

The Fabricius decision on the Stransham-Ford case – an enlightened step in the right direction



Many diseases are associated with incredible pain and suffering. Others impair function and independence to the extent that human dignity is

eroded. In many instances the natural history of such conditions often leads to death within a reasonable period of time. In some cases, protracted ill health, pain, suffering and indignity ensue. Such circumstances have since time immemorial triggered the debate on euthanasia – a debate on what it means to have a good death. Acting compassionately, many South African (SA) doctors have, to some extent, either passively or actively assisted patients in achieving a good death.

Ending a tormented existence

In recent times, evolving expertise in the medical profession and some technological advances in medical science have inadvertently created the need for assisted suicide. We have found ways to artificially prolong existence at the expense of quality of life, independence and dignity. We 'play God' each time we intervene to interrupt the natural progression of disease. Although we primarily intend to act beneficently, we do inadvertently cause harm. Many of our medical and surgical interventions, particularly in the field of oncology, have adverse events that cause incredible suffering in the hope of prolonging life. Such suffering often results in patients choosing death over a severely eroded quality of life. Surely the rights of patients who are enduring unbearable suffering, indignity and pain must be respected, even if this includes the expression of their right to die? Compassion, a primal virtue of the profession, demands that we respect the wishes of patients who choose to end a tormented existence of pain, indignity and dependence. Against this background, I am extremely pleased with the Fabricius judgment in respect of the recent Stransham-Ford case.

However, it is clear that my opinion is not shared by the South African Medical Association, the Health Professions Council of South Africa or the Ministry of Health – all major opponents of the Fabricius ruling. Arguments against legalising assisted suicide in SA have included cultural and religious objections, professional duties and moral obligations of doctors and the classic 'slippery slope'.

'Cultural resistance' untested

Assisted suicide may be perceived as the ultimate expression of liberal individualism, a phenomenon common to urban, so-called Western societies. Some have argued that culturally, only a segment of the SA population will support assisted suicide. While this may be true, to a large extent this view remains untested. We have no empirical evidence to support this assertion. It is well documented that African philosophy supports the concept of communal good rather than individual good. However, is this a phenomenon of traditional rural communities only, or does it apply to urban communities as well? The Bill of Rights enshrined in the Constitution is firmly rooted in the tradition of liberal individualism, and the rest of our existing health legislation in the form of statutory law strongly supports individual patient choice, from as early as the age of 12 years – individual informed consent, privacy, confidentiality, truth-telling, and ultimately choice on termination of pregnancy. SA women of all cultural and ethnic origins exercise individual choice every time they opt for a termination of pregnancy, often without consent from the father of the child or the extended family. Do we hear arguments about *Ubuntu* being advanced with respect to these pieces of legislation that are firmly entrenched in SA society? Admittedly many unexplored religious and cultural views exist with respect to assisted suicide. Many questions remain unanswered.

Professional duties of doctors require that they promote life and prevent harm. According to the World Medical Association Declaration on Terminal Illness, adopted in 1983 and revised in 2006, the 'duty of physicians is to heal, where possible, to relieve suffering and to protect the best interests of their patients'. This statement in and of itself does not exclude assisted suicide, which is intended to relieve suffering and to protect the best interests of the patient. The declaration goes on to assert that the patient's 'right to autonomy in decision-making must be respected with respect to decisions in the terminal phase of life'. This right to autonomy is, however, restricted to refusal of treatment and requesting palliative treatment to relieve suffering that may have the additional

effect of accelerating the dying process – the doctrine of double effect. The right to assisted suicide, which would otherwise be included in the patient's right to autonomy in end-of-life decision-making, is excluded. However, legally this could be regarded as exculpatory language – use of language that limits or waives the rights of patients.

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No 'slippery slope'

The classic 'slippery slope' argument has been advanced by others, with opinions on the euthanasia legislation in the Netherlands presented as evidence. While the Dutch legislation around euthanasia has been based on strict criteria limited to terminal illness only since 2002, recent reports indicate that some doctors are bending the rule and extending the criteria to include less severe forms of illness. There are therefore allegations that some Dutch doctors are treading down the proverbial slippery slope. This is to be expected in a minority of members of the profession in any country – members who cross boundaries in various other aspects of professional conduct too – and legislation should be in place to sanction such transgressions via professional bodies and via the courts. We can learn from the Dutch experience and ensure that the necessary safeguards are built into our end-of-life legislation, such that assisted suicide is an option of last resort. Careful and robust construction of legislation around assisted suicide must therefore make provision for extremely strict criteria, as outlined by the South African Law Commission in 1999. The Death with Dignity Act has been in place in Oregon in the USA for the past 17 years, and unlike the controversial Dutch legislation, appears to be more robust. Finally, legislation merely creates options that can only

be exercised by patient choice. Assisted suicide does not imply that doctors can force this option onto patients. Our National Health Act supports informed consent, which guards against doctors imposing treatment of any sort on patients. The Act also supports refusal of treatment options recommended by a doctor. Likewise, not all doctors have to participate in assisted dying. The option of conscientious objection by doctors must be included in such legislation.

Concluding thoughts

Assisted suicide is an emotive topic that is ethically, legally and culturally

challenging. Views of all relevant stakeholders must therefore be explored before general legislation can be introduced. Resolving these questions requires intense community engagement, a process that can be initiated via empirical research. However, research can be a slow, costly and challenging process. If the question of assisted suicide is deemed a serious enough matter, a referendum could be held to test societal views in SA on this extremely contentious issue. Until such data are obtained, requests should be treated on a case-by-case basis, as has occurred in the Stransham-Ford matter.

In societies that are allowed to exercise choice in virtually all domains of their lives, limiting autonomy at the end of life is at best myopic and represents the last remnants of paternalism in healthcare.

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