



## Medical students' perspectives on euthanasia and physician-assisted suicide and their views on legalising these practices in South Africa

**To the Editor:** We read the article by Jacobs and Hendricks<sup>[1]</sup> with great interest. In the *SAMJ* of September 2018<sup>[2,3]</sup> there are two letters to the Editor responding to this article.

Are medical students and doctors in South Africa well informed on how to handle questions about euthanasia and physician-assisted suicide, and are they able to respond to their patients with information that is correct and evidence-based?<sup>[2]</sup> Do we learn from Europe, with their Exit and 'dignity clinics' where doctors help you to end your life? Do we teach the 'art of dying with dignity'? Maybe *Do You Call This A Life?: Blurred Boundaries in The Netherlands' Right-To-Die Laws*, by van Loenen<sup>[4]</sup> is food for thought ...

In 'To persuade or to inform?' by Barit<sup>[3]</sup> the author argues that people have different opinions, and doctors should respect that. Patients can 'make a decision based on their own beliefs and wants', and trying to persuade them to do certain things is regarded as unprofessional and wrong.

Let us give two examples of patients we saw recently, cases in which doctors have tried to influence the patient's decision to do the 'right thing' (i.e. the best medical option under the circumstances in a resource-constrained environment).

The first patient, a 40-year-old woman with young children, was seen at the oncology head and neck clinic at Steve Biko Academic Hospital. She had carcinoma of the larynx, at a stage where a laryngectomy with neck dissection would give her a real chance to be cured of her cancer. Her second option was radical radiotherapy, but this had less chance of curing her, and surgery might have to follow anyway and would be more difficult after a course of high-dose radiation. This patient was reluctant to undergo laryngectomy and lose her voice, and refused the operation after explanation by the ENT specialist and the social worker. In discussion at the head and neck clinic, it was suggested that 'we' should try to convince the patient to go for the operation with the best chance of curing her. A young patient with a 'voice box' would visit her, so that she could see that she would be able to talk even after a laryngectomy. The other argument was that she would also lose her voice after curative radiotherapy, and she had not been informed about this yet. Furthermore, curative radiotherapy would only be available after 14 weeks and an operation could be done within 4 weeks. The final decision was that the medical team would speak to her again, give her all the options, and see if she was willing to change her mind. At the end of the day, the patient needs to give consent for any management after considering all the information available.

The second patient was a young woman with HIV, multidrug-resistant tuberculosis (MDR-TB) and substance use (intravenous heroin). She lived in a shelter with a few hundred other people, including at least 50 children, some of them only a few weeks old. When we saw her, we realised that she was in a very bad condition – short of breath at rest, coughing continuously, and very wasted. She

agreed to go to the local district hospital and was seen by the staff in the TB clinic, who knew her very well. She was put on MDR-TB treatment but defaulted after 3 months. It was decided to call the social worker and clinical associate from the community-orientated substance use programme (COSUP) team to explain to her that she would be able to receive methadone when admitted to hospital. The doctor phoned the referral hospital to confirm this before referring her there for admission and inpatient treatment. The TB nurses took her sputum for TB culture and sensitivity and did her vitals – she weighed 34 kg. But she refused to be admitted and went back to the shelter, where she lived with an ill man in a room without any windows. The team was disappointed and frustrated by her refusal to stop using IV heroin and start MDR-TB treatment again as an inpatient. It was decided that the community health worker and the COSUP social worker would do a home visit. We hoped to convince her that it was of the utmost importance to treat her HIV and restart MDR-TB treatment, and to screen her boyfriend and her 8-year-old daughter as well. Should we respect this patient's autonomy, or focus on the risk that she will infect the many people around her, and force her to be treated?

Doctors, medical students and other healthcare workers are not robots who give a patient the correct information and then wait to see what the patient 'wants'. They understand very well that patients have strong feelings and emotions, fears and concerns – no one wants to give up a certain lifestyle or favourite habits, become disfigured or be unable to speak, have a leg amputation, etc. But there are many doctors in the world who will refuse to operate on you for obstructed blood vessels unless you stop smoking. This is particularly important in a resource-constrained environment, where scarce resources will be used for the patients with the highest chance of success.

That is the difference between theory and practice. Doctors are also human beings, and their experience, world view and commitment to good results and the wellbeing of their patients makes many of them compassionate carers and not just paternalistic doctors. We think that it is not just the technical worldview of liberalism that can guide us on how best to treat our patients and fellow human beings as whole persons and assist them to die with dignity.

### Martin Bac, Ellenore Meyer

Department of Family Medicine, School of Medicine, Faculty of Health Sciences,  
University of Pretoria, South Africa  
martin.bac@up.ac.za

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