LD has no competing interests.

Italy – The Italian Constitutional Court has held that, in certain specific circumstances, prosecution for assisted suicide, is not compatible with the Constitution.

**Petrini, C.** 2020.

"The Italian Constitutional Court has held that, in certain specific circumstances, prosecution for assisted suicide, regulated by Article 580 of the Criminal Code, is not compatible with the Constitution. The circumstances in question relate to individuals who are being kept alive by life-sustaining treatments, who are fully capable of taking free, informed decisions and are suffering from irreversible conditions that are a source of intolerable physical or mental suffering. The Court has held that the Ethics Committees must assess a request for assisted suicide made by an individual meeting these conditions. The decision requires the identification of the Ethics Committee authorised to issue authorisation in such cases and a guarantee that these Ethics Committees are able to deal with this type of issue. The Court's decision is an important opportunity to establish and promote clinical Ethics Committees, which are not nationally regulated in Italy and exist in very small numbers in only a few parts of the country."

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.

Religion and Belief – The influence of religion and belief should never be overlooked

**Sharp, S.** 2020.

"Using data from the 2007 Baylor Religion Survey, I evaluate whether beliefs in heaven and hell are associated with attitudes toward physician-assisted suicide. I find that those who believe in heaven and those who believe in hell tend to have negative attitudes toward physician-assisted suicide, even when controlling for other religiosity and sociodemographic variables. I also find that the belief in hell mediates the effect of the belief in heaven on attitudes toward physician-assisted suicide, suggesting that the fear of hell, more so than the reward of heaven, may lead people to have negative attitudes toward physician-assisted suicide."

The Islamic Perspective

**Madadin, M., Al Sahwan, H.S., Altarouti, K.K., Altarouti, S.A., Al Eswaikt, Z.S. & Menezes, R.G.** 2020.

"Physician-assisted suicide (PAS) and euthanasia can be debated from ethical and legal perspectives, and there are a variety of views regarding their acceptability and usefulness. Religion is considered an important factor in determining attitudes towards such practices. This narrative review aims to provide an overview of the Islamic perspective on PAS and euthanasia and explore the Islamic approach in addressing the related issues. The PubMed database was searched to retrieve relevant articles, then the references listed in the selected articles were checked for additional relevant publications. Additionally, religious books (Quran and hadith) and legal codes of selected countries were also consulted from appropriate websites. The Islamic code of law discusses many issues regarding life and death, as it considers any act of taking one's life to be forbidden. Islam sanctifies life and depicts it as a gift from God (*Allah*). It consistently emphasises the importance of preserving life and well-being. Therefore Muslims, the followers of Islam, have no right to end their life. All Islamic doctrines consider PAS and euthanasia to be forbidden. However, if the patient has an imminently fatal illness, withholding or withdrawing a futile medical treatment is considered permissible. From a legal perspective, Islamic countries have not legalised PAS and euthanasia. Such practices are therefore considered suicides when patients consent to the procedure, and homicides when physicians execute the procedure."

**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).

*Latest developments in South Africa (February, 2021)*
An atheist advocate and doctor have added their voices to a crucial legal challenge to determine whether or not euthanasia should be legalised in South Africa.

The last time the issue was raised in court in South Africa was in 2015 when lawyer Robert Stransham-Ford, who was dying, launched an urgent application in the Pretoria High Court for an order that a doctor be legally entitled to give him a lethal dose to end his life.

It was an individual application, not done in the public interest. Judge Hans Fabricius ruled in his favour, but unbeknown to the judge, Stansham-Ford died, naturally, two hours before the judgment. The case went to the Supreme Court of Appeal, the State respondents fearing a precedent.

In essence, the SCA ruled that this was not the right matter to develop the common law and that Judge Fabricius’s ruling was moot and had no effect since Stansham-Ford had died already.

Now medical doctor Suzanne Walter, a palliative care specialist, and her patient Diethelm Harck, who have both been diagnosed with terminal diseases, are hoping to persuade Johannesburg High Court Judge Raylene Keightly to develop the law to allow both physician-assisted suicide (PAS) (where the doctor prescribes and the patient self-administers) and physician assisted euthanasia (PAE) (where the doctor administers any medicine to end life).

The matter is set down for hearing on 22 February, and is expected to start with the evidence of Walter, who was diagnosed in February 2017 with Multiple Myeloma, and Harck, who was diagnosed in 2013 with Motor Neuron Disease.

In pleadings they both say they are suffering “torturing symptoms”. While it is not unlawful for them to commit suicide, they fear when the time is right, they will not be capable of swallowing pills or self-administering medication.

If a willing doctor were to help them, he or she would face criminal charges and would also face being struck off the roll by the Health Professionals Council of South Africa (HPCSA) for unprofessional conduct.

The two say that the law as it stands, and the attitude of the HPCSA, impinge on their right to dignity and right to live a life and choose the way they want to die.

They want Parliament to enact legislation to give effect to their rights to self-determination. In the meantime, they say, the court should rule that any mentally competent terminally ill person may approach the high court for an order allowing them to undergo either PAS or PAE.

Joining their cause as friends of the court are Advocate Bruce Leech and Dr Paul Rowe, both atheists. In an affidavit filed with the court, Leech says public policy is rooted in the Christian ethic inherited via South Africa’s colonialist legal systems first of Roman-Dutch Law and then of English Law. So too is the HPCSA’s rule against PAS and PAE.

“Christian values are imposed directly and indirectly on people who do not necessarily share those values. I do not share these beliefs and neither does Dr Rowe.”

“And once it is shown that this is the case, the retention of this policy is plainly a limitation imposed on the right under the Constitution to freely exercise one’s religious choice and freely believe or think what one chooses.”

“The decriminalisation of PAS and PAE does not in any way infringe on the rights of those who do not believe in PAS and PAE, based on their own religious and moral convictions.”

The HPCSA – and the State respondents, the Ministers of Health, Justice, and the National Director of Public Prosecutions – are all opposing the application.

The HPCSA says doctors should be willing to obey its code of conduct “which protects the public and is in the best interests of patients”. It says the ban on euthanasia and assisted suicide does not offend the Constitution, and if it does, it is justified because it is necessary to protect the right to life and protect and preserve trust in the doctor-patient relationship.

“Medicine and medical treatment ameliorates the pain and suffering of those who have or are in the terminal phase of a serious disease. Such treatments are available (to Walter and Harck) and are progressively being made available to all persons in South Africa.”

The state respondents have essentially denied all the allegations made and say Walters and Harck are not entitled to the legal relief they seek.

Civic organisation Cause of Justice, also a friend of the court, is also opposing the application. The organisation says doctors must not be allowed to kill a person because no matter the loss of quality of life, each human life has inherent worth.

"To depart from the principle will result in a cultural shift and a slippery slope towards acceptance of death as a solution to human pain and suffering. We must guard against this at all costs."

The Centre for Applied Legal Studies (CALS) has been given permission by Judge Keightly to present evidence.

It supports the right to "die with dignity".

Attorney Sheena Swemmer said the case raises important constitutional issues about the rights to human dignity, life, health and bodily autonomy.

The Centre will present evidence from experts in Canada, the Netherlands and Oregon, in the USA, where assisted dying is legal.

"These specialists are well-placed to outline the policies and checks and balances and provide first hand experience in implementing them.

They are also able to speak more generally to the evolution of medical ethics and the nature of terminal illnesses and end of life care generally," she said.

After the evidence of Walters and Harck, the matter is expected to be adjourned until later this year. *(Tania Broughton)*

**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.

Whilst CANSA has taken every precaution in compiling this Fact Sheet and Position Statement, neither it, nor any contributor(s) to this document can be held responsible for any action (or the lack thereof) taken by any person or organisation wherever they shall be based, as a result, direct or otherwise, of information contained in, or accessed through, this Fact Sheet and Position Statement.

## 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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