

**FRAMEWORK FOR THE
IMPLEMENTATION OF
EUTHANASIA IN SOUTH
AFRICA**

by

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Summary

This dissertation aims to examine and analyse the current South African position with regard to voluntary euthanasia. An examination is made from constitutional law, common law, case law and statutory law perspectives, including the legislation proposed by the South African Law Commission (project 86). The writings of prominent authors are considered. Once the South African position is examined, a comparative study is undertaken concerning relevant aspects in the Dutch law. The most important findings are that the South African Constitution may allow, and perhaps even demand, the legalization of voluntary euthanasia in South Africa, provided that sufficient safeguards can be established to effectively and sufficiently minimize the risk of abuse. Should this be impossible, the proscription of euthanasia may be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. Finally, some recommendations are made for changes to the South African Law Commission's Final Draft Bill.

Key terms: euthanasia; assisted suicide; end of life; advance directive; living will; passport of life; right to die; mercy killing; terminal illness; human life; dignity; project 86

Opsomming

Hierdie skripsie het ten doel om die huidige Suid-Afrikaanse posisie met betrekking tot vrywillige genadedood te ondersoek en te analiseer. `n Ondersoek word gedoen vanuit die oogpunte van konstitusionele reg, gemenereg en wetgewing, insluitend konsep-wetgewing voorgestel deur die Suid-Afrikaanse Regskommissie (projek 86). Die werk van sommige prominente outeurs word in ag geneem. Nadat die Suid-Afrikaanse posisie ondersoek is, word `n regsvergelykende studie met Nederland gedoen rakende relevante aspekte. Die belangrikste bevinding is dat die Suid-Afrikaanse Grondwet vrywillige genadedood mag toelaat en moontlik selfs vereis, solank as wat voldoende veiligheidsmeganismes daar gestel kan word om die risiko van misbruik effektiewelik en genoegsaam te beperk. Sou dit nie moontlik wees nie, mag die verbod op genadedood redelik en regverdigbaar wees in `n oop en demokratiese samelewing gebaseer op menswaardigheid, gelykheid en vryheid. Ten slotte word voorstelle gemaak vir veranderings aan die Suid-Afrikaanse Regskommissie se Finale Konsepwet.

Sleutel terme: genadedood; selfmoord hulp; einde van lewe; lewende testament; paspoort van lewe; reg om te sterf; eutanاسie; terminale siekte; menslike lewe; waardigheid; projek 86

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Chapter 1: Introduction

Background

1.1.1 Introductory remarks

The topic of euthanasia (including “passive”, “active”, “voluntary”, “involuntary” and “non-voluntary” euthanasia, physician-assisted suicide and the use and legality of “living wills” or “advance directives”) is a topic of increasingly widespread and intense debate all over the globe. Although euthanasia in various forms has been practiced for centuries, the renewal of the debate is partly the result of growing interest in human rights and the awareness that modern medical science has created a hitherto unknown situation.¹

Modern developments in medicine have given rise to the so-called technological imperative, a term used to describe the phenomenon where any incident where a life is not saved at all costs is seen as suspect.²

This nobly-intended motive, combined with baffling advances in medical science, has proved to be a double-edged sword. While the lives of many people who as recently as 50 years ago would have died can now be saved, it is often not possible to restore the quality of life they previously enjoyed. Heroic measures may sever the association between the preservation of biological life and the retention of a person as a thinking, feeling being capable of interacting with loved ones and his / her environment.³

¹ Leenen “The development of euthanasia in The Netherlands” 2001 *European Journal of Health Law* (“Leenen”) p.125.

² Nel “Regsrae rondom die geneeskundige behandeling van ernstig gestremde pasgeborenes” 1998 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* (“Nel”) p.74.

³ Benatar “Dying and ‘euthanasia’” 1992 *South African Medical Journal* (“Benatar”) p.35.

In essence, some people “outlive their own deaths”⁴ and then become trapped in a situation where they are alive, but wish they weren’t. In many such cases, they linger on until they die alone, often in clinical settings. To quote Benatar, “it is not surprising that there is now widespread fear of a prolonged, dehumanized, lonely death among strangers, and requests for active euthanasia are made to preempt this.”⁵

On the other side, legalizing euthanasia is not a simple matter. Firstly, it forces us to reconsider much of our classical thinking and law on subjects that are intimate and touch the core of our perception of ourselves as human beings and of our futures, both before and after death. The questions that we are confronted with include the following: What is the value of “human life”? What is “human life”? When does death occur? What are our obligations when death does occur? What right does a human being have to end his / her own life, if any, and what right, if any, does the state have to prevent him or her from doing so? If human beings have the right to end their own lives, under which circumstances would this right come into existence and for whom? Does a human being then have the right to assistance in ending his or her life? What is the purpose of medicine and what are the moral duties of doctors? To what extent should the moral duties of doctors also be legal duties? To what extent should the doctor-patient relationship be regulated?

To a large extent, many of the same questions are at hand that were originally addressed in the abortion debates, but for many people the issue is, in the case of euthanasia, more personal. In the case of abortion many of us can psychologically remove ourselves from the issue (everyone capable of thinking about it can at least be sure that he / she will not be aborted) and most can believe that they will never be in the situation where they would have to make a choice regarding abortion. Even should we be in a situation where we have to make this

⁴ Messinger “A gentle and easy death: from ancient Greece to beyond Cruzan toward a reasoned legal response to the societal dilemma of euthanasia” 1993 *Denver University Law Review* (“Messinger”) p.177.

⁵ Benatar (fn. 3 above) p.36.

choice, we know which actor we will be. In the case of euthanasia, everyone capable of thinking about it is in a situation where their future can be touched intimately by the outcome of the euthanasia debate, either by the possibility of their own death by means of euthanasia, or the death of someone else. In short, we are much closer to being behind John Rawls' "veil of ignorance", where we do not know, at the time that we make a policy decision, which actor we will be when said policy is implemented.

Combined with the fact that it is almost impossible to separate these questions from one's highly personal, moral and religious views, it is easy to see why the debate could turn into an intense and complicated one. In the past, most people could categorize it as an academic debate – one with no practical impact on their everyday lives. That all changed when euthanasia was formally recognized in The Netherlands.

1.1.2 The rise of the debate in South Africa

South Africa, like the rest of the world, showed increasing interest in euthanasia, especially in the light of the *de facto* impunity with which it was performed in The Netherlands. However, we truly took note when euthanasia was formally included in the statutes there. Confronted with the same problems created by medical science as in the rest of the world, and the increased awareness of human rights brought about by our interim and 1996 Constitutions, euthanasia suddenly became the subject of more attention than before.

The South African Law Commission investigated euthanasia and related issues and made a final legislation proposal in 1998. Up to date, no such legislation has been implemented, for reasons open to speculation. Perhaps it is due to the complexity of the topic, being inherently multi-disciplinary in nature.⁶ Perhaps it is due to the fact that in South Africa, as a relatively poor country, access to

⁶ Labuschagne "Dekriminalisasie van eutanase" 1998 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* ("Labuschagne: dekriminalisasie van eutanase") p.168.

health care is subject to economical pressures and this makes the risks of abuse associated with euthanasia all the more relevant. Perhaps it is because of personal, religious or moral views held by those in power. Whatever the reason, decisive action is needed, whether it be a decision to legalize euthanasia or a clear decision not to.

1.2 Purpose and problem statement

Why is there a (perceived) need for re-considering euthanasia now? In part because frequently invoked legal principles, that were formulated centuries ago, might not be appropriate to address modern issues.⁷

As indicated above, the world has changed significantly from the time when our law (or “non-law”)⁸ on euthanasia was created; modern technology would make our world unrecognizable to those who lived a mere hundred years ago. Socio-politically, South Africa has changed to no lesser degree. In practise, suicide pacts and similar phenomena seems to become increasingly common.⁹ Quite apart from the advances of medical technology, we are confronted with new challenges, of which we bore little or no knowledge 50 years ago. An example of such a challenge would be the number of people living and dying in South Africa with cancer and HIV / AIDS.

At the same time, the value we attach to life is brought to the foreground by all of the above. In the light of normal considerations, together with South Africa’s past and world history in the previous century, many people fear that the real risk of abuse is too high to legalize euthanasia.

⁷ Nel (fn 2 above) p.73.

⁸ See Strauss *Doctor, patient and the law* (1991) (“Strauss”) p.342.

⁹ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.174.

It is proposed that a comparative study be done to help identify potential pitfalls and solutions concerning the practical implementation of euthanasia in South Africa, specifically with the view of developing the proposed “safeguards”.

1.3 Choice of legal systems

The Netherlands is chosen as a comparative focal point for this study for two reasons: first, it is the country with the most experience with open euthanasia at this stage and second and more importantly, the Dutch legal system lends itself to comparison with the South African system due to the similarities and common heritage of the two systems.

1.4 Research methodology

The Constitution will provide the starting point for the consideration of euthanasia in a legal context; it is the highest law in the country and all other law must be interpreted with regard to the spirit of the Constitution.

South African common-, case- and statutory law will then be considered to determine the current position, any conflicts with the Constitution and the need, if any, for change.

At that stage, the Dutch Law will be used as a comparative focal point for evaluation. By drawing on the experiences in The Netherlands, a system can be developed that builds on their strengths and avoid the pitfalls they encountered, in the same way that the South African Constitution drew heavily on the experiences of other countries.

The literature on euthanasia is extensive. Out of necessity, reliance will often be placed on secondary (English) sources for information regarding the situation in The Netherlands.

Bearing in mind the above, as well as the writings of prominent authors, suggestions will be made, if necessary, for changes to the South African Law Commission's proposal.

1.5 Overview of chapters

It has been commented that unclear and especially value-loaded definitions often debilitate debates on euthanasia.¹⁰ In an attempt to avoid this, this dissertation will begin the discussion by briefly defining some terms for the purpose of the writings here. The rest of chapter 2 will provide an overview of the South African law on euthanasia, including constitutional law, common law, case law and statutory law, also interpreted with the aid of the writings of prominent authors.

In chapter 3, an overview of the South African Law Commission's report will be given, followed by a short analysis thereof in chapter 4.

Chapter 5 will consider the legal situation in The Netherlands with regard to euthanasia.

Chapter 6 provides suggested changes to the South African Law Commission's proposed legislation with chapter 7 being a brief conclusion.

1.6 Note on quotes and citations

Block quotes are used for all quotes longer than two lines.

The first footnote referring to a specific authority will contain the full citation in *THRHR* style, but including between brackets and quotation marks an indication as to how this authority will be referred to further on. Any subsequent citations will indicate the authority as indicated in the first citation and will also include,

¹⁰ Leenen (fn 1 above) p.127.

between brackets, a referral to the footnote containing the full citation. This is to ease the process of finding the original footnote.

Chapter 2: Overview of the South African Law on Euthanasia

2.1. General

To find the law in South Africa, one has to firstly go to the Constitution, which is the highest law in the country. After that, one has to drill down, interpreting the common law, statutes and case law through the perspective provided by the Constitution. Finally, the interpretation process can be eased with the aid of the writings of prominent authors.

This process is hindered somewhat in the discourse on euthanasia by the fact that the terminology is not really set and terms are used slightly differently by various authors or bodies; the subject “lends itself to confusion with regard to the terminology used.”¹¹ As such, it is firstly necessary to define, for the purposes of this dissertation, the terms that will be used.

2.2. Terminology

For the purpose of this dissertation, the following terms will, unless indicated otherwise, carry the indicated meanings. These are the meanings ascribed to the terms by the present author for purposes of this dissertation and cannot be assumed to be the meanings ascribed thereto by other authors, nor can the terms used by any other author be considered to be exactly matched.

“Euthanasia” - The killing or allowing to die of another person with mercy or compassion for that person as primary motive.¹²

¹¹ South African Law Commission Report – Project 86 par. 1.5.

¹² See in general Schwär, Olivier & Loubser *The forensic ABC in medical practice – a practical guide* (1988) (“Schwär, Olivier & Loubser”) p.24. See also Oosthuizen “Doctors can kill – active euthanasia in South Africa” 2003 *Medicine and Law* (“Oosthuizen”) p.551, one example from several where the element of terminal illness is also included in the definition of

“Passive euthanasia” - Euthanasia by means of non-interference or non-intervention in the death of another person.¹³

“Active euthanasia” - Any euthanasia that is not passive euthanasia.¹⁴

“Voluntary euthanasia” - Euthanasia performed as a result of the real and informed wishes of the person to be euthanized.¹⁵

“Involuntary euthanasia” - Euthanasia performed against the real and informed wishes of the person to be euthanized. Also called murder.¹⁶

“Non-voluntary euthanasia” - Any euthanasia that is neither voluntary nor involuntary euthanasia, for example euthanasia where the wishes of the person to be euthanized is unknown and unascertainable.

“Physician-assisted suicide” - Where a medically-trained person assists another person in some way to commit suicide by use of medical knowledge or technology.

euthanasia. Another element often found in definitions of euthanasia is gentleness or painlessness of the killing – see for example Rall “The doctor’s dilemma: relieve suffering or prolong life?” 1977 *SALJ* (“Rall”) p.41, but where it is also argued that it should not be an absolute requirement and thereby exclude killing by shooting as a possible form of euthanasia.

¹³ Rall (fn 12 above) p.45. There is much confusion and difference of opinion with regard to the active / passive distinction. Compare, for example, the different manners in which the active / passive distinction is made by Van Oosten in Van Oosten *International Encyclopaedia of Laws* (1996) (“Van Oosten”) p.113 and by Burchell in Burchell *Principles of criminal law* (2005) (“Burchell”) p.159. It has been observed that all almost all relevant acts can have both active and passive sides – see for example Price “Liability in delict for acts of omission” 1950 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* (“Price”) 1. The Dutch have done away with the distinction completely.

¹⁴ See McQuoid-Mason “Recent developments concerning euthanasia in South Africa” 1995 *Law and Medicine* (“McQuoid-Mason”) p.7.

¹⁵ See McQuoid-Mason (fn 14 above) p.7.

¹⁶ See McQuoid-Mason (fn 14 above) p.7.

2.3. Constitution

The Constitution is the supreme law in South Africa. The Bill of Rights, which forms part of the Constitution, “applies to all law”.¹⁷ This often gives it direct application, but it also has indirect application through the effect it has on the interpretation of our law – section 39(2) provides that:

“When interpreting any legislation, and when developing the common law or customary law, every Court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.”

When interpreting the Bill of Rights itself, section 39(1) provides that:

“When interpreting the Bill of Rights, a Court, tribunal or forum –

- (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom
- (b) must consider international law; and
- (c) may consider foreign law.”

In considering international instruments, such instruments are an important guide to interpreting the rights in the Bill of Rights, even where said instruments are not binding.¹⁸

Section 39(3) then proceeds to recognise common law, customary law and legislated rights and freedoms, but only to the extent that they are consistent with the Bill of Rights.

Several rights contained in the Bill of Rights may bear upon the issues surrounding euthanasia and have to be considered and analysed. These include the rights to equality,¹⁹ dignity;²⁰ life;²¹ freedom and security of person;²² and

¹⁷ Constitution of the Republic of South Africa, 1996 section 8.

¹⁸ *Grootboom v Oostenberg Municipality* 2000 (3) BCLR 227 (C) (“*Grootboom v Oostenberg Municipality*”).

¹⁹ Section 9.

²⁰ Section 10.

²¹ Section 11.

privacy,²³ which are discussed below, together with the limitation clause in the Bill of Rights,²⁴ which determines the extent to which these rights may be limited.

The concept of values is deeply ingrained into the Constitution, and the Constitutional Court has committed itself to a purposive approach to interpretation of the Bill of Rights, sometimes also referred to as “value oriented” or “teleological”.²⁵

2.3.1 Right to Dignity

Section 10 of the Bill of Rights provides that

“[e]veryone has inherent dignity and the right to have their dignity respected and protected”

While protection for dignity is commonly found in international instruments, the exact meaning of the word is not clear. It is, however, clear that the international instruments suggest a meaning which is noticeably broader than the Roman-Dutch common law use, definition²⁶ or concept of *dignitas*²⁷ (relating to the inviolability of an individual’s personality or self-esteem) and establishes dignity as a core right, reflected in specific provisions as well as the ethos of the great international human rights instruments. The Constitutional Court has also given an extensive interpretation to the right to dignity.²⁸ Devenish concludes that dignity “therefore constitutes the moral premise for the existence and operation of other cognate rights.”²⁹

Degrading treatment has been defined as treatment which

²² Section 12.

²³ Section 14.

²⁴ Section 36.

²⁵ Pearmain *A critical analysis of the law on health service delivery in South Africa* 2004 (unpublished LLD-thesis, University of Pretoria) (“Pearmain”) p.113.

²⁶ Cheadle, David & Haysom *South African Constitutional Law: The Bill of Rights* (2002) (“Cheadle *et al*: The Bill of Rights”) p.137.

²⁷ Devenish (fn 62 above) p.88.

²⁸ *Gardener v Whitaker* 1994 5 BCLR 19(E) (“*Gardener v Whitaker*”) p.36.

²⁹ Devenish (fn 62 above) p.81.

“grossly humiliates an individual or drives a person to act against his or her will or conscience [...] any act which diminishes a person in rank, position, reputation or character can be regarded as degrading treatment, if it reaches a certain level of severity.”³⁰

In an extensive analysis of the Constitutional Court’s jurisprudence, Woolman identifies five primary definitions of dignity, and then argues that they all

“draw down on the same basic insight: that we recognize all individuals as ends-in-themselves capable of self-governance” [...] Dignity “secures the space for self-actualisation.”³¹

Devenish states that “impairment of dignity can assume many forms and obviously there is no *numerus clausus*” .³²

One of the reasons why it is so difficult to define the right to dignity, is that it is not easily separated from other fundamental rights, such as freedom and security of person; privacy and life, as it is inherent in or overlaps such rights. It has even been stated that it is the source of a number of these rights. By its very nature, it demands respect for all of a person’s rights.³³ Even if a particular right finds no express protection in the Constitution, the Constitutional Court will protect it if it is related to dignity.³⁴ In the context of health care, dignity is often equated with quality of life and the dignity of a person who no longer has quality of life is usually significantly impaired.³⁵

The rights to dignity and equality are intricately linked. At the heart of the prohibition against unfair discrimination lies the recognition that “all human

³⁰ Devenish (fn 62 above) p.128.

³¹ Woolman “Dignity” in Chaskalson *et al Constitutional law of South Africa* (2005) (“Woolman: Dignity”) p.36-6.

³² Devenish (fn 62 above) p.83 .

³³ Devenish (fn 62 above) p.82.

³⁴ Joubert (ed) *The Law of South Africa* (2004) Volume 5 Part 3 (“Joubert vol 5 part 3”) p.58 .

³⁵ Pearmain (fn 25 above) p.121.

beings, regardless of their position in society, must be accorded equal dignity”,³⁶ and the goal of the Constitution is to achieve such a society.³⁷

Furthermore, whether or not discrimination has impaired the dignity of the victim is one of the considerations with regard to the impact it has on the person discriminated against, which in turn is the determining factor of the unfairness of the discrimination.³⁸

In terms of the Constitutional Court’s decision in *Christian Education South Africa v Minister of Education*,³⁹ this does however not mean that everyone is treated the same way, but that everyone is treated with equal concern and respect.

What seems clear, however, is that dignity is impaired if a person is subjected to degrading or humiliating treatment or to conduct which treats a person as subhuman⁴⁰ and that “dignity” itself embraces subjective emotions.⁴¹ Surgically removing a bullet from a person’s body against his / her will, for example, constitutes a serious infringement on said person’s human dignity,⁴² and keeping a man imprisoned until such time as he became “visibly debilitated and bedridden could not be regarded as humane treatment in accordance with his inherent dignity”.⁴³

³⁶ *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC) (1997) (6) BCLR 708 (“*President of the Republic of South Africa v Hugo*”).

³⁷ Ackerman ‘Equality under the 1996 South African Constitution’ in Rüdiger Wolfrem (eds) *Gleichheit und Nichtdiskriminierung im Nationalen und Internationalen Menschenrechtsschutz* (2003) (“Ackerman”) p.105.

³⁸ *President of the Republic of South Africa v Hugo* (fn 36 above).

³⁹ *Christian Education South Africa v Minister of Education* 2000 (4) SA 757, 2000 (10) BCLR 1051 (CC) (“*Christian Education South Africa v Minister of Education*”).

⁴⁰ Cheadle *et al*: *The Bill of Rights* (fn 26 above) p.137.

⁴¹ Devenish (fn 62 above) p.82.

⁴² *Minister of Safety and Security v Gaqa* 2002 (1) SACR 654 (C) (“*Minister of Safety and Security v Gaqa*”).

⁴³ *Stanfield v Minister of Correctional Services* 2004 (4) SA 43 (C) (“*Stanfield v Minister of Correctional Services*”).

The Court seems to not only have regard for the dignity of individuals, but also that of society and the effect certain actions, directed at individuals or groups, have on society. This is illustrated by the following:

“It is not only the dignity of the poor that is assailed when homeless people are driven from pillar to post in a desperate quest for a place where they and their families can rest their heads. Our society as a whole is demeaned when state action intensifies rather than mitigates their marginalisation.”⁴⁴

It is clear that human dignity is a pre-eminent and core Constitutional right. According to Currie & De Waal, human dignity is considered to be, in moral philosophy, what gives a person intrinsic worth.⁴⁵ As a result, dignity is “above all price and admits of no equivalent”.⁴⁶ All the other rights in the Bill must be so construed as to promote “an open and democratic society based on human dignity, equality and freedom” and rights may only be limited to the extent justifiable in such a society.⁴⁷ In terms of section 37, dignity is a non-derogable right.

Chaskalson P stated that: “The rights to life and dignity are the most important of all human rights and the source of all other personal rights” and that “[b]y committing ourselves to a society founded on the recognition of human rights we are required to value these rights above all others.”⁴⁸ O’Regan J commented in her concurring judgement that

“The importance of dignity as a founding value of the new Constitution cannot be overemphasised. Recognizing a right to dignity is the acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many of the other rights that are specifically entrenched in chapter 3.”⁴⁹

⁴⁴ *Port Elizabeth Municipality v Various Occupiers* 2005 (1) SA 217 (CC), 2004 (12) BCLR 1268 (CC) (“*Port Elizabeth Municipality v Various Occupiers*”).

⁴⁵ Currie & De Waal *The bill of rights handbook* (2005) (“Currie & De Waal”) p.273.

⁴⁶ Kant *Principle of Personality* (1971) (“Kant”) p.127 as quoted in Devenish (fn 62 above) p.81.

⁴⁷ Cheadle *et al*: *The Bill of Rights* (fn 26 above) p.137.

⁴⁸ *S v Makwanyane* 1995 3 SA 391 (CC); 1995 6 BCLR 665 (CC) (“*S v Makwanyane*”).

⁴⁹ *S v Makwanyane* (fn 48 above).

Even though *S v Makwanyane* was decided before the 1996 Constitution, there is no substantial difference between the respective formulations of the right to dignity in the interim- and 1996 Constitutions, the only difference in terminology used being that the 1996 Constitution declares dignity to be “inherent”.⁵⁰

This is in line with the approach of the Technical Committee on Human Rights for the interim Constitution, which gave this right the “highest priority from the outset, and the formulation suggested originally was never questioned or altered.”⁵¹ It has even been asserted that, all things considered, human dignity is probably the most important right in the Constitution.⁵²

Dignity is also a constitutional value of prime importance in the limitations analysis,⁵³ in which capacity it informs and gives substance to all the provisions of the Constitution, while not being an enforceable right in itself.⁵⁴ An example where dignity was applied in such a manner is the case of *Carmichele v Minister of Safety and Security*,⁵⁵ where the Constitutional Court found that the value of dignity, amongst others, required the expansion of the duty of care placed on the state in delictual actions in order to ensure that the state not allow known and dangerous criminals to endanger the lives of citizens.⁵⁶

Cheadle is of the opinion that this right, as enshrined in the Constitution, may go so far as to require that the state protect persons’ dignity against attack by others.

“The implication of such a reading is the imposition of a duty on the state to provide mechanisms, legal or otherwise, by means of which a citizen can ensure that his

⁵⁰ Devenish (fn 62 above) p.83.

⁵¹ Devenish (fn 62 above) p.83 .

⁵² Joubert vol 5 part 3 (fn 34 above) p.56 .

⁵³ *Dawood v Minister of Home Affairs* 2000 (3) SA 936 (CC), 2000 (8) BCLR 837 (CC) (“*Dawood v Minister of Home Affairs*”).

⁵⁴ *Minister of Home Affairs v National Institute for Crime Prevention* 2005 (3) SA 280 (CC), 2004 (5) BCLR 445 (CC) (“*Minister of Home Affairs v National Institute for Crime Prevention*”).

⁵⁵ *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC), 2001 (10) BCLR 995 (CC) (“*Carmichele v Minister of Safety and Security*”).

⁵⁶ Woolman: Dignity (fn 31 above) p.36-25.

or her dignity is not improperly or unlawfully impaired by others. Even the phrase ‘respect for’ imposes positive obligations such as to establish accessible legal remedies.”⁵⁷

He came to this conclusion after an examination of the decisions of the European Commission and international law.⁵⁸ As indicated above,⁵⁹ such examination of international law as aid in interpreting the Bill of Rights is provided for in article 39(1) (b) and (c) of the South African Constitution.

Devenish goes so far as to say that dignity is even more of a pre-eminent value in the 1996 Constitution than the right to life.⁶⁰

In South Africa, a mentally competent patient may choose to discontinue medical treatment or refuse its initiation,⁶¹ but so-called “active euthanasia” is unlawful.

Despite this, South African courts have shown “the utmost leniency” with people who euthanized others out of a sense of mercy or compassion where there was terrible suffering or terminal illness.⁶² In none of the reported South African cases on euthanasia, has effective imprisonment been imposed.

Any person who assists a medical practitioner in the execution or provision of unlawful medical procedures or treatment may be liable as co-perpetrators or accomplices if they are aware, at the time, of the unlawfulness.⁶³ While suicide is not a crime in itself, assisting someone with suicide is. It would follow that knowingly assisting someone in assisting someone with suicide may also give rise to liability. This creates the bizarre situation that X can theoretically be liable

⁵⁷ Cheadle *et al*: The Bill of Rights (fn 26 above) p.140.

⁵⁸ It should be noted here that international law does not take a very clear position on euthanasia *per se*. See Joubert vol 5 part 3 (fn 34 above) p.64.

⁵⁹ See page 10 above.

⁶⁰ Devenish (fn 62 above) p.81.

⁶¹ Labuschagne “Beëindiging van mediese behandeling en toestemming onbekwames” 1995 *Obiter* (“Labuschagne: beëindiging van mediese behandeling”) p.176.

⁶² Devenish *A commentary on the South African bill of rights* (1999) (“Devenish”) p.98.

⁶³ Joubert (ed) *The Law of South Africa* (1999) Vol. 17 (“Joubert vol 17”) p.155 .

for assisting a medical practitioner in assisting X self in attempting to commit suicide. It is suggested that such an approach would not find favour in our courts.

It is important to note the distinction between the right and the value. Section 10 envisions dignity as a discrete right giving rise to enforceable claims.⁶⁴ According to Woolman, “however dignity is construed in a given matter, its meaning will never stray far from our core concern with the treatment of individuals as end-in-themselves.”⁶⁵

This gives particular importance to the fact that some people find the effect of intensive medical care on the process of dying degrading, reducing the patient to a research specimen “subjected to treatment after treatment in the hopeless quest for a continued heartbeat”.⁶⁶ Because a dying person is still a living person, it follows that to die without dignity is also to live without dignity.⁶⁷ Labuschagne is of the opinion that the current system may force people to die in cruel and undignified ways merely to satisfy abstract and merciless legal rules requiring the maintenance of life at all costs. This, he submits, cannot be justified from a human rights perspective.⁶⁸

The way in which a person dies affects more than the final biological moments of that person’s life. In many cases, it affects the enduring memories of this person held by loved ones and others. This is often a factor for consideration and the cause for potential pain (though non-physical) for the person while still alive. If people were only concerned about physical pain and other unpleasant physical experiences, they would probably not care about whether or not their bodies continued to live after they became permanently comatose. In reality, people care a great deal about this and similar matters, and equate it with their dignity. Such

⁶⁴ Woolman: Dignity (fn 31 above) p.36-23.

⁶⁵ Woolman: Dignity (fn 31 above) p.36-25.

⁶⁶ Messinger(fn 4 above) p.226 .

⁶⁷ Labuschagne “Aktiewe eutanasië: mediese prerogatief of strafregtelike verweer?” 1996 *South African Law Journal* (“Labuschagne: aktiewe eutanasië”) p.411.

⁶⁸ Labuschagne: aktiewe eutanasië (fn 67 above) p.413.

matters include how they are remembered, how other people view them, and whether or not they live and die in a way that they personally consider dignified.⁶⁹ These are some of the concerns that may explain the horror many people feel at the idea of living for years as a “vegetable” - a pointless, bare biological existence, with no cognition or sensibility. These people do care very much about whether or not their bodies continue to live in such a situation – they consider it to be “something bad for them, something that damages their lives as a whole.”⁷⁰ Even should the person not be a “vegetable”, the most frightening aspect of death for many people is not physical pain, but the pain of losing control and independence, the pain of dying in a manner or condition that they consider undignified or existentially unacceptable.⁷¹

Each person may have their own view of what constitutes a manner or condition that is undignified or existentially unacceptable; this does not have to be in line with another person’s beliefs or observations. Ultimately, respect for someone’s dignity forces the admission that “[m]aking someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.”⁷²

Our courts have held that “[e]ven the worst of convicted criminals should be entitled to a humane and dignified death”.⁷³ If this is true, why can it be considered humane treatment in accordance with a person’s inherent dignity to be forced against his / her will to visibly deteriorate and fade away, confined to a hospital bed?

⁶⁹ In the case of *Soobramoney v Minister of Health (Kwazulu- Natal)* 1997 BCLR (12) 1696 (CC) (“*Soobramoney v Minister of Health*”), the Court observed that dying is part of life.

⁷⁰ Dworkin “Do we have a right to die?” in Uhlman (ed) *Last Rights – Assisted suicide and euthanasia debated* (1998) (“Dworkin”) p.83.

⁷¹ Quill “Death and dignity” in Uhlman (ed) *Last Rights – Assisted suicide and euthanasia debated* (1998) (“Quill”) p.334.

⁷² Harris “Euthanasia and the value of life” in Keown *Euthanasia examined: ethical, clinical and legal perspectives* (1997) (“Harris”) p.19

⁷³ *Stanfield v Minister of Correctional Services* (fn 43 above).

Applied to euthanasia, the right to dignity therefore protects individuals against dying in a manner that they consider undignified and may in fact create the obligation on the state to provide for accessible legal remedies to address the problem. Legislation providing for euthanasia could provide such a legal remedy.⁷⁴

The right to dignity can, however, still be limited in terms of section 36(1), discussed later;⁷⁵ within limits, the state is still entitled to pursue its legitimate interests for the good of society as a whole, despite the fact that these may impact on the dignity of individuals.⁷⁶

2.3.2 Right to Life

Section 11 of the Bill of Rights provides that

“[e]veryone has the right to life”

The right to life may seem simple, as it is stated positively and without qualifications, but the broad protection it enjoys integrates itself into inordinately complex and controversial moral and social issues, including euthanasia.⁷⁷ To resolve the issue of euthanasia, the right to life might have to be balanced against other values and rights protected in the Constitution.⁷⁸

As indicated earlier,⁷⁹ the rights to life and dignity are the “most important of all human rights and the source of all other personal rights.”⁸⁰ The question was also raised (but not answered) in the Constitutional Court by Mohamed J as to how the right would be applied in cases of both passive and active euthanasia:

⁷⁴ For a general argument against the recognition of any sort of human right to choose the time and condition of one’s death, see Leonard-Taitz “Euthanasia, the right to die and the law in South Africa” 1992 *Medicine and Law* (“Leonard-Taitz”) p.597.

⁷⁵ See 2.3.8 Limitation Clause on p.45 below.

⁷⁶ Joubert vol 5 part 3 (fn 34 above) p.60.

⁷⁷ Devenish (fn 62 above) p.94 .

⁷⁸ Cheadle *et al*: The Bill of Rights (fn 26 above) p.143 fn 3.

⁷⁹ See p.14 above.

⁸⁰ *S v Makwanyane* (fn 48 above).

“Does the ‘right to life’ within the meaning of s 9, preclude the practitioner of scientific medicine from withdrawing the modern mechanisms which mechanically and artificially enabled physical breathing in a terminal patient to continue, long beyond the point, when the ‘brain is dead’ and beyond the point when a human being ceases to be ‘human’ although some unfocussed claim to quality as a ‘being’ is still retained? If not, can such a practitioner go beyond the point of passive withdrawal into the area of active intervention? When? Under what circumstances?”⁸¹

Life is a concept that is not easily circumscribed or defined,⁸² but already there is a clear approach of taking cognisance of the quality of a human life in interpreting the right to life and to acknowledge the inherent fusion of the right to life with the right to dignity; in essence, everyone is entitled to a dignified life:

“It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity. This concept of human life is at the centre of our Constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. So the right to human dignity and life are entwined. The right to life is more than existence; it is a right to be treated as a human being with dignity”.⁸³

Like the right to dignity, the right to life is listed in the table of non-derogable rights.⁸⁴

The terms “everyone” (as used in the 1996 Constitution) and “every person” (as used in the interim Constitution) are used and understood interchangeably.⁸⁵

What is meant by “everyone” or “every person”? It is clear from our jurisprudence that a foetus has no right to life.⁸⁶ Yet a foetus has or is a form of

⁸¹ *S v Makwanyane* (fn 48 above).

⁸² See Pearmain (fn 25 above) p.120.

⁸³ *S v Makwanyane* (fn 48 above).

⁸⁴ Constitution of the Republic of South Africa, 1996 section 37.

⁸⁵ *Christian Lawyers Association of South Africa v Minister of Health* 1998 4 SA 1113 (T); 1998 11 BCLR 1434 (T) (“*Christian Lawyers Association v Minister of Health*”)

life – human life, in fact.⁸⁷ The metaphorical line is always drawn by saying that a foetus is not a person, and as such cannot be the bearer of the right to life. This distinction is common in the interpretation of the right to life in many countries of the world.

So, it is submitted that it is not “life” that is being protected (otherwise you would not have been allowed to arbitrarily kill an ant) and it is not even mere biological human life that is being protected. The Constitution, in fact, only protects the life of “every person”. The right to life is therefore limited to “persons”. While our courts do often refer to the protection of “human life”, it is clear that the term “human life” is not used synonymously with biological human life,⁸⁸ but rather with a qualitative interpretation of “human life” or, it is submitted, personhood.

The term “person” is used to denote a particular sort of individual. Being a member of a specific species is not by itself sufficient to qualify as a “person” (otherwise all biological human life would have been protected), so personhood rather describes an individual that can be identified by certain capacities or powers⁸⁹ and is normally conferred on human beings when they meet certain criteria, for example being born alive.⁹⁰

This currently creates the situation where someone who is in the process of being born bears no rights, yet the moment such individual is born alive and separated from the mother, he / she not only enjoys all the normal rights afforded to

⁸⁶ *Christian Lawyers Association v Minister of Health* (fn 85 above)

⁸⁷ Swanepoel “Embryonic stem cell research and cloning: a proposed legislative framework in context of legal status and personhood” (Unpublished LLM dissertation, University of Pretoria, 2006) (“Swanepoel”) p.89.

⁸⁸ Compare, however, Joubert vol 5 part 3 (fn 34 above) p.60, where it is stated that the rights to life and dignity protect the “physical-biological existence of human beings.” It is submitted that an alternative but similar interpretation would be that a certain quality of life is what is being protected, and that at present only humans enjoy a quality of life above the elusive threshold. The conclusion of such argument would be the same in the context of euthanasia, even if a different route is followed to get there.

⁸⁹ Harris (fn 72 above) p.8.

⁹⁰ Currie & De Waal (fn 45 above) p. 288 fn 42.

persons, but also the special protection and rights afforded only to children. Within a moment, this individual goes from having no rights to being one of the most protected members of our society. While this type of problem is extremely common in legal science, where a specific line sometimes (and unfortunately) has to be drawn, a purposive approach to interpreting the Constitution requires one to delve deeper – to find the reason for the seemingly disproportionate protection given to any “person”, and to determine the probable rationale for when “personhood” is conferred on an individual.

Unfortunately, there seems to be no clear answer to the question. Many people from various countries of the world and from various disciplines debated this question for a long time. John Locke identified self-consciousness, which is coupled with fairly basic intelligence, as the most important criteria. Currently, this seems to be the most common account for personhood internationally,⁹¹ and finds indirect support in the National Health Act⁹², which defines “death” as brain death.

This self-consciousness, however, is more than merely being aware of oneself in the most basic of senses; it is the ability to value one’s own existence. This element explains the wrong that is being committed to a being that is deprived of existence – it is wronged by being killed due to the fact that it is being deprived of something it values.⁹³

From this it follows that non-persons or beings that are merely potential persons cannot be wronged by being killed, because they cannot wish to live and death does not deprive them of anything they value. This can also explain why, until such time as a foetus becomes a person, there are no “rights” of the foetus to consider, merely the rights of the mother, the state and society.

⁹¹ Harris (fn 72 above) p.8.

⁹² The National Health Act 61 of 2003.

⁹³ Harris (fn 72 above) p.8.

Applied to euthanasia, this logic ultimately rebels against the idea that someone can be wronged by having their genuine wish to die granted through voluntary euthanasia. If the person does not wish to live, his death does not deprive him of anything he values. In such a case, forcing life upon this person against his wishes is completely against the spirit and purpose of the right to life. It is submitted that forcing life upon such a person may even constitute an abuse of the right to life.⁹⁴

But what of the situation where a person loses the capacity to value his / her life, for example a comatose individual in a permanently vegetative state? Wouldn't this individual then lose "personhood", thereby also losing all his / her rights protected in the Constitution?

It is submitted that the capacity to value one's life must be lost permanently before "personhood" can be lost. If this was not the case, we could go around killing off unconscious or maybe even sleeping people. The obvious problem this raises is that it can be almost impossible to say with absolute certainty that someone has permanently lost this ability.

Moreover, our law protects someone's interest in what happens to his / her body after his / her death (for example, by allowing a person to donate his / her body after his / her death,⁹⁵ or to give a direction that his / her body may not be donated after his / her death).⁹⁶ It can also not be easily explained as a protection of public interest – if public interest was the only consideration, it is conceivable that people could be forced to donate their organs after their death, but they are not; they are given a choice. As an individual is no longer a person and cannot be the bearer of rights after death, it is clearly the living person's current interest in

⁹⁴ It is submitted that, while this argument is very similar to a general "quality of life" argument, it is superior in the sense that a general "quality of life" argument poses a greater risk of abuse, for example third parties arbitrarily "determining" the quality of life of the patient concerned. This could potentially lead to a scenario similar to that experienced in Germany under Nazi rule.

⁹⁵ The National Health Act 61 of 2003 section 62(1).

⁹⁶ The National Health Act 61 of 2003 section 62(2).

what will happen to his / her body in future (even after losing “personhood”) that is being protected in such cases.

In the absence of a clear and informed valuation by the individual of his / her life, or when the individual is unable to communicate such, some sort of proxy is needed. Where the individual is already legally dead when such proxy becomes needed, the law often provides certain categories of people that may make the relevant decisions.⁹⁷ Where the individual is not yet dead, however, the approach so far taken by the courts differs slightly.

In such cases, the approach taken by our courts prior to the Constitution is that decisions must be made in the best interest of the individual concerned,⁹⁸ an important consideration being the quality of that individual’s (future) life, assessed as far as possible through the eyes of the individual concerned. This assessment has to be done on an individual basis by the courts, or by someone empowered thereto by the courts, before any action may be taken in terms of such assessment.⁹⁹

A similar general approach is followed in cases where the patient is a minor, where the welfare of the child is of paramount importance, rather than the refusal or not of the parents to consent.¹⁰⁰

The above approach has, however, not yet been tested in the Constitutional Court. Moreover, like the reasoning that a foetus is not a person because it is completely dependant on the mother, it does not really address the issue that a live birth itself does not suddenly change the level of dependency or self-consciousness of the individual. Many people are completely dependant on one other person at various stages of their lives, and this person would not necessarily

⁹⁷ The National Health Act 61 of 2003 section 62(2).

⁹⁸ *Clarke v Hurst* 1992 4 SA 630 (D) (“*Clarke v Hurst*”).

⁹⁹ Dörfling “Eutanasië: Die reg van die curator personae om verdure behandeling van ’n pasiënt te verbied - ’n nuwe regverdigingsgrond in die Suid-Afrikaanse reg – *Clarke v Hurst*” 1993 *TSAR* (“Dörfling: Eutanasië”) p.350.

¹⁰⁰ *Hay v B* 2003 (3) SA 492 (W) (“*Hay v B*”).

be their mother; many people are even completely dependant on machines, yet they are recognized as persons. Be that as it may, the above approach seems to come closest to providing a plausible and reasonable rationale for the law's approach to personhood.

Does the fact that the rights enshrined in the Constitution are “inalienable” not actually convert these rights into obligations - in this case that everybody has the duty to live? It is submitted that human rights instruments are not drafted to restrict the freedom of the individual concerned,¹⁰¹ but rather to protect the individual from outside interference with his / her rights and to protect the individual from arbitrary deprivation or limitation of such rights. The right to live cannot be an unqualified obligation to continue living – if it were to be interpreted in such a way, both passive euthanasia and the so-called “double effect” would run afoul of this “right-became-duty”.

There is another angle to the right to life. Just as is the case with abortion, the state has a ‘detached’ interest in protecting human life.¹⁰² In the case of abortion, O’Sullivan & Bailey argue that:

“[t]here are good reasons to allow a state to prohibit abortion after viability [which occurs after the second trimester]. At about that point, fetal brain development is sufficient to feel pain, which indicates that the foetus has protectable interests of its own. By then a woman has had sufficient opportunity to decide whether she believes that it is best to terminate the pregnancy [...] The reasons advanced for the limitation of a right to abortion at viability appear to be sufficiently compelling to satisfy the limitations test set out in s 33 (1) of the interim Constitution.”¹⁰³

“Protectable interests” here should be distinguished from “rights”, as a foetus cannot be the bearer of rights under South African law. The above argument nevertheless applies very strongly in the case of euthanasia – the “viability” of a

¹⁰¹ Leenen (fn 1 above) p.130 .

¹⁰² O’Sullivan & Bailey “Reproductive Rights” in Chaskalson *et al Constitutional law of South Africa Revision Service 2* (1998) (“O’Sullivan & Bailey”) p.16-6A.

¹⁰³ O’Sullivan & Bailey (fn 102 above) p.16-6B.

terminally ill patient will depend on the exact meaning of “viable”, but at the very least the patient has an interest to be protected from pain, as in the case of the foetus above.

Finally, the right to life is not absolute, but subject to limitation in terms of section 36 of the Constitution. This was confirmed by all the judges save one¹⁰⁴ in *S v Makwanyane*.¹⁰⁵

2.3.3 Right to Security of the Person

Section 12(1) of the Bill of Rights provides that

“[e]veryone has the right to freedom and security of the person, which includes the right –

- (a) not to be deprived of freedom arbitrarily and without just cause;
- (b) not to be detained without trial;
- (c) to be free from all forms of violence from either public or private sources;
- (d) not to be tortured in any way; and
- (e) not to be treated or punished in a cruel, inhuman or degrading way.”

Section 12(2) continues that

“[e]veryone has the right to bodily and psychological integrity, which includes the right

- (a) to make decisions concerning reproduction;
- (b) to security in and control over their body; and
- (c) not to be subjected to medical or scientific experiments without their informed consent.”

The equivalent rights in the interim Constitution was first considered by the Constitutional Court in the case of *Ferreira v Levin NO*,¹⁰⁶ where it was interpreted narrowly to be limited to physical integrity “and within the framework of unlawful detention and proscriptions against cruel, inhuman and

¹⁰⁴ Devenish (fn 62 above) p.111 .

¹⁰⁵ *S v Makwanyane* (fn 48 above).

¹⁰⁶ *Ferreira v Lenin NO* 1996 1 SA 984; 1996 1 BCLR 1 (CC) (“*Ferreira v Lenin NO*”).

degrading treatment.”¹⁰⁷ In Canada, whose Constitution was one of the models for our own, it was held that the right against cruel and unusual treatment or punishment was limited to “state-imposed punishment in the context of criminal law regarding a person brought into the legal system” and was therefore not applicable to euthanasia.¹⁰⁸ Yet in South Africa’s 1996 Constitution, as opposed to the interim Constitution, we have the inclusion of the right to bodily and psychological integrity, which makes the ambit of the definition much broader than other international definitions.¹⁰⁹ Additionally, the 1996 Constitution applies horizontally as well as vertically,¹¹⁰ so the application of the right is not limited to state action.

Both international and national human rights instruments provide for the right to life and the rights to freedom and security of the person separately.¹¹¹ This indicates that these are conceptually different and distinct rights.¹¹² Thus, as Cheadle stated:

“[T]he section seeks to protect persons from seven different modes of conduct: torture, cruel treatment, cruel punishment, inhuman treatment, inhuman punishment, degrading treatment and degrading punishment. Internationally, this right is absolute, non-derogable and unqualified. All that is therefore required to establish a violation of the relevant section is a finding that the state concerned has failed to comply with its obligation in respect to any of these modes of conduct. No justification is possible.”¹¹³

In their analysis of the right, Currie and Woolman explains that:

“‘Security in’ and ‘control over’ one’s body are not synonymous. The former denotes the protection of bodily integrity against intrusions by the state and others. The latter denotes the protection of what could be called bodily

¹⁰⁷ O’Sullivan & Bailey (fn 102 above) p.16-12.

¹⁰⁸ Somerville “The sound of death: The lyrics of euthanasia” 1993 *Journal of Contemporary Health Law and Policy* (“Somerville”) p.27 .

¹⁰⁹ Cheadle *et al*: *The Bill of Rights* (fn 26 above) p.157.

¹¹⁰ Constitution of the Republic of South Africa, 1996 section 8(2).

¹¹¹ Cheadle *et al*: *The Bill of Rights* (fn 26 above) p.154.

¹¹² Devenish (fn 62 above) p.115.

¹¹³ Cheadle *et al* *Fundamental rights in the new Constitution* (1995) (“Cheadle *et al*: Fundamental rights”) p.37.

autonomy or self-determination against interference. The former is a component of the right to be left alone in the sense of being left unmolested by others. The latter is a component of the right to be left alone in the sense of being allowed to live the life one chooses.”

In essence, they say, the right to freedom and security of the person is a right to be left alone.¹¹⁴ This also entails a positive component:

“[T]he Constitution itself does not encompass merely a negative or defensive idea of freedom, but rather a positive one, akin to self-fulfilment and individual autonomy.”¹¹⁵

In the cases of *Carmichele v Minister of Safety and Security*¹¹⁶ and *NK v Minister of Safety and Security*,¹¹⁷ the Constitutional Court found that, amongst others, the right to freedom and security of the person imposed a positive obligation on the state to prevent violations of physical integrity, where possible.

This right then represents the value of individual autonomy. Currie & Woolman indicates that this leads to a right to bodily self-determination which is more concerned with an individual’s integrity than his / her welfare:

“The right to bodily self-determination stems from the value of individual autonomy. We should be left alone to make choices about the kind of lives we want to lead: ‘framing the plan or our life to suit our own character’.¹¹⁸ [...] [T]he recognition of a constitutional right to bodily autonomy means we have to abandon, or at least minimize, moralistic and paternalistic intervention in other peoples’ lives. This is because the right to bodily autonomy is concerned not with the welfare of the individual but rather with preserving that individual’s integrity.”¹¹⁹

Devenish submits that, while freedom as such is not defined in the Bill of Rights, it should be given a general and broad meaning.¹²⁰ The word “includes” clearly

¹¹⁴ Currie & Woolman “Freedom and Security of the Person” in Chaskalson *et al Constitutional law of South Africa Revision Service* 2 (1998) (“Currie & Woolman”) p.39-43.

¹¹⁵ Devenish (fn 62 above) p.120.

¹¹⁶ *Carmichele v Minister of Safety and Security* (fn 55 above).

¹¹⁷ *NK v Minister of Safety and Security* 2005 JOL 14864 (CC) (CCT 52/04) (“NK v Minister of Safety and Security”).

¹¹⁸ *Mill On Liberty* (1859) (“Mill”).

¹¹⁹ Currie & Woolman (fn 114 above) p.39-44.

¹²⁰ Devenish (fn 62 above) p.120.

indicates that the specific aspects of freedom that are listed are not meant to be exhaustive, but merely explanatory; the list does, in other words, not constitute a *numerus clausus*.¹²¹ With regards to the right in a negative sense, surgery on a person without his / her consent is an affront to the person's physical and perhaps even psychological integrity,¹²² even if it is to remove a bullet from his body, unless under some law that limits the right in accordance with section 36 of the Constitution.¹²³ The mere act of a patient entering a hospital, for example, does not constitute consent and operating on a person without consent could give rise to both delictual¹²⁴ and criminal¹²⁵ action.

An interesting and technically correct argument made by Currie & De Waal is that day-to-day medical care and therapy amounts to experimentation:

“Medical knowledge is controvertible and partial. When doctors prescribe approved drugs or engage in accepted practices on their patients, they are still experimenting: no two patients react exactly alike to the same drug or procedure; and it is often the case that it is not until after years of treatment on a willing and large population of patients that doctors know the side-effects and untoward reactions of various courses of treatment.”¹²⁶

This line of thought is also supported by Currie & Woolman.¹²⁷

It may then be argued that the person who requests euthanasia should be freed from the unforeseen and unintended consequences of such “experimentation” – the effects being for example that the life of the person was prolonged, but the quality of life could not be maintained, leaving the patient alive but in terrible suffering. Had the patient known what the result would have been, the patient could then have chosen to rather not prolong his / her life, in which case he / she

¹²¹ Devenish (fn 62 above) p.116.

¹²² *Minister of Safety and Security v Gaqa* (fn 42 above).

¹²³ *Minister of Safety and Security v Xaba* 2003 (2) SA 703 (D) (“*Minister of Safety and Security v Xaba*”).

¹²⁴ *Stoffberg v Elliott* 1923 CPD 148 (“*Stoffberg v Elliott*”).

¹²⁵ Strauss (fn 8 above) p.345.

¹²⁶ Currie & De Waal (fn 45 above) p.310; Claasen & Verschoor *Medical Negligence in South Africa* (1992) (“*Claasen & Verschoor*”) p.54.

¹²⁷ Currie & Woolman (fn 114 above) p.39-47.

would now be dead and not suffering. To redress this situation, the patient should now, with full knowledge of the consequences, be given the opportunity to opt for the latter situation.

It is submitted that such an argument cannot stand. Firstly, it is unlikely that the section will be interpreted to give such a wide meaning to “experiments”. Secondly, even should “experiments” be given such a broad meaning, it is impossible for the medical practitioner to inform the patient as to consequences which cannot even reasonably be foreseen by the practitioner.

Should the practitioner, however, be able to reasonably foresee a material risk of such negative consequences of the treatment, even if not in specific detail, we are dealing with experimentation in the proper sense. In such a situation, the above argument may hold true.

While the right to choose what medical treatment one is willing to receive or not receive clearly falls within the ambit of the freedoms protected in section 12(2), it is less clear whether or not there is protection for the “right” to certain “treatment” that will undoubtedly result in death.

As a patient is allowed to refuse treatment, and feeding and hydration are considered forms of treatment, passive euthanasia by means of the withdrawal of such feeding and hydration is in some cases legally allowed in South Africa. Death that is caused in such a way includes, by design, the progressive erosion of the body’s functioning and with it increasing levels of pain and suffering and a general degradation of the person. In no other context would we hesitate at all in identifying this as torture, or at the very least both cruel and inhuman treatment (or non-treatment, as the case may be). It is suggested that a purposive interpretation of section 12(1) would recognize such non-treatment as a potential violation of section 12(1) (e). The freedom protected in section 12, however, allows a person the choice to refuse treatment, and as such effectively impose such non-treatment on him or herself. Still, condoning such systematic and purposeful non-treatment of a patient, with all the side-effects, while denying

positive relief, and doing all of this in the spirit of a Bill of Rights that exalt human dignity, equality and freedom, smacks of ethical hypocrisy.

In South African law, the freedom to obtain treatment that will undoubtedly result in death is *de facto* acknowledged in cases where the so-called “double effect” applies.¹²⁸ The “double effect” is where a person is given drugs or treatment with the primary aim of relieving pain, whilst it is also known that such treatment will undoubtedly simultaneously shorten or end the patient’s life. This approach seems to be accepted both legally and morally¹²⁹ and there is little reason to believe that it will ever even be challenged constitutionally.

This is indicative that, in principle, a person has the right to choose active treatment that will shorten or end their life. The objection to the exercise of such right normally arises where the primary intention of the treatment is to shorten or end the patient’s life. Given that pain and suffering is not limited to the physical, a plausible argument can be made that a proper and genuine act of euthanasia will, by definition, always have as primary intention the relief of pain, recognizing that, for some pains, a certain kind of death is the only effective relief. This would imply that it is wholly improper to consider euthanasia as having the shortening or ending of a patient’s life as primary aim and that, in fact, our law should already recognize active euthanasia as a manifestation of the “double effect”. Our courts, however, have never expressly considered euthanasia from this angle.

There are certain justifications recognized in common law for the interference with the body of another: Where the interference is not unlawful, for example where a police officer arrests someone under a warrant; where the interference is excused, for example if you bump into someone while moving through a crowd, and if there is consent, for example if a boxer is hit in a boxing match.¹³⁰

¹²⁸ *Clarke v Hurst* (fn 98 above).

¹²⁹ Burchell (fn. 13 above) p. 159.

¹³⁰ *Stoffberg v Elliott* (fn 124 above).

In some cases, the interest of justice (and thereby the community) will weigh more than an individual's right to bodily and psychological integrity. An example would be where the infringement in the form of having a blood sample taken against a person's will is balanced against the interest of justice (and by implication the interests of the community).¹³¹

Be that as it may, the ultimate criterion for determining whether or not or to what extent the right may or should be limited in terms of the law, from a Constitutional law viewpoint, is found in article 36.¹³²

2.3.4 Right to Equality

Section 9 of the Bill of Rights reads as follows:

- (1) Everyone is equal before the law and has the right to equal protection and benefit of the law
- (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination may be taken.
- (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
- (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
- (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

¹³¹ *S v Orrie* 2004 (3) SA 584 (C) (“*S v Orrie*”).

¹³² See 2.3.8 Limitation Clause on p.45 below.

Most of our Constitutional Court jurisprudence on equality is based on section 8 of the interim Constitution. Section 9 of the 1996 Constitution is, however, similar enough for the Court's interpretation of the clause in the interim Constitution to apply to the 1996 Constitution, but with horizontal application added by section 9(4) in the new Constitution.¹³³

The grounds of discrimination are not a *numerus clauses*.¹³⁴ At its most basic, equality means that people that are similarly situated should be treated alike, and that people that are not similarly situated should be treated unlike, having regard to the degree in which they are differently situated.¹³⁵ This gave rise to the different approaches of formal and substantive equality.

Formal equality means sameness of treatment; substantive equality means sameness of result. Both of these have associated with them substantial problems. It is submitted that the best approach would have been seeking sameness or equality of opportunity. Due to South Africa's history of inequality, however, our courts interpret the right to equality as referring to substantive equality.¹³⁶

The Constitutional Court tabulated the stages to be followed when trying to determine whether there is a violation of the interim Constitution's equality clause:

“(a) Does the provision differentiate between people or categories of people? If so, does the differentiation bear a rational connection to a legitimate government purpose? If it does not then there is a violation of section 8(1). Even if it does bear a rational connection, it might nevertheless amount to discrimination.

(b) Does the differentiation amount to unfair discrimination? This requires a two stage analysis:

¹³³ Currie & De Waal (fn 45 above) p.234.

¹³⁴ *Brink v Kitshoff NO* 1996 (6) BCLR 752 (CC) 769.

¹³⁵ Currie & De Waal (fn 45 above) p. 230.

¹³⁶ Currie & De Waal (fn 45 above) p. 233.

(b)(i) Firstly, does the differentiation amount to ‘discrimination’? If it is on a specified ground, then discrimination will have been established. If it is not on a specified ground, then whether or not there is discrimination will depend upon whether, objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner.

(b)(ii) If the differentiation amounts to ‘discrimination’, does it amount to ‘unfair discrimination’? If it has been found to have been on a specified ground, then unfairness will be presumed. If on an unspecified ground, unfairness will have to be established by the complainant. The test of unfairness focuses primarily on the impact of the discrimination on the complainant and others in his or her situation.

If, at the end of this stage of the enquiry, the differentiation is found not to be unfair, then there will be no violation of s8 (2).

If the discrimination is found to be unfair then a determination will have to be made as to whether the provision can be justified under the limitations clause.”¹³⁷

Intention does not play a big role here; an applicant need not show that discriminatory law or conduct was intended to discriminate. Intention does, however, play a role in determining whether or not such discrimination is unfair.¹³⁸ According to the Constitutional Court, the purpose of the discriminatory conduct or action in question plays a role in determining whether or not such discrimination has an unfair impact.¹³⁹ Logically, it is difficult to see how the intention of an act can, of and by itself, change the fairness of the impact of that act. If one were to kill another in putative private defence, he or she may well be found not guilty of murder in court, but it does not make the impact of the killing any less unfair. Be that as it may, in our legal system, conduct or action that is performed with the intention to discriminate is more likely to be

¹³⁷ *Harksen v Lane NO* 1998 1 SA 300 (CC); 1997 11 BCLR 1489 (CC) (“*Harksen v Lane NO*”).

¹³⁸ Currie & De Waal (fn 45 above) p.263.

¹³⁹ *Harksen v Lane NO* (fn 137 above).

considered unfair than conduct or action where such intention cannot be shown.¹⁴⁰

This gives rise to several categories into which conduct can be classified. It could be:

- mere differentiation;
- discrimination that is fair;
- discrimination that is unfair; or
- none of the above.

In the case of euthanasia, we find that many people who are suffering are in a position where they are able to commit suicide (which is no longer a crime). Other similarly situated people suffering in the same manner and degree may, due to physical inability or other reasons, not be able to commit suicide.¹⁴¹ These people also cannot enlist the aid of someone else in hastening their own death, as the rendering of such aid constitutes a crime.¹⁴²

It is clear that there is differentiation between these two groups of people. From a formal equality point of view, there is no discrimination, as people in the first group can also not enlist the aid of another in hastening their own deaths. But from the perspective of substantive equality, these two groups are clearly not being treated equally, based on disability. The result is that these people are being discriminated against. While it is most unlikely that such discrimination is intentional, it is based on one of the grounds listed in section 9, creating a presumption of unfairness until the contrary is proven.¹⁴³

To some extent it may be argued that, because anyone can refuse food and hydration, everyone is able to commit suicide. The discrimination, however, is

¹⁴⁰ *Pretoria City Council v Walker* 1998 2 SA 363 (CC); 1998 3 BCLR 257 (CC) (“*Pretoria City Council v Walker*”).

¹⁴¹ Burchell (fn. 13 above) p.331.

¹⁴² See *McQuoid-Mason* (fn 14 above) p.16.

¹⁴³ *Currie & De Waal* (fn 45 above) p. 248.

still found in the different manners of death experienced by the two groups. Suicide can be committed in a relatively quick and pain free manner, whereas starvation is a drawn-out, degrading and painful process. This also illustrates why the different legal approaches to “active” and “passive” euthanasia may run afoul of section 9.

Finally, Labuschagne¹⁴⁴ asks whether or not section 9 also protects the right to equal social-moral stigmatization? He submits that if it does, then it is a human rights violation to find a person who commits active euthanasia and a person who tortures another to death guilty of the same crime – murder. This is also entwined with the distinction between active and passive euthanasia, as the latter is not regarded as a crime at all. Of course, this consideration may also impact upon the right to dignity of the person who performs euthanasia.

2.3.5 Right to Privacy

Section 14 of the Bill of Rights provides that

“[e]veryone has the right to privacy, which shall include the right not to have –

- (a) their person or home searched;
- (b) their property seized;
- (c) their possessions seized; or
- (d) the privacy of their communications infringed.”

In terms of common law, privacy, which now also enjoys constitutional protection, impacts *inter alia* upon the record-keeping and consultation with regard to euthanasia requests and related information provided in a confidential fashion: “The duty of a physician to respect the confidentiality of his patient is not merely ethical but is also a legal duty recognised by the common law”.¹⁴⁵ Fault is not a requirement for something to be recognized as an infringement of a

¹⁴⁴ Labuschagne "Dodingsmisdade, sosio-morele stigmatisering en die menseregtelike grense van misdaadsistematiesing" 1995 *Obiter* (“Labuschagne: dodingsmisdade”) p.34.

¹⁴⁵ *Jansen van Vuuren NNO v Kruger* 1993 (4) SA 842 (A) 1993 (4) SA (“*Jansen van Vuuren NNO v Kruger*”).

constitutional right to privacy.¹⁴⁶ The right of the patient and the duty of the doctor are, however, relative and not absolute.¹⁴⁷

The constitutional right to privacy may, in addition to impacting the development of the common law, give rise to new actions for invasion of privacy reflecting important personal interests as against the state.¹⁴⁸

In *Bernstein v Bester NO*,¹⁴⁹ Ackerman J identified privacy with the

“inner sanctum of a person, such as his / her family life, sexual preference and home environment, which is shielded from erosion by conflicting rights of the community.”

He indicates that the right to privacy is normally limited to the most personal aspects of a person’s existence. The right is essentially the right to live one’s own life with a minimum of interference, and concerns, amongst other things, physical and moral integrity, (which includes the right not to have a blood test for DNA profiling taken against one’s will),¹⁵⁰ the right not to be exposed to constant radio broadcasts of which neither the content nor the volume is of one’s choosing¹⁵¹ and the right to have one’s *dignitas* protected.¹⁵²

In considering the right to privacy, Labuschagne quotes from a South African Constitutional Court case and states that the “autonomous identity” referred to should surely include the power to end such an identity in an autonomous fashion, should such identity be senseless and unbearable:¹⁵³

“The scope of privacy has been closely related to the concept of identity and it has been stated that rights like

¹⁴⁶ McQuoid-Mason “Privacy” in Chaskalson *et al Constitutional law of South Africa* (2005) (“McQuoid-Mason: privacy”) p.38-34.

¹⁴⁷ *Jansen van Vuuren NNO v Kruger* (fn 145 above).

¹⁴⁸ McQuoid-Mason: privacy (fn 146 above) p.38-19.

¹⁴⁹ *Bernstein v Bester* 1996 (2) SA 751 (CC), 1996 (4) BCLR 449 (CC) (“*Bernstein v Bester*”).

¹⁵⁰ *S v Orrie* (fn 131 above).

¹⁵¹ *Pretorius v Minister of Correctional Services* 2004 (2) SA 658 (T) (“*Pretorius v Minister of Correctional Services*”).

¹⁵² *Jansen van Vuuren NNO v Kruger* (fn 145 above).

¹⁵³ Labuschagne “Die strafregtelike verbod op hulpverlening by selfdoding: ’n menseregtelike en regsantropologiese evaluasie” 1998 *Obiter* (“Labuschagne”) p.51.

the right to privacy, are not based on a notion of the unencumbered self, but on the notion of what is necessary to have one's own autonomous identity".¹⁵⁴

Personal autonomy privacy rights (sometimes called substantive privacy rights) protect individuals against interference with and intrusions on their private lives. They permit individuals to make important decisions about their lives without interference.¹⁵⁵

While an involuntary blood test, for example, "undoubtedly entails an invasion of the subject's right to privacy", such right must, in appropriate circumstances, yield to considerations of public policy.¹⁵⁶ To determine whether *prima facie* invasion of the right to privacy was justified, the principles formulated in the context of justification in the law of defamation is in general applicable.¹⁵⁷ The right to privacy grounded in individual autonomy specifically would have to yield when the greater good so requires.¹⁵⁸

2.3.6 Right to Freedom of Religion, Belief and Opinion

Section 15(1) of the Bill of Rights provides that "[e]veryone has the right to freedom of conscience, religion, thought, belief and opinion."

This right can be impaired by forcing people to act in a manner contrary to their religious beliefs.¹⁵⁹ Currie & De Waal also observe that a generally applicable law with a neutral purpose may violate section 15 if it has the effect of restricting certain persons' freedom to exercise their religion.¹⁶⁰

¹⁵⁴ *Bernstein v Bester* (fn. 149 above).

¹⁵⁵ McQuoid-Mason: privacy (fn 146 above) p.38-22.

¹⁵⁶ *S v Orrie* (fn 131 above).

¹⁵⁷ *Jansen van Vuuren NNO v Kruger* (fn 145 above).

¹⁵⁸ Woolman: Dignity (fn 31 above) p.36-45 with reference to case law .

¹⁵⁹ *S v Lawrence* 1997 4 SA 1176 (CC); 1997 10 BCLR 1348 (CC), as quoted in Currie & De Waal (fn 45 above) p.339.

¹⁶⁰ Currie & De Waal (fn 45 above) p.339.

The interest of the broader community must also be considered. In the case of *Prince v President, Cape Law Society*,¹⁶¹ the Constitutional Court held that the state was justified in proscribing a Rastafarian's ritual use of cannabis, due in great part to evidence led by the state that the smoking of cannabis, even if limited, could lead to broader drug use and greater drug trafficking in South Africa.¹⁶²

In the context of euthanasia, this right should not be the source of much contention. Its effect is merely that someone, whose beliefs reject euthanasia, should not be forced to participate in an act of euthanasia. The most obvious implications are that a person may not be pressured into undergoing euthanasia if it goes against his / her beliefs and a medical practitioner may similarly not be forced to perform euthanasia if it is against his / her beliefs.

2.3.7 Right to Access to Health Care

Section 27 of the Constitution provides that:

- “(1) Everyone has the right to have access to –
- (a) health care services, including reproductive health care;
 - (b) sufficient food and water; and
 - (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- (3) No one may be refused emergency medical treatment.”

¹⁶¹ *Prince v President, Cape Law Society* 2002 (2) SA 794 (CC) (“*Prince v President, Cape Law Society*”).

¹⁶² Woolman: Dignity (fn 31 above) p.36-39.

The rights enshrined in section 27 are justiciable socio-economic rights.¹⁶³ These rights have not only a negative dimension (prohibiting the state from interfering with the enjoyment of the rights), but section 27(2) also incorporates a positive dimension, requiring active action from the state. In international law, the positive dimension of socio-economic rights requires two forms of action from the state: firstly, the state must create a legal framework that enables individuals to pursue these rights; secondly the state has to implement programs designed to assist individuals in realising their rights.¹⁶⁴ A right of access to health care is, however, not as direct a right as a right to health care services *per se*.¹⁶⁵

Section 27(2) qualifies the positive dimension of the rights by adding that the state must act “within its available resources, to achieve the progressive realisation of each of these rights.”

The Constitutional Court expressly refused to interpret the right to health-care services so that it would require the state to provide individuals with benefits immediately, but rather looked at the broader need of society. This approach can be seen in the *Soobramoney*¹⁶⁶ and *Grootboom*¹⁶⁷ cases. What is required of the state is to develop a comprehensive and workable plan to meet these needs – to take reasonable measures to progressively realize the rights.¹⁶⁸

The Court set out its approach to the interpretation of section 26 (very similar in style to section 27) in the *Grootboom* case. The second subsection imposed a positive obligation on the state, but this duty is qualified in terms of three elements:

(a) Reasonable legislative and other measures must be taken;

¹⁶³ *Ex parte Chairperson of the Constitutional Assembly: In re certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC) (“*Ex parte Chairperson of the Constitutional Assembly*”).

¹⁶⁴ Currie & De Waal (fn 45 above) p.575.

¹⁶⁵ Pearmain (fn 25 above) p.135.

¹⁶⁶ *Soobramoney v Minister of Health* (fn 69 above).

¹⁶⁷ *Grootboom v Oostenberg Municipality* (fn 18 above).

¹⁶⁸ Bilchitz “Health” in Chaskalson *et al Constitutional law of South Africa* (2005) (“Bilchitz”) p. 56A-6 .

- (b) to achieve the progressive realisation of the right;
- (c) within available resources.

In *Grootboom*,¹⁶⁹ the Court held that “the real question in terms of our Constitution is whether the measures taken by the state to realize the right afforded by s 26 are reasonable.” Having regard to the cases of *Grootboom*, *Treatment Action Campaign*¹⁷⁰ and *Khosa*,¹⁷¹ David Bilchitz attempts to systemize the Constitutional Court’s thinking on the elements of reasonableness with regards to this right in the following list:

- “(1) A reasonable programme must allocate responsibilities and tasks to the different spheres of government.
- (2) It must ensure that the appropriate financial and human resources are available.
- (3) The programme must be capable of facilitating the realization of the right in question.
- (4) A wide range of possible measures can be reasonable. The question is not whether other measures are more desirable or favourable. (This criterion seems to indicate a difference between reasonableness in the context of socio-economic rights and reasonableness in relation to the limitations clause; the limitation clause requires that the measures adopted be the least restrictive means of violating a right and realising an important social purpose.)
- (5) The measures must be reasonable ‘both in their conception and their implementation.’
- (6) A reasonable programme must be balanced and flexible.
- (7) A reasonable programme must attend to ‘crises’: a reasonable programme must ‘respond to the urgent needs of those in desperate situations.’
- (8) A reasonable programme must not exclude ‘a significant segment’ of the affected population.

¹⁶⁹ *Grootboom v Oostenberg Municipality* (fn 18 above).

¹⁷⁰ *Minister of Health v Treatment Action Campaign* 2002 10 BCLR 1033 (CC) (“*Minister of Health v Treatment Action Campaign*”).

¹⁷¹ *Khosa v Minister of Social Development* 2004 (6) SA 505 (CC) (“*Khosa v Minister of Social Development*”).

(9) A reasonable programme must balance short, medium and long-term needs.

(10) A reasonable programme does not render the best the enemy of the good: it is not necessary to design the ideal programme prior to its initial implementation. For instance, in *TAC*, waiting for the best programme to be developed for a protracted period of time before deciding to extend the use of nevirapine beyond the research sites was not reasonable given the benefits that could be achieved by rolling out the drug in the interim.

(11) A reasonable programme will not discriminate unlawfully between persons on grounds which can have a serious impact upon dignity¹⁷²

This “reasonableness approach” of the Court has been the target of some academic criticism, mainly based on the fact that it fails to provide adequate content to socio-economic rights.¹⁷³

Currie & De Waal concludes that the positive dimension of these rights is in reality a right to have the state justify to its citizens the use of its resources; “should resources become available, it will be difficult for the state to justify its failure to devote those resources to the fulfilment of the rights.”¹⁷⁴

In terms of international law, the state is not completely free to choose if and how to implement these rights. Unwillingness of the state to comply with its obligations would constitute a violation. In the case of inability, the fact that the rights should be realized “progressively” does not mean that the state may postpone its obligations to some indeterminate or distant time in the future; the state has to take those steps that it can immediately and then take other steps as soon as possible. While the Constitutional Court would be slow to interfere in policy decisions of the state, the state must show that it is exercising its discretion rationally and in good faith.¹⁷⁵

¹⁷² Bilchitz (fn. 168 above) p.56A-12.

¹⁷³ Bilchitz (fn. 168 above) p.56A-19.

¹⁷⁴ Currie & De Waal (fn 45 above) p.575.

¹⁷⁵ Currie & De Waal (fn 45 above) p.576.

This clearly reinforces the fact that the state does not have an unfettered discretion regarding the use of resources and that such use must still be reasonable.

A later case in which section 27 was considered is *Minister of Health v Treatment Action Campaign*.¹⁷⁶ Of all the rights argued, the outcome essentially depended on the interpretation of section 27. The High Court held that the Government's actions fell short of being reasonable measures to realize the rights as enshrined in section 27 and found in favour of the applicants. This resulted in the Government appealing to the Constitutional Court.

The Constitutional Court upheld the decision of the High Court, indicating that while Government was better situated than the courts to determine the policy on HIV, Government had failed to take reasonable measures to achieve the progressive realization of rights as envisioned in section 27. According to the Court, the Government's decision to confine Nevirapine to eighteen sites was unreasonable and therefore constituted a breach of the obligations that section 27 places on the Government to the extent that it was rigid and inflexible, denying people falling outside of the pilot sites access to drugs that could save their lives, while such drugs could have been provided within the state's available resources.

Considering the section 27 rights in the context of euthanasia, two rights can be identified:

Firstly, the person who is requesting euthanasia has the right to access to health care. Here it should be noted that "health" is not limited to physical health.¹⁷⁷

Secondly, the state has a duty to take measures to realize the rights of individuals in similar positions to that of Soombramoney. It seems irrational to, due to a lack of resources, let individuals die who wish to live, yet at the same time expending

¹⁷⁶ *Minister of Health v Treatment Action Campaign* (fn 170 above).

¹⁷⁷ Pearmain (fn 25 above) p.121.

such resources to force life upon individuals that do not wish it. This, at the very least, places a duty on the state to sufficiently justify its policy and use of resources, failing which there is a duty on the state to immediately take those steps that it can to realize the rights enshrined in section 27. Section 237 of the Constitution, which provides that “[a]ll constitutional obligations must be performed diligently and without delay”, affirms this.

In a substantial study on health care delivery in South Africa, Pearmain comments on individuals in a persistent vegetative state that:

“There are thus circumstances in which, even if the resources may, technically speaking, be available, there is no right to their use for the purpose merely of evading death. The right of a person in a persistent vegetative state to be maintained in that state indefinitely is thus questionable. However, this calls into the play the fact that in South Africa, the withdrawal of life support could in certain circumstances amount to criminal conduct due to the fact that euthanasia is not legally recognized. One cannot avoid getting involved in discussions involving utilitarianism at this level. The hard question is that in a country in which there is a shortage of health care personnel to treat a patient, how can one justify keeping such a patient ‘alive’ when the nursing staff and possibly the bed may be required for the purpose of the delivery of health care services to other patients who have a good chance of recovery. At present it seems that an answer to the question of the legal acceptability of euthanasia lies somewhere between the fact that the right to life does not encompass the right to indefinitely evade death and the legal convictions of society upon which issues of wrongfulness depend.”¹⁷⁸

The legalization of euthanasia, with proper safeguards, seems the clear candidate for meeting the state’s obligations and should the state not implement it, the burden is on the state to justify why it does not. Additionally, when the section 27 rights are read with the rights to human dignity and psychological integrity, Pearmain argues that a terminally ill patient who cannot benefit from curative care may well have a right to palliative care services.¹⁷⁹ Where a patient cannot

¹⁷⁸ Pearmain (fn 25 above) p.146.

¹⁷⁹ Pearmain (fn 25 above) p.133.

benefit from palliative care, it is submitted, a similar right may arise with regards to euthanasia.

2.3.8 Limitation Clause

Section 36 of the Bill of Rights regulates how and when the other rights may be limited, and does so in the following terms:

“(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including

- (a) the nature of the right;
 - (b) the importance of the purpose of the limitation;
 - (c) the nature and extent of the limitation;
 - (d) the relation between the limitation and its purpose;
- and
- (e) less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.”

According to Woolman, the limitation clause has a fourfold purpose. It: reminds us that the constitutional rights are not absolute; tells us that constitutional rights may only be limited where and when the stated objective behind the restriction is designed to reinforce constitutional values; provides us with a mechanism for weighing and balancing competing fundamental values against one another; and

“represents an attempt to solve the problem of judicial review by establishing a test which determines the extent to which the democratically elected branches of government may limit our constitutionally protected rights and the extent to which an unelected judiciary may override the general will and write the law of the land.”¹⁸⁰

It has been held that

¹⁸⁰ Woolman “Limitation” in Chaskalson *et al Constitutional law of South Africa Revision Service 2* (1998) (“Woolman: limitation”) p.12-1.

“[t]he application of s 36 involves a process of the weighing up of competing values and ultimately an assessment based on proportionality which calls for the balancing of different interests. Inherent in this process of weighing up is that it can only be done on a case-by-case basis with reference to the facts and circumstances of the particular case.”¹⁸¹

So, for example, the taking of an involuntary blood sample for DNA profiling (which infringed the rights to dignity, privacy and bodily security and integrity) is a reasonable and justifiable limitation in terms of section 36 in the light of the community’s interest in justice.¹⁸²

Some rights, however, cannot be limited or may only be limited to such an extent as indicated in the Constitution. This raises the question of whether cruel, inhuman or degrading treatment, for example, can be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. An answer to these questions may be sought in the preamble to the Universal Declaration of Human Rights of 1948, which forms part of International Law and has therefore been incorporated into our Constitution, insofar as it is compatible. The preamble says that recognizing these rights as inviolable “is the foundation of freedom, justice and peace in the world.”¹⁸³

If the right is in fact limitable by article 36, a two-stage process must be followed. Firstly, it must be determined if there is an infringement of a fundamental right. This entails that the applicant has to demonstrate that the activity for which protection is sought falls within the ambit of the protection provided by a specific right and that the law or government action impedes the exercise of such activity.¹⁸⁴

¹⁸¹ *Dotcom Trading D 121 (Pty) Ltd t/a Live Africa Network News v The Honourable Mr Justice King NO 2000 (4) All SA 128 (C)* (“Dotcom Trading v King NO”).

¹⁸² *S v Orrie* (fn 131 above).

¹⁸³ *Cheadle et al: Fundamental rights* (fn 113 above) p.40.

¹⁸⁴ *Woolman: limitation* (fn 180 above) p.12-2.

If there is an infringement, the second stage is to first ask if the policy underlying the cause of the infringement is reasonable and justifiable in a free and open society based on human dignity, equality and freedom and secondly if the method used to implement the policy is acceptable.¹⁸⁵

In considering the legitimacy of a limitation, reference should be made to the following paragraph as stated in *S v Makwanyane*, where limitation in terms of the interim Constitution was considered:

“The limitation of Constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of section 33. The fact that different rights have different implications for democracy, and in the case of our Constitution, ‘for an open and democratic society based on freedom and equality,’ means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case-by-case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question. In the process regard must be had to the provisions of section 33, and the underlying values of the Constitution, bearing in mind that, as a Canadian Judge has said, ‘the role of the Court is not to second-guess the wisdom of policy choices made by legislators.’”¹⁸⁶

¹⁸⁵ Currie & De Waal (fn 45 above) p. 166.

¹⁸⁶ *S v Makwanyane* (fn 48 above).

2.3.9 Balancing the constitutional rights in the context of euthanasia

“The balancing of constitutional rights, values or interests at its best often involves terminological confusion. At its worst, it is an impossible undertaking.”¹⁸⁷

When fundamental rights clash, the clash must not be resolved at the first stage, where the scope of the right is defined, but rather as part of the balancing of interests contemplated by the limitation clause.¹⁸⁸ In finally determining the impact of the Bill of Rights on a specific topic, rights should not be read in isolation.¹⁸⁹ Rights in the Bill of Rights are elements of an inextricably linked system of fundamental rights.¹⁹⁰

The balancing of different rights and state interests will be affected by the respective “weights” attached to these different rights. For example, in the case of *Minister of Safety and Security v Gaqa*,¹⁹¹ the Court held that the granting of the state’s application would involve a limitation of the Respondent’s rights in terms of section 36 of the Constitution, but that the Respondent’s interests in that case were of less significance in the balancing act than the considerable weight carried by, amongst others, the public’s substantial interest in the resolution of serious crimes.¹⁹²

In the case of euthanasia it may well be that the permissibility of restrictions on such rights will be affected by, amongst others, the age, physical condition or mental condition of the patient, in a similar manner to which the permissibility of such restrictions are affected in abortion cases, based on the progression of the pregnancy.

¹⁸⁷ Woolman: limitation (fn 180 above) p.12-55.

¹⁸⁸ O’Sullivan & Bailey (fn 102 above) p.37.

¹⁸⁹ *Berstein v Bester* 1996 (4) BCLR 449 (CC).

¹⁹⁰ Pearmain (fn 25 above) p.117.

¹⁹¹ *Minister of Safety and Security v Gaqa* (fn 42 above).

¹⁹² *S v Orrie* (fn 131 above).

Here freedom, equality and dignity take on special importance; all the rights must be read in a way that promotes these values,¹⁹³ and rights may only be limited to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.¹⁹⁴ Chaskalson emphasizes the importance of dignity as a value in the balancing process even further, stating that dignity, as an abstract value common to the core values of the Constitution, informs the content of all the discrete rights and plays an important role in bringing different rights and values into harmony.¹⁹⁵

Devenish writes that, where there is ambiguity in the interpretation of a provision that interferes with fundamental rights, interpretation should be *in favorem libertatis* – it should favour the liberty of the individual. But it goes further than that:

“Generality, vagueness and flexibility of language to a lesser or greater extent requires interpretative creativity on the part of the courts. Therefore, ambiguity is not, and should not be, the only characteristic of language that necessitates an investigation into the purpose or aim of the statute and justifies the application of the *in favorem libertatis* maxim. Provisions in the bill of rights should as a matter of course be interpreted *in favorem libertatis*.”¹⁹⁶

As was indicated above, the values of dignity, freedom and equality all favour an interpretation that would allow euthanasia, and might even demand it. It can, however, be argued that euthanasia would not limit the right to life, but completely ignore it, and that dignity can only be at issue where the person is alive.¹⁹⁷ Moreover, the state has an interest in the preservation of life; in the past, the protection of life often weighed in more heavily than the protection of freedom and physical integrity.¹⁹⁸ This is clearly not the case anymore – it is now generally accepted that one may refuse life-sustaining treatment. Increasingly,

¹⁹³ Constitution of the Republic of South Africa, 1996 section 39.

¹⁹⁴ Constitution of the Republic of South Africa, 1996 section 36.

¹⁹⁵ Chaskalson “Human dignity as a foundational value of our Constitutional Order” 2000 *South African Journal for Human Rights* (“Chaskalson”) 196.

¹⁹⁶ Devenish (fn 62 above) p.612.

¹⁹⁷ Submission of Magistrate FVA Von Reiche to South African Law Commission.

¹⁹⁸ Currie & De Waal (fn 45 above) p. 287.

our laws have and are moving towards favouring freedom of choice. This approach, in the case of euthanasia, also arguably brings the state more in line with the duties placed upon it with regard to access to health care, as indicated above.

Most of the objections against legalizing euthanasia are either based on religious grounds or essentially amounts to an argument that the risk of abuse is too great. In South Africa, where we have freedom of religion, religious objections cannot bind those individuals who are not members of such a religion. By and large, these are theological arguments, but cannot for present purposes be considered legal arguments.

That the simple legalization of euthanasia carries with it substantial risks of abuse is incontrovertible. The only clear way that euthanasia could constitutionally be prohibited, is in terms of section 36. It is here that the argument regarding the risk of abuse carries tremendous weight.

This finally leads to one conclusion: The Constitution allows for the legalization of voluntary euthanasia, and arguably even requires it, provided that the risks of abuse can be limited to an acceptable level. Hence, if it is possible to limit the risks to an acceptable level (it will never be possible to eliminate such risks in total), euthanasia should be legalized. Otherwise it should not.

Common Law

In South Africa, euthanasia is currently unlawful,¹⁹⁹ and euthanasia is not a ground of justification.²⁰⁰ In The Netherlands, necessity (which is of a very similar nature in Dutch law as in South African law) has been used as a ground of justification in euthanasia cases. Some authors argue that it can be used in a

¹⁹⁹ See Snyman *Criminal Law* (2002) (“Snyman”) p. 93, where it is submitted that “unlawfulness” is a confusing term and a term like “unjustified” better describes what is meant.

²⁰⁰ Snyman (fn 199 above) p.423

similar fashion in South Africa.²⁰¹ This is a problematic argument, as difficult value judgements have to be made – necessity can only serve as a ground of justification if a lesser interest is sacrificed for a greater one, or serve to negate culpability in certain circumstances if an interest is sacrificed for one of equal value.²⁰² It is submitted that this creates serious legal uncertainty (especially since no such case has been decided by a South African court) and potential for abuse and that pro-active legislation provides a preferred alternative.

Another ground of justification that is often discussed in the context of euthanasia is consent. It is generally stated that consent as justification ground cannot stand in a case of euthanasia, as the *boni mores* does not recognize the consent. However, it has additionally been argued that:

“Consent would justify euthanasia when society thinks that it is right that a person’s death be hastened to end his suffering: when society regards relieving pain to be preferable to prolonging life under all circumstances. Consent to death could therefore be recognized by our law at present without any legislative intervention.”²⁰³

Of all the South African sources of law, references to euthanasia, whether directly or indirectly, are most commonly found in reported cases, which constitute our common law. As indicated above, the Constitution recognises the rights and freedoms in our common law to the extent that they are consistent with the Bill of Rights. The following judgements were amongst the most important in circumscribing the rights and freedoms in euthanasia and the issues surrounding it.

2.4.1 *R v Peverett*²⁰⁴

2.4.1.1 Facts

Saunders, Peverett’s girlfriend, suggested that they commit suicide together. Peverett agreed to it and prepared the means for their suicide: he connected his

²⁰¹ Labuschagne: aktiewe eutanasië (fn 67 above) p.413

²⁰² Snyman (fn 199 above) p.116

²⁰³ Rall (fn 12 above) p. 47.

²⁰⁴ *R v Peverett* 1940 AD 213 (“*R v Peverett*”).

motor vehicle's exhaust with the inside of the vehicle. Peverett and Saunders entered the car and closed the doors, where after Peverett started the vehicle's engine. Both Saunders and Peverett were later found sitting in the car, both of them unconscious but alive. Peverett was charged with murder.

2.4.1.2 Decision

Peverett argued that he was not criminally liable, as Saunders acted voluntarily (by breathing the poisonous air). The Court specifically rejected this argument:

“With regard to the first branch of the argument, there is no doubt that the accused, with the concurrence of Ms. Saunders, made the arrangement by means of which poisonous gas was led into the enclosed body of the car. His purpose in leading poisonous gas into the car was to enable them both to inhale the poisonous gas, and their breathing of the poisonous gas was in turn the means whereby their death was to be caused. He is therefore responsible in law for the result of these actions [...] The fact that Ms. Saunders was free to breathe the poisonous gas was in turn the means whereby their death was to be caused. He is therefore responsible in law for the result of these actions [...] The fact that Ms. Saunders was free to breathe the poisonous gas or not, as she pleased, cannot free the accused from criminal responsibility for her unconsciousness and illness, because she had told him of her suicidal purpose and he knew that in the course of events contemplated by him she would remain passive and would breathe the poisonous gas and die. His acts, therefore, were a means to that end and so closely connected with it as to be more than mere acts of preparation for that end.”

Peverett was convicted of murder. Van Oosten comments that the Court based the causal link between acts of Peverett and the unconsciousness of Saunders on fault, ie found that, because Peverett foresaw the death of Saunders, his actions can be considered the cause of her unconsciousness.²⁰⁵

2.4.1.3 Application

The first case in South Africa that dealt specifically with one person assisting another to commit suicide was *R v Peverett*. Assisted suicide and euthanasia have

²⁰⁵ Van Oosten “Aandadigheid aan selfmoord in die Suid-Afrikaanse strafreg” 1985 *Tydskrif vir die Suid-Afrikaanse Reg* (“Van Oosten: aandadigheid aan selfmoord”) p.189.

much in common, to the extent that the South African Law Commission could make no meaningful distinction between the two.²⁰⁶

2.4.2 *R v Davidow*²⁰⁷

One of the earlier cases in the South African law where we find “active euthanasia” is *R v Davidow*.

2.4.2.1 Facts

In this case, Davidow’s mother suffered from an incurable disease. Davidow shot his mother in the hospital, with the intention of relieving her from her suffering, and was charged with murder.

2.4.2.2 Decision

The Court did not convict Davidow of murder because, the Court found, he did not have the necessary capacity.²⁰⁸

2.4.2.3 Application

This is the first case dealing with euthanasia proper, but due to Davidow’s lack of capacity, the question of euthanasia didn’t have to be decided.

2.4.3 *R v Nbakwa*²⁰⁹

Another case in which incitement to suicide or assistance with suicide played a role is that of *R v Nbakwa*.

2.4.3.1 Facts

In this case, Nbakwa suspected that his mother was responsible for the death of his child. He confronted her with his suspicion, upon which she asked him to kill her. A week later Nbakwa went to his mother’s hut where she lay ill. He fastened a piece of rope with a noose on the end to one of the beams in the roof and told

²⁰⁶ South African Law Commission Report – Project 86 par.4.109

²⁰⁷ *R v Dawidow*, unreported; June 1955 as discussed in Van Dyk “Die Dawidow saak” 1956 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* p.286.

²⁰⁸ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.175.

²⁰⁹ *R v Nbakwa* 1956 2 SA 557 (SR) 113 (“*R v Nbakwa*”).

his mother to hang herself. She asked him to help her up and to give her something to stand upon, which he did. He left the hut and watched as his mother hung herself.

2.4.3.2 Decision

Nbakwa was charged with murder, but he raised an exception – that the indictment did not reveal any crime – which was maintained by the Court. The Court held that

“[t]he accused did not actually kill the deceased himself, but if his acts could be construed as an attempt to do so he could be legally convicted of attempted murder, since on indictment for murder a verdict of attempted murder is a competent one. I will first consider, therefore, whether these particulars disclose on the part of the accused an attempt to murder the deceased. In my view the acts of the accused on this occasion do not go far enough to constitute an attempt; they go no further than what are commonly called acts of preparation. The accused provided a means for causing death and he persuaded the woman to kill herself, but the actual act which caused the death of the woman was the act of the woman herself. There was, to use a common legal expression, a *novus actus interveniens* between the actions of the accused and the death of the deceased which in my view broke the chain of causation between the act of the accused and the death of the deceased. The direct cause of the death of the deceased was the act of the deceased woman in getting up on to the block of wood, putting her head in the noose and then kicking away the block of wood. The direct cause of the death was not the action of the accused. I come to the conclusion, therefore, that the accused’s acts did not go far enough to constitute an attempt to murder; at most his acts went no further than acts of preparation. [...] If suicide is not a crime in Southern Rhodesia the facts disclose nothing more than that the accused has been guilty of inciting the deceased to do something which was in itself not a crime. This being so, I am of the opinion that the indictment, on the particulars disclosed, does not disclose the offence of murder, or any other offence for which the accused can be found guilty on that charge.”²¹⁰

²¹⁰ Labuschagne: dekriminalisasie van eutanاسie (fn 6 above) p.172.

2.4.3.3 Application

In this case, a *novus actus interveniens* (new intervening act), in the form of action taken by the deceased, was recognized as breaking the causality between the acts of the accused and the deceased's death.

2.4.4 *S v Gordon*²¹¹

In the case of *S v Gordon* we find facts similar to those in *S v Peverett*.

2.4.4.1 Facts

Gordon's girlfriend proposed that they commit suicide together, which Gordon agreed to. He obtained several sleeping pills, met his girlfriend at an agreed location and they both took some of the pills, her first, then him. Gordon survived, but his girlfriend died from the pills. Subsequently, Gordon was charged with murder.

2.4.4.2 Decision

The Court acquitted Gordon on a charge of murder after approvingly referring to the case of *R v Nbakwa* regarding causality and distinguishing the case from that of *S v Peverett*:

“Now it will be observed that in that case the accused completed every necessary act to bring about the death of himself and Ms. Saunders, the starting of the engine being the final act. In the present case it is an accepted fact that the deceased took the tablets herself and that was the final act which brought about her death. To my mind, the mere fact that he provided the tablets knowing the deceased would take them and would probably die cannot be said to constitute, in law, the killing of the deceased. The cause of her death was her own voluntary and independent act of swallowing the tablets. He undoubtedly aided and abetted her to commit suicide, but that is not an offence. The fact that he intended her to die is indisputable, but his own acts calculated to bring that result about fall short of a killing or an attempted killing by him of the deceased. One might say that the accused, as it were, provided the deceased with a loaded pistol to enable her to shoot herself. She

²¹¹ *S v Gordon* 1962 (4) SA 727 (“*S v Gordon*”).

took the pistol, aimed it at herself and pulled the trigger. It is not a case of *qui facit per alium facit per se*.”

The Court further held that incitement to suicide is not a crime, as suicide itself is not a crime.

2.4.4.3 Application

The approach to a *novus actus interveniens* by way of acts of the deceased was confirmed and the Court held that incitement to suicide was not a crime.

2.4.5 S v Grotjohn²¹²

2.4.5.1 Facts

In this case, the deceased was the accused’s manic depressive wife. She refused the accused conjugal rights, whereupon the accused entered into an extra-marital affair with another woman.

This affair was the cause of great conflict between the parties, which eventually resulted in the deceased threatening to shoot herself. In response, the accused fetched and loaded a gun before handing it to the deceased. He told her to shoot herself, as she was a nuisance. The deceased took the gun and fatally shot herself and the accused was charged with murder.

2.4.5.2 Decision

The Court found the accused not guilty of murder and the case was taken on appeal. The following two questions had to be decided by the Supreme Court of Appeal: Firstly, does it constitute a crime in South Africa if someone helps, encourages or enables another to commit suicide? Secondly, which crime, if any, would that be?

The Court decided on both questions that a simple answer cannot be given and that the specific circumstances will have to be taken into account, but the crimes of murder, attempted murder or manslaughter could potentially be committed,

²¹² *S v Grotjohn* 1970 2 SA 355 (A) (“*S v Grotjohn*”).

despite the fact that neither suicide nor attempted suicide is a crime in South Africa. The Court used the term “accessory” in describing the role of someone assisting another in suicide and emphasized that both unlawfulness and intent were important elements. This, says Burchell, left the door wide open for future courts to take account of changing attitudes to death and dying.²¹³ But the Court’s main focus in this case was the element of causation.

In most cases, the legal principles surrounding a *novus actus interveniens*, which breaks causality, would also not be of any avail to the accused in such cases. The Court found that, to effectively break the causality, the intervening act would have to be completely independent from the acts of the accused. In other words, where the accused causes and uses the act by another person (in this case the deceased who shot herself) as a means to an end, the accused’s acts will still be the cause of death.

2.4.5.3 Application

This case overturned the approach taken in the previous two cases. Here the *novus actus interveniens* was of no avail to the accused, as the Court held that it would have to be completely independent from the acts of the accused.

2.4.6 S v De Bellocq²¹⁴

2.4.6.1 Facts

In this case, De Bellocq killed her own baby. The baby had toxoplasmosis, a condition that severely affected the mental capabilities of the baby and also meant that the baby’s life-expectancy was minimal. De Bellocq, who had some previous medical training and knew what the effects of toxoplasmosis would be on the child, drowned the baby in his bath and was then charged with murder.

²¹³ Burchell *Principles of criminal law* (2005) p.159.

²¹⁴ *S v De Bellocq* 1975 (3) SA 538 (T) (“*S v De Bellocq*”).

Decision

The Court convicted De Bellocq of murder with mitigating circumstances, but the sentence the Court gave was that the Court could summon De Bellocq for sentencing anytime within the following six months:

“The law does not allow any person to be killed whether that person is an imbecile or very ill. The killing of such a person is an unlawful act and it amounts to murder in law. However, on the facts of this case and the extenuating circumstances it seems to me that there would be no object in sending the accused to prison and I do not think that a suspended sentence is appropriate in a case like this because it would be difficult to decide what condition to impose when a sentence is suspended [...] The sentence will be that the accused is discharged on condition that she enters into recognizances to come up for sentence within the next six months if called upon. I will not order any amount of money to be deposited in connection with these recognizances.”²¹⁵

De Bellocq was never summoned back to court.

2.4.6.3 Application

Here we find the first example where the Court found someone guilty of murder, but gave punishment that was not much more than symbolic in nature.

2.4.7 *S v Hartmann*²¹⁶

2.4.7.1 Facts

In the case of *S v Hartmann*, Hartman²¹⁷ was a medical practitioner. His father suffered from cancer and Hartman looked after him. Eventually, Hartman killed his father by means of a lethal injection of Pentothal, because he could no longer bear seeing the suffering his father went through. Hartman was charged with murder.

²¹⁵ Labuschagne: dekriminalisasie van eutanاسie (fn 6 above) p.175.

²¹⁶ *S v Hartmann* 1975 3 SA 532 (C) (“*S v Hartmann*”).

²¹⁷ “Hartmann” is apparently spelled incorrectly and should be “Hartman” - see Rall (fn 12 above) p.40. The spelling with the double n is maintained here when referring to the case, as it is the spelling used in the Law Reports.

2.4.7.4 Decision

Hartman was tried and found guilty of murder with mitigating circumstances.

The Court held that:

“[t]he general picture of such a patient is one of extreme misery due to bodily wasting [...] There comes a time when the patient’s quality of life becomes meaningless to himself through the misery of his pain and physical disability, which results from the potent drugs used to free him of it. At this stage the patient presented a problem to his medical attendant which brings about a conflict in ethical principles, namely to save life and to relieve pain and suffering”.

However,

“[i]t is true that the deceased was in a dying condition when this dose of pentothal was administered and that there is evidence that he may very well have died as little as a few hours later. But the law is clear that it nonetheless constitutes the crime of murder even if all that an accused has done is to hasten the death of a human being who was due to die in any event [...] Here the state has proved that but for the accused’s actions, the deceased would not have died when he did. That such action, if wilfully undertaken, constitutes murder”.

The Court gave Hartmann a suspended sentence and ordered that he be held in custody until the Court adjourned.

2.4.7.3 Application

This was the first case in which a medical practitioner actively “euthanized” another person. The verdict indicated disapproval of Hartmann’s actions, but the sentence was, as in the previous case, almost limited to a symbolic gesture.

2.4.8 *S v McBride*²¹⁸

2.4.8.1 Facts

McBride and his wife, the deceased, were under the impression that she had cancer. The family’s financial position became worse and worse as they attempted to treat her while her health was deteriorating. McBride finally decided

²¹⁸ *S v McBride* 1979 (4) SA 313 (W) (“*S v McBride*”).

to kill both his wife and himself. He shot his wife dead, but was unsuccessful in taking his own life, as other people intervened with his attempt. He was charged with murder.

2.4.8.2 Decision

The Court found that he was not criminally capable, and thus the charge against him was dismissed.

2.4.8.3 Application

In this case, like that of Davidow, the Court found a way to not find the accused guilty of murder on grounds of lack of capacity.

2.4.9 *Phillips v De Klerk*²¹⁹

2.4.9.1 Facts

Phillips was involved in a motor vehicle collision due to which he sustained several fractures and was hospitalized. He also contracted a lung infection at a later stage. Dr. De Klerk, the orthopaedic surgeon who treated Phillips, approached the Supreme Court in Pretoria ten days after the accident. He made an urgent, *ex parte* application for an order that would authorize either himself or another doctor to give Phillips a life-saving blood transfusion. De Klerk stated that the patient had suffered serious blood loss and that there was not enough blood to carry oxygen to his vital organs, especially the brain, with the result that Phillips would die if a blood transfusion was not performed within six hours. The reason why court authorization for the blood transfusion was sought was that Phillips' wife, who was at the hospital, had refused to consent to a blood transfusion on religious grounds.

The Court granted the order on the same day. The blood transfusion was apparently never administered and Phillips later recovered from his injuries without a blood transfusion. Some months later, Phillips brought an application

²¹⁹ *Phillips v De Klerk* 1983 TPD unreported, as discussed in Strauss (fn 8 above) p.29.

to the Supreme Court to have the order rescinded. He contended that he specifically refused a blood transfusion upon his admission to hospital; that he was of sound mind at the time, that he had at no stage been notified by De Klerk of his intention to apply for a court order and that his rights of personality had been affected by the previous order, which was still in effect.

2.4.9.2 Decision

The case was dealt with on the basis that it was unopposed. The Court found on the papers (which included affidavits from other medical practitioners) that Phillips was *compos mentis* at the relevant time and was entitled to refuse being given blood. The previous order was set aside.²²⁰

2.4.9.3 Application

While this was not a case of euthanasia (neither mercy nor suffering played a substantial role here), it did emphasize a person's right to refuse potentially life-saving treatment, which is directly related to passive euthanasia. At the time the Court made the decision, it had every reason to believe that Phillips would have died as a result of the events flowing from the court order.

2.4.10 *S v Hibbert*²²¹

2.4.10.1 Facts

The deceased, who was the wife of the accused, had a secret affair with another man. When this affair was ended, she fell into a state of depression, which in turn led to alcohol abuse on the part of the deceased and concomitant conflict between the parties. During one of their fights, the deceased expressed the desire to commit suicide. The accused asked her what method she had in mind and made a few suggestions in this regard. The deceased indicated that she wanted to shoot herself. The accused then loaded a fire-arm and handed it to the deceased. She took the fire-arm and shot herself through the head. The accused, Hibbert, was charged with murder.

²²⁰ Strauss (fn 8 above) p.29.

²²¹ *S v Hibbert* 1979 (4) SA 717 (D) ("*S v Hibbert*").

2.4.10.1 Decision

In court Hibbert indicated that he had no intention to assist the deceased to kill herself and it did not occur to him that she might actually pull the trigger; he submitted that he merely intended to embarrass her. This was rejected by the Court:

“We find it inconceivable that a person with the knowledge and background of the accused could not have appreciated that putting a person in possession of an obviously lethal and clearly loaded weapon was attended by a substituted measure of risk that the deceased would pull the trigger and cause injury and possibly death to herself. We do not find that the death of the deceased was a desired result. We do not find that the accused planned to bring about any injury or death to the deceased. We do, however, find upon the evidence that the accused’s course of conduct from the time when the (deceased) mentioned her desire to kill herself, was directed towards creating a situation where she was in possession of a loaded fire-arm.”

Hibbert was convicted of murder and sentenced to four years imprisonment, all of which was suspended for five years.

2.4.10.3 Application

In this case there was no motive of mercy or compassion. It did not, therefore, deal with euthanasia proper. The Court, however, still imposed an extraordinary light sentence.

2.4.11 *S v Williams*²²²

2.4.11.1 Facts

In *S v Williams*, the accused had shot the deceased in her neck. At the hospital, she was attached to and kept breathing by a respirator. However, a CAT scan indicated total inactivity in her brain stem. Consequently, the respirator was switched off and ten minutes later her heart stopped beating and her breathing stopped. The accused was convicted on a charge of murder.

²²² *S v Williams* 1986 (4) SA 1188 (A) (“*S v Williams*”).

2.4.11.2 Decision

The accused, Williams, entered an appeal against his conviction and submitted, amongst other things, that the causal link between his actions and the deceased death was broken as there was a *novus actus interveniens* in the form of the disconnection of the respirator and that such disconnection was a *sine qua non* of death itself.

Chief Justice Rabie rejected this argument, reasoning that the disconnection did not cause the deceased's death, but merely terminated a fruitless attempt to save her life. He stated that "Dr. Buchmann het haar... nie gedood nie, maar hoogstens toegelaat om te sterf" (Dr Buchmann did not kill her, but merely allowed her to die) – an appearance of the common and much criticized distinction between "active" and "passive" euthanasia. Chief Justice Rabie did however back his statement by referring with approval to Lord Lane's statements in the English case of *R v Malcherek; R v Steel*²²³ where a similar contention was advanced by the defence, Chief Justice Lord Lane stated:

"Where a medical practitioner adopting methods which are generally accepted comes *bona fide* and conscientiously to the conclusion that the patient is for practical purposes dead, and that such functions that exist (for example, circulation) are being maintained solely by mechanical means, and therefore discontinues treatment, that does not prevent the person who inflicted injury from being responsible for the victim's death [...] Whatever the strict logic of the matter may be, it is perhaps somewhat bizarre to suggest [...] that where a doctor tries his conscientious best to save the life of a patient brought to hospital in extremis, skilfully using sophisticated methods, drugs and machinery to do so, but fails in his attempt and therefore discontinues treatment, he can be said to have caused the death of the patient."

Boister states that:

"[b]y his unequivocal support for these statements Rabie CJ implied that he agreed with Lord Lane and the medical practitioners that brain stem death placed the patient in a position beyond the limit on the scale between life and the extinction of biological activity where further conduct by

²²³ *R v Malcherek; R v Steel* 1981 2 All ER 422 ("*R v Malcherek; R v Steel*").

the doctor could cause death. In effect, he rejected the idea that a patient attached to a respirator whose brain stem was dead, could be killed by the switching off of that machine as ‘bizarre logic.’”²²⁴

He then concludes that “Rabie CJ was driven by policy to conclude that the death of a patient in such a debilitated state cannot be caused by any further conduct. But it is submitted that this policy is underpinned by the Chief Justice’s tacit acceptance that brain stem death is death for purposes of the law of causation.”²²⁵

2.4.11.3 Application

In this case, death was defined as brain stem death. Therefore, in cases of brain stem death there could be no cause of death afterwards, merely the termination of a fruitless attempt to save a life.

2.4.12 *S v Marengo*²²⁶

2.4.12.1 Facts

The deceased was an 81-year old man who suffered from cancer. The accused was his daughter, Marengo, who killed him with a fire-arm because she could no longer endure her father’s suffering. She was charged with murder.

2.4.12.2 Decision

Marengo pleaded guilty and was sentenced to three years imprisonment, suspended for five years.

2.4.12.3 Application

This case followed the pattern of light sentencing, but an important element in the facts were that Marengo shot her father because *she* could no longer endure his suffering.

2.4.13 *S v Smorenburg*²²⁷

²²⁴ Boister “Causation at the death” 1993 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* (“Boister”) p.518.

²²⁵ Boister (fn. 224 above) p. 518.

²²⁶ *S v Marengo* 1990 WLD unreported (“*S v Marengo*”).

2.4.13.1 Facts

The accused, who was a nurse, attempted on more than one occasion to end the lives of patients who were terminally ill. She was charged with attempted murder.

2.4.13.2 Decision

In all the cases, the accused's motive was to end the patients' suffering or to put an end to the patients' useless existence. While this could not make the acts lawful, and the accused was found guilty, she was sentenced to three months imprisonment, suspended in its entirety.

2.4.13.3 Application

In this case, the (unsuccessful) acts of a nurse driven by compassion for the patients and done of own volition were also dealt with extremely leniently by the court.

2.4.14 *Clarke v Hurst*²²⁸

2.4.14.1 Facts

Mrs. Clarke, the applicant, was the wife of Mr. Clarke, who formed the subject of the case. Mr. Clarke was a lifelong member of the South African Voluntary Euthanasia Society (SAVES) and publicly spoke out in favour of passive euthanasia. During pain treatment for a war injury, complications arose and Mr. Clarke went into cardiac arrest. His pulse and breathing stopped for a considerable amount of time before it was successfully restored, which led to Mr. Clarke suffering extensive brain damage.

Medically, Mr. Clarke's medical condition was the following:

“(a) He has suffered serious and irreversible brain damage of a diffuse and generalised nature which has left

²²⁷ *S v Smorenburg* 1992 (2) SACR 289 (C) (“*S v Smorenburg*”).

²²⁸ *Clarke v Hurst* (fn 98 above).

him in an irreversible persistent vegetative state. As a result of the brain damage:

- (i) there has been a serious loss of brain tissue;
- (ii) gross atrophy of the cortex;
- (iii) large areas of the brain have become fluid filled as the ventricles expand to occupy the space left by the retreating brain tissue;
- (iv) the patient has no control over and no use of his limbs and is not capable of any movement;
- (v) the patient has no cognitive, sapient and intellectual life and no volitional functioning;
- (vi) the patient has no self-awareness or awareness of his external environment at any level;
- (vii) the patient cannot speak and is not capable of deliberate vocal noise;
- (viii) the patient has no auditory capacity;
- (ix) the patient cannot communicate and cannot receive any communications; he has no capacity for conscious thinking or purposive action;
- (x) the patient does not have any sense or sensory perception or sentient life.

(b) The patient's swallowing mechanism is non-functional owing to damage to the cortex and brain-stem. The patient therefore cannot swallow voluntarily or involuntarily and cannot take food or fluids in the natural way.

(c) Because the autonomic nervous system which controls the biological life of the body is largely unimpaired (although there is evidence of some brain-stem damage), the patient's respiratory system, digestive system, circulatory system, kidneys, heart and lungs are functioning satisfactorily.

(d) The patient does not experience pain or discomfort because he has lost the capacity to experience these sensations.

There is, however, no doubt that legally the patient is still alive; nor is death imminent. His life expectancy is uncertain.”

The relief sought by Mrs. Clarke in this case was to be appointed as Mr. Clark's *curatrix personae*, with specific powers to decide about the future treatment or refusal and withdrawal of treatment of Mr. Clarke, including the power to

withdraw naso-gastric feeding. Mr. Clarke's two sisters and four children supported Mrs. Clarke's application.

2.4.14.2 Decision

In considering Mrs. Clarke's application with regard to unlawfulness, the Court seems to have attached most weight to (a) preservation of life; (b) the best interests of the patients; (c) the patient's autonomy and the wishes expressed by the patient himself. These were then weighed in a balancing act where no single factor carried absolute weight:

“The decision of that issue depends on the quality of life which remains to the patient, ie the physical and mental status of that life [...] Lastly it has to be decided whether the steps which the applicant proposes to take would be in the best interests of the patient [...] [T]he Court approaches those interests with a strong predilection in favour of the preservation of life, which, however, does not extend as far as requiring that life should be maintained at all costs, irrespective of its quality [...] [T]he patient in this case has passed beyond the point where he could be said to have an interest in the matter [...] but I think the patient's wishes as expressed when he was in good health should be given effect to.”

The Court granted the relief sought by Mrs. Clarke and found that Mrs. Clarke could refuse naso-gastric feeding of Mr. Clarke without incurring criminal or delictual liability, even should such action shorten the life of Mr. Clarke.

2.4.14.3 Application

Here the Court implicitly partly supports the approach suggested in the right to life argument presented above,²²⁹ by stating that the patient (presumably due to his inability to value his own life) cannot be said to have an interest in the matter anymore, but that the patient's wishes as expressed previously should be given effect to.

In an *obiter dictum*, the judge also stated that the element of legal causation would not be met by the intended actions of Mrs. Clarke, as the *sine qua non* for

²²⁹ See p.21 above.

a person's death can, under certain circumstances and with due regards to reasonableness, fairness and justice, be too remote to give rise to criminal liability. This was despite the fact that the judge accepted that the removal of the feeding tube would be the factual cause of death. Boister submits that the judge's conclusions appear to contradict the accepted legal position in such situations, where any act that hastened death would be both the factual and legal cause of death. The judge reconciled this, with reference to the case of *S v Williams*,²³⁰ by

“in effect, placing the patient, because of his condition, on a scale between life and death (in the sense of total extinction of all organic activity) beyond the limit where any further action could cause his death.”²³¹

Unlike the deceased in the case of *S v Williams*, however, Dr. Clarke was not brain stem dead. The judge equated Dr. Clarke's condition with a state very near death;

“[Public] policy intruded by way of the enquiry into legal causation to allow someone who is at least biologically alive, to be considered to be partially dead or at most in a state of limbo between life and death.”²³²

The *Clarke v Hurst* decision is very influential, especially in the sense that it provided a guideline for doctors and future litigation to the effect that human life amounts to more than mere biological functions but must also be accompanied by both cortical and cerebral functioning.²³³ It has been described as “the most equitable, logical, and well-reasoned judgement given the pleadings before [the Court]”.²³⁴

But the decision also invited important criticism. Leonard-Taitz, for example, submits that the judgement would have been more convincing had it either reconciled or distinguished the judgement from existing principles of law. He specifically refers to the approach taken in *S v Williams* with regard to a *novus actus interveniens* and seems to argue that, in *Clarke v Hurst*, the matter could

²³⁰ *S v Williams* (fn 222 above).

²³¹ Boister (fn. 224 above) p.517.

²³² Boister (fn. 224 above) p.519.

²³³ Lupton “*Clarke v Hurst* NO, Brain NO & Attorney-General, Natal (unreported 1992 (N)) – A living will, brain death and the best interest of a patient” 1992 *SACJ* (“Lupton”) p.342.

²³⁴ Lupton (fn 233 above) p.342.

merely have been treated as a fruitless attempt to save a life, rather than something new that ended a life.²³⁵

Another aspect that drew some criticism is the manner in which reliance was placed on the legal convictions of society. Leonard-Taitz rejects Snyman's suggestion that there is no real difference between society's "legal convictions" and *boni mores*, and argues that there is no single South African society as such and the very concept of the "legal convictions of society" could be a cloak for public policy²³⁶ or even the judge's own beliefs.²³⁷ Moreover, the judge

"sought to justify his use of the so-called legal convictions of society by comparing judicial views on societal attitudes in America and England regarding aspects of euthanasia [...] His lordship gives no specific references to such American and English judicial views of the attitudes of society but merely makes this general comment. Further, he would appear to regard American and English 'societal attitudes' to various aspects of euthanasia as being synonymous with the 'societal attitudes' or 'legal convictions of society' in South Africa – a conclusion that is not necessarily justified."²³⁸

Other authors make similar arguments, asking whether we are not just one step away from applying the reasonable man test.²³⁹

Nadasen also argues that finding the *boni mores* or any sort of generic medical-legal perception on this issue is and will continue to be very difficult, because euthanasia "traverses issues which transcend the strict confines of medical science and legal jurisprudence both normatively and empirically."²⁴⁰ Nadasen then submits that

²³⁵ Leonard-Taitz "Euthanasia and the 'legal convictions of society' in a South African context" 1993 *South African Law Journal* ("Leonard-Taitz: euthanasia and the legal convictions of society") p.442.

²³⁶ Policy, due to its inherent vagueness, infringes upon legal certainty. See in general Boister (fn. 224 above) p.520.

²³⁷ Leonard-Taitz: euthanasia and the legal convictions of society (fn 235 above) p.443.

²³⁸ Leonard-Taitz: euthanasia and the legal convictions of society (fn 235 above) p. 443.

²³⁹ Boister (fn. 224 above) p.520.

²⁴⁰ Nadasen "Euthanasia: an examination of the Clark judgment in the light of Dutch experience" 1993 *Obiter* ("Nadasen") p.63.

“while there may be *boni mores* which could justify euthanasia under certain circumstances, *boni mores* per se does not constitute a sufficient or adequate jurisprudential basis to justify the administration of euthanasia. Because euthanasia also has such an intense personal element to it – both in respect of the patient and for the next of kin – could their *boni mores* not assist a court as one of a host of factors taken into account in coming to a conclusion after considering all the circumstances including society’s interest in the preservation of life?”²⁴¹

Boister argues that the Court could have limited liability by finding that the accused’s conduct was justifiable in medical-ethical terms and therefore, because of policy reasons, not unlawful, rather than resorting to policy to decide the issue of causation.²⁴²

2.4.15 *S v Nkwanyana*²⁴³

2.4.15.1 Facts

The facts in *S v Nkwanyana* were as follows: In 1993 the accused, Nkwanyana, and the deceased became friends while working in the same shopping centre. The deceased suffered from *anorexia nervosa*, of which one of the symptoms is severe depression. She told the accused that she had emotional problems which led to “unbearable suffering in her head”, as a result of which she wanted to end her life and that she has in fact tried to end her life on previous occasions, but unsuccessfully. She told the accused further that she was, on several occasions, hospitalized, sometimes for extended periods, but that despite treatment she could not overcome her condition.

Early in 1998 the deceased asked the accused to help her end her life, as she said that she has suffered enough. The accused refused because he knew that it would be unlawful. Later in 1998 the deceased told the accused that her boyfriend left her to marry another woman. She was very upset and told the accused that, should he not help her to end her life, she would ask someone else to help her.

²⁴¹ Nadasen (fn 240 above) p.64.

²⁴² Boister (fn. 224 above) p.522.

²⁴³ *S v Nkwanyana* 2003 1 SA 303 (WLD) (“*S v Nkwanyana*”).

The accused subsequently agreed to help her, as he was, according to his testimony, afraid that the deceased could be sexually or otherwise abused if someone else were to help her to end her life.

The accused then went to Alexandra, Johannesburg, and when he came back he told the deceased that he could procure a firearm for R400, whereupon they went to the Alexandra mortuary in the deceased's car. The deceased handed the accused the necessary money and asked him to buy the firearm, which he did. When he returned to the vehicle (in which the deceased was still waiting) the accused had second thoughts and asked the deceased to rather shoot herself, but she convinced the accused by replying that she was afraid of another failed attempt to commit suicide. They then prayed together, at the request of the deceased, after which the deceased handed the accused an envelope and told him that he can keep it, as she would not be able to use it. The accused was not aware at that stage that the envelope contained money. The accused carried the firearm around to the side of the vehicle where the deceased was still sitting. The deceased asked him to wait a while and then she prayed in her mother tongue. Then she told him that she was ready, looked straight ahead of her and the accused shot her in her head, causing her death. The accused then walked away and disposed of the firearm next to the path. He later testified that he was very sad. Nkwanyana was charged with murder.

2.4.15.2 Decision

The accused pleaded guilty. Several people testified and confirmed the mental state of the deceased. The only fact of consequence that the state disputed concerned the envelope containing money, which the state argued was payment to the accused for killing the deceased and that the accused was therefore in a position analogous to that of a hit man. The goal was to prevent the Court from finding urgent and compelling mitigating circumstances that would be necessary to allow the Court to give a lesser sentence than the prescribed minimum for murder, but Judge Makhanya rejected the state's submission. He further

indicated, with reference to *S v Robinson*²⁴⁴ that "our Courts have not failed to take a firm stand regarding the finding of extenuating factors on a murder charge where the deceased has consented to his or her own killing."

The Court found the accused guilty and sentenced him to five years imprisonment, suspended for five years on the condition that the accused not be found guilty, during that period, of a crime involving the intentional, serious physical scarring of another. This is again an extremely light sentence for murder.²⁴⁵

2.4.15.3 Application

This case follows the normal pattern, except that the deceased here suffered from a psychological problem, rather than a physical or terminal illness.

2.5. Statutory law

2.5.1 National Health Act²⁴⁶

For the purposes of euthanasia and the establishment of a framework therefore, certain parts of the National Health Act of 2003 are especially relevant.

The National Health Act was assented to in July 2004 and aims to

“provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith.”²⁴⁷

In the act “death” is defined as brain death and the terms “user” is used rather than “patient”. While the term “user” as defined in the act has a broader meaning

²⁴⁴ *S v Robinson* 1968 1 SA 666 (A) (“*S v Robinson*”).

²⁴⁵ Labuschagne “Anorexia nervosa, psigiatriese lyding en aktiewe eutanasië” 2003 *Obiter* (“Labuschagne: anorexia nervosa”) p.228.

²⁴⁶ National Health Act 61 of 2003.

²⁴⁷ Prelude.

than the normal meaning of “patient”, for the purpose and scope of this dissertation the terms may be understood interchangeably.

The objects recognized by the act include the establishment of a national health system which provides the population of the Republic, in an equitable manner, with the best possible health services that available resources can afford²⁴⁸ and the progressive realization of the constitutional right of access to health care services.²⁴⁹

The act also incorporates a form of informed consent,²⁵⁰ requiring that, with a few exceptions, a health service may not be provided to a user without the user’s informed consent.²⁵¹ For the purposes hereof, “informed consent” is defined as the consent given for the provision of such a health service by a person who has the legal capacity to do so²⁵² and who has been informed by the health care provider, in a language and manner that the user understands,²⁵³ of:

- “(a) The user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user;
- (b) the range of diagnostic procedures and treatment options generally available to the user;
- (c) the benefits, risks, costs and consequences generally associated with each option; and
- (d) the user’s right to refuse health services and explain the implications, risks and obligations of such refusal.”²⁵⁴

²⁴⁸ Section 2 (a) (ii).

²⁴⁹ Section 2 (c) (i).

²⁵⁰ See in general on informed consent Van Oosten “*Castell v De Greef* and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy” 1995 *De Jure* p.164 and Earle “‘Informed consent’: is there room for the reasonable patient in South African law?” 1995 *SALJ* p.629

²⁵¹ Section 7(1).

²⁵² Section 7(3).

²⁵³ Section 6(2).

²⁵⁴ Section 6(1).

Importantly, the act then also provides that a user has the right to participate in any decision affecting his / her personal health and treatment.²⁵⁵ Where a user refuses to accept recommended treatment, he or she must sign a discharge certificate or release of liability.²⁵⁶

The confidentiality of user information is protected,²⁵⁷ but a health care worker or provider that has access to a user's records may disclose the user's personal information (as defined in the Promotion of Access to Information Act, 2000²⁵⁸) to "any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his / her duties where such access or disclosure is in the interests of the user."²⁵⁹

The act recognizes the importance of protecting health records from, amongst other things, unauthorized access;²⁶⁰ falsification;²⁶¹ unauthorized editing;²⁶² unauthorized copying;²⁶³ or unauthorized destruction²⁶⁴. The person in charge of a health care establishment in possession of a user's health records must set up control measures to prevent unauthorized access to such records or the place / medium that stores such records, and failure to comply, or any tampering as indicated above by any person is, in terms of the act, an offence. On conviction, an offender is liable to a fine or to imprisonment for a period not exceeding one year, or both such fine and imprisonment.²⁶⁵

²⁵⁵ Section 8(1).

²⁵⁶ Section 19(d).

²⁵⁷ Section 14.

²⁵⁸ Promotion of Access to Information Act 2 of 2000.

²⁵⁹ National Health Act 61 of 2003 Section 15(1).

²⁶⁰ Section 17(1).

²⁶¹ Sections 17(2)(b) and 17(2)(e).

²⁶² Section 17(2)(c).

²⁶³ Section 17(2)(f).

²⁶⁴ Section 17(2)(c).

²⁶⁵ Section 17(2).

The act also provides for the establishment of Inspectorates of Health Establishments²⁶⁶ and an Office of Standards Compliance.²⁶⁷ These are empowered and required to monitor and inspect health care establishments and agencies to ensure compliance with the act.²⁶⁸

Besides affirming certain rights of users, the National Health Act also creates some infrastructure that could potentially be used in the control of legalized euthanasia.

2.6. Authors

Many important and influential authors have written on the topic of euthanasia. Due to the limited scope of this dissertation, only a few of these authors can be discussed here.²⁶⁹

2.6.1 Strauss

Strauss is probably the leading expert on medical law in South Africa. He discusses the topic of euthanasia briefly in his book, “Doctor, patient and the law”, the most recent edition of which was published in 1991,²⁷⁰ some time before even the interim Constitution.

²⁶⁶ Section 77.

²⁶⁷ Section 78.

²⁶⁸ Sections 77 and 79 .

²⁶⁹ See in general on euthanasia and closely related topics also Nadasen “‘Suffer the little children...’ – euthanasia and the best interests of the child” 1997 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* p.124; Scott “Assisted suicide and the South African constitutional order” 1998 *Responso Meridiana* p.1; Dreyer “Redelike dokter versus redelike pasiënt” 1995 *Tydskrif vir Hedendaagse Romeins-Hollandse Reg* p.532 as well as all the South African authors referenced in this dissertation. As far as possible, where an author could not be discussed separately, unique contributions were incorporated into the remainder of the dissertation.

²⁷⁰ Strauss also wrote several articles related to the topic, but his book summarizes the topics most relevant to this dissertation neatly and the articles are dated. Two such articles, where the content falls slightly outside of the scope of this dissertation, are Strauss “Toestemming deur `n jeugdige” 1964 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* p.116 and Strauss “Onvrywillige genadedood: `n belangrike Transvaalse beslissing” 1969 *Tydskrif vir die Hedendaagse Romeins-Hollandse Reg* p.385

Strauss starts off by noting the incalculable value of life and remarking that respect for life is “the hallmark of Western civilisation”.²⁷¹ At the same time, he already referred to a change in emphasis at the time of writing the chapter in his book, which chapter was based on Strauss’ contribution at an international symposium in 1979:

“Perhaps the preoccupation with the sanctity of life in our civilization has in recent times largely shifted from sheer preservation of life to the *quality of life*. This has manifested itself in particular in the legalisation of abortion in our century, where the emphasis has increasingly been put on consideration of the woman’s interest relating to the quality of her own life, rather than on preservation, at all costs, of the incipient life – *die wordende lewe* – in her womb.”²⁷²

He then proceeds to discuss some of the conflicting views of euthanasia in South Africa at the time and, based in part on a national symposium held in 1977 “in which all major national groups and religions were represented”,²⁷³ comes to the conclusion that South Africans, at the time, “overwhelmingly reject any suggestion of active euthanasia being legalised”.²⁷⁴

Contrasting this with the tremendous leniency in South African case law on euthanasia and the apparent wide support for the manner in which the cases were dealt with by the courts, Strauss asks the question whether we have not transformed criminal law into criminal “non-law”:

“In the public’s mind then, the law as it is applied to mercy-killing would seem to be ideal. Brand the mercy-killer a murderer. But do not punish him at all [...] or, if the law says murderers shall be punished, impose a sentence which is nominal only, e g imprisonment until the rising of the court [...] or a suspended prison sentence. Thereby the law registers society’s disapproval in the strongest terms, and yet it is largely symbolic only [...] One may well ask whether it is still criminal law which is applied when we say that murder is our most serious crime, that capital punishment, *sub condicione*, is in fact

²⁷¹ Strauss (fn 8 above) p.336.

²⁷² Strauss (fn 8 above) p.336.

²⁷³ Strauss (fn 8 above) p.338.

²⁷⁴ Strauss (fn 8 above) p.339.

the prescribed punishment, but that we recognise a class of murderers whom we do not want to punish at all. Have we not thereby transformed the criminal law into criminal ‘non-law’?”²⁷⁵

Regardless of this, a doctor involved in active euthanasia may (and probably will) still face disciplinary proceedings and sanctions from the Medical Council.²⁷⁶ Strauss apparently support the view of Hillel Shapiro that it may be best to simply maintain the *status quo* and avoid the dangers involved in trying to create a statutory framework.²⁷⁷

In conclusion, Strauss supports a strong distinction between active and passive euthanasia, arguing that the *boni mores* eminently allows for the *bona fide* practice of passive euthanasia.²⁷⁸ He then gives his own opinion:

“[P]ain and suffering may torment a man until his desire is to live no more and to receive no further medical treatment. That desire [, like the desire to live,] we should also respect.”²⁷⁹

This is wholly consistent with his personal opinion on a form of passive euthanasia as expressed elsewhere in his book:

“[I]f it amounts to euthanasia to withhold medical treatment of grossly defective newborns – who have no hope of being cured or of living for any length of time – and the withholding doesn’t inflict starvation or any other form of cruelty and allows the baby to die a natural and hopefully early death, I for one, am in favour of that kind of euthanasia.”²⁸⁰

In a different chapter, Strauss addresses the issues regarding the “right to die” and living wills or advance directives, based on a paper he contributed to a special lecture series in August 1983.²⁸¹

²⁷⁵ Strauss (fn 8 above) p.342.

²⁷⁶ Strauss (fn 8 above) p.342.

²⁷⁷ Strauss (fn 8 above) p.342.

²⁷⁸ Strauss (fn 8 above) p.343.

²⁷⁹ Strauss (fn 8 above) p.343.

²⁸⁰ Strauss (fn 8 above) p.200.

²⁸¹ Strauss (fn 8 above) p.344.

Strauss indicates that the South African Living Will Society (SAVES) distributes the so-called “Living Will” for execution by its members, which grew steadily in numbers since 1974 and in 1991 exceeded 20 000, including many medical practitioners.²⁸²

At the time Strauss wrote the chapter, the living will read:²⁸³

“If the time comes when I can no longer take part in decisions for my own future, let this declaration stand as the testament to my wishes. If there is no reasonable prospect of my recovery from physical illness or impairment I request that I be allowed to die and not be kept alive by artificial means and that I receive whatever quantity of drugs may be required to keep me free from pain or distress even if the moment of death is hastened.”

Strauss indicates that, in principle, every person has the right to refuse medical attention, even if the effect is that his / her death is hastened; “[i]n this sense the individual has a ‘right to die’.” What is required to make a living will a legally valid refusal of medical treatment, is that the person making his / her refusal known must be of sound mind at the time. This refusal will then remain valid even if the person is later not of sound mind, for example due to a physical or mental illness. It can still, however, be freely revoked at any time by the person who made it.²⁸⁴

The medical practitioners should respect the statement of refusal and should they disregard it and keep the patient alive by artificial means, Strauss is of the opinion that the medical practitioner will be “‘technically’ guilty of an assault, both from the point of view of civil law and criminal law.”

Furthermore, he asserts that there is no public policy against the terminally ill patient refusing treatment, and that it does not matter what the patient’s motive is,

²⁸² Strauss (fn 8 above) p.344.

²⁸³ Strauss (fn 8 above) p.344.

²⁸⁴ Strauss (fn 8 above) p.344.

“be it fear of prolonging his suffering when terminally ill or critically injured, a desire to spare his next of kin the agony of watching him over a long-drawn period of illness, or a desire to save his estate the major expense involved in lengthy treatment in a hospital’s intensive care unit.”²⁸⁵

A part of the living will that may present problems is the request for whatever quantity of drugs may be required to keep the patient free of pain, even if the moment of death is hastened. Strauss then discusses the situation with regard to the “double effect”, although he does not call it such.

Strauss writes that in South African law, to hasten the death is to cause it. However, Strauss supports a view that a physician’s conduct will not be unlawful and he or she will thus not be guilty of murder²⁸⁶ in the following cases:

“A patient is suffering from an incurable disease accompanied by excruciating pain. The physician administers the minimum dosage of drugs necessary to make the pain endurable knowing that such minimum dosage will probably also cause death. A patient is suffering from a painful and incurable disease and a drug is administered. Because of the resistance consequent upon the habitual administering of the drug, steadily increasing doses have to be administered. This means that unless the patient dies beforehand due to another cause, a point must be reached when the dosage becomes lethal.”²⁸⁷

An important consideration here is the intention of the medical practitioner: not to kill the person, but to combat pain; many drugs and medical procedures have side-effects, but are not defined from the viewpoint of those side-effects. In the same manner, death is here merely a side-effect of the pain relieving treatment.²⁸⁸

Strauss then comes to the conclusion that this provision of a living will “therefore seems to be legally unassailable” and the medical practitioner who complies will not be subject to criminal or civil liability, provided that the

²⁸⁵ Strauss (fn 8 above) p.345.

²⁸⁶ Strauss (fn 8 above) p.346.

²⁸⁷ Strauss (fn 8 above) p.345.

²⁸⁸ Strauss (fn 8 above) p.346.

medical practitioner acts in good faith, employs the usual pain-relieving substances in reasonable quantities and has the intention to relieve pain, not to kill.²⁸⁹

Lastly, Strauss considers the implication a living will or advance directive might have on life-insurance. He is of the opinion that the refusal of treatment cannot be regarded as suicide, but the mere fact that a person has made a living will might affect the risk to be undertaken by the insurer. He then advises anyone who has signed a living will to make the fact known to the insurance company when taking out life insurance.²⁹⁰

2.6.2 David McQuoid-Mason

David McQuoid-Mason very briefly discusses euthanasia in the book “Introduction to medico-legal practice”.²⁹¹

He starts off by briefly defining active and passive euthanasia. While worded differently, the content of the definition of active euthanasia used seems to be substantially the same as those used in this dissertation.²⁹²

Regarding active euthanasia, McQuoid-Mason, with reference to case law, states that it is regarded as murder in South Africa. Interestingly, he seems to equate suicide with “active euthanasia” by the patient.²⁹³ This is completely in keeping with the South African Law Commission’s logic that assisted suicide and active euthanasia are different manifestations of the same thing. It should be noted here that this view is by no means adopted universally; in fact, in the international community great care is sometimes taken to maintain a distinction between

²⁸⁹ Strauss (fn 8 above) p.346.

²⁹⁰ Strauss (fn 8 above) p.347.

²⁹¹ Dada and McQuoid-Mason *Introduction to Medico-Legal Practice* (2001) (“Dada & McQuoid-Mason”) p.26.

²⁹² Dada & McQuoid-Mason (fn 291 above) p.26.

²⁹³ Dada & McQuoid-Mason (fn 291 above) p.26.

active euthanasia and assisted suicide.²⁹⁴ That being said, doctor-assisted suicide is also considered murder in South African law.²⁹⁵

Passive euthanasia is defined by McQuoid-Mason as something which “occurs where a health professional or member of a patient’s family withdraws or withholds treatment from a patient who is suffering from a terminal injury or illness or one that is so serious that the prospects of recovery is nil.”²⁹⁶

He then, with reference to the case of *Clarke v Hurst*,²⁹⁷ comes to the conclusion that such conduct “may not be regarded as murder as nature is allowed to take its course and the patient is regarded as having been killed by the underlying illness or injury”.²⁹⁸

A patient who is mentally competent, and terminally ill or suffering unbearably may rely on the constitutional rights to privacy, freedom and security of the person and respect for and protection of dignity.²⁹⁹

Additionally, according to McQuoid-Mason, the converse of the right to life “must be that every person has the right to take his or her life should they wish to do so.” In the medical context, such person has the right “to refuse medical treatment even if it would lead to the person’s death.”³⁰⁰

McQuoid-Mason states that such refusal of treatment or request for withdrawal of treatment by the patient normally does not pose a legal problem where the

²⁹⁴ See for example the Oregon “Death with Dignity” Act, which serves as an example for many countries.

²⁹⁵ Dada & McQuoid-Mason (fn 291 above) p.28.

²⁹⁶ Dada & McQuoid-Mason (fn 291 above) p.26.

²⁹⁷ *Clarke v Hurst* (fn 98 above).

²⁹⁸ Dada & McQuoid-Mason (fn 291 above) p.27.

²⁹⁹ Dada & McQuoid-Mason (fn 291 above) p.28.

³⁰⁰ Dada & McQuoid-Mason (fn 291 above) p.28.

patient is mentally competent. In the cases where the patient is not competent one of two situations may arise, both with their own problems.³⁰¹

Firstly, “advance directives” or “living wills” may be used, but it is not always clear if the living will, having been made some time before, still accurately reflects the patient’s wishes. This results in some medical practitioners being reluctant to recognize them.³⁰²

McQuoid-Mason apparently agrees with Straus that such living wills or advance directives should be respected, provided it is reasonably clear that they reflect the patient’s wishes.³⁰³

Secondly, “substituted judgement” may be used. This is where someone else makes the decision on behalf of the incompetent patient, either by way of an “enduring power of attorney” or through application to court. At present South African law does not recognize enduring powers of attorney.³⁰⁴

2.6.3 Labuschagne

The late Labuschagne was quite outspoken in his support for the decriminalisation of euthanasia. Beside his writings on the topic,³⁰⁵ he also wrote about a number of overseas euthanasia cases as the judgements became available.

At the start of his article titled “Dekriminalisatie van euthanasie”³⁰⁶ (decriminalisation of euthanasia), Labuschagne asks the question why euthanasia has in modern time again become such a widely-discussed topic.

³⁰¹ Dada & McQuoid-Mason (fn 291 above) p.27.

³⁰² Dada & McQuoid-Mason (fn 291 above) p.27.

³⁰³ Dada & McQuoid-Mason (fn 291 above) p.27.

³⁰⁴ Dada & McQuoid-Mason (fn 291 above) p.28.

³⁰⁵ Due to space considerations, only the most relevant of Labuschagne’s writings are discussed here. See for example also Labuschagne “Aktiewe euthanasie van ’n swaar gestremde baba: ’n Nederlandse hof hersetel die *ius vitae necisque* in ’n medemenslike gewaad” 1996 *SALJ* p.216, where the focus is more on euthanasia and babies. Where appropriate, more of Labuschagne’s work is incorporated into the text of this dissertation.

He then identified the following main reasons:

- Medical technology advanced to the stage where we can, in some cases, keep a patient alive indefinitely, but the prolonging of life often also results in the prolonging of suffering.³⁰⁷
- The rise of the philosophy of human individualism, combined with the development of opposition to the power of medicine and the demand that the law must be religiously and dogmatically neutral to allow every individual to, as far as possible, live life according to his / her own beliefs, led to deregulation that can be seen over a wide front in the criminal law.³⁰⁸
- Socio-psychologically, especially old and terminally ill people are more often spending their last days in the cold, clinical setting of a hospital (where the advanced medical technology is found), rather than in the setting of warmth, love and support from their families. The feelings of loneliness and uselessness, combined with anxiety due to amongst other things dependency, invalidity, illness, pain and suffering, creates a favourable atmosphere for euthanasia requests.³⁰⁹
- Economically, patients may not want to incur huge expenses in a scenario where, according to the medical knowledge of the time, they have no chance of recovery.
- Due to the tremendous development of medical technology, the number of aged people increased substantially, and it is especially in this group that request for euthanasia are most often encountered.
- Suicide pacts are also much more common than they were before, especially where an aging man and woman decide to end their lives

³⁰⁶ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.167.

³⁰⁷ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.169.

³⁰⁸ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.169.

³⁰⁹ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.169.

where one or both of them are suffering from grave illness which occupies their thoughts.³¹⁰

Labuschagne then proceeds to shortly discuss two cases in the South African law where there rests a duty on a person to try to prevent the death of another and the causing of death by inaction may be criminal:

Where there is a protective relationship between the two parties, for example

“where the potential victim is helpless through infancy, senility or illness and the potential killer stands, either naturally or through a deliberate acceptance of responsibility, in a protective relationship to the victim”;³¹¹

And where the relationship is one between a medical practitioner and patient, where the medical practitioner has the duty to treat the patient, even if the latter has suicidal tendencies, to prevent the patient’s death.

As a general comment, Labuschagne remarked that it is ironic that, while it is commonly allowed to kill animals for “humanitarian” reasons, mankind masochistically reserved for itself the “duty” to endure even the worst suffering without such recourse.³¹² To the question what makes a human a human, Labuschagne identifies two approaches.

The first approach attempts to define a human by certain unique characteristics, for example the argument that a human is a human due to the fact that a human has self awareness. Labuschagne criticizes this example, stating that according to him, animals also have a rudimentary self awareness; otherwise they would not defend themselves against attacks by other animals. According to Labuschagne, a human is differentiated from animals by the fact that a human has an analytical self awareness, but would also include those that merely has the potential for such analytical self awareness, for example newly borns and people suffering from a temporary loss of consciousness.³¹³

³¹⁰ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.174.

³¹¹ *R v Chenjere* 1960 1 SA 473 (FC) 482 as quoted in Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.176.

³¹² Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.167.

³¹³ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.184.

The second approach merely defines anything that was born of a woman as a human. Labuschagne notes that, while he uses this second approach in his discussion, the first approach is philosophically more pure but is not used as mankind has not yet reached the level of emotional and moral development to argue from the first approach.³¹⁴

Labuschagne also emphasises that a dying person is still a living person and thus to die in a worthy or dignified manner is to live in a worthy or dignified manner.³¹⁵

In comparing the Dutch and South African common law, Labuschagne states that the defence of necessity has the same origin and elasticity in both legal systems, and that the South African courts would be able to follow the same route the Dutch courts did with allowing necessity as a defence in euthanasia cases.³¹⁶

That being said, Labuschagne noted in the same article that in The Netherlands, the emphasis in the courts has been moving from “necessity” to an occupation right, for if it was only about necessity, why limit it to medical practitioners?³¹⁷ He also observed that using necessity in all cases is forced and fictional, as necessity in the legal sense is not always present.³¹⁸ It was clear to Labuschagne that the developments with regards to active euthanasia in The Netherlands required the attention of the Dutch legislature.³¹⁹ This was before the enactment of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001).

³¹⁴ Labuschagne: dekriminalisasie van eutanase (fn 6 above) p.185.

³¹⁵ Labuschagne “Die reg om waardig te sterf, aktiewe eutanase en bystand tot selfdoding” 1995 *SAJC* (“Labuschagne: die reg om waardig te sterf”) p.228.

³¹⁶ Labuschagne: aktiewe eutanase (fn 67 above) p.413.

³¹⁷ Labuschagne: aktiewe eutanase (fn 67 above) p.412.

³¹⁸ Labuschagne “Aktiewe eutanase en professionele hulpverlening by selfdoding van ’n psigiatriese pasiënt” 1995 *South African Law Journal* (“Labuschagne: professionele hulpverlening”) p.229.

³¹⁹ Labuschagne: aktiewe eutanase (fn 67 above) p.412.

A few years later, Labuschagne writes that he supports the new Dutch law on euthanasia, as it prioritizes patient autonomy as, amongst others, a component of human dignity.³²⁰ He also writes that euthanasia by someone other than a medical practitioner can now only be excused in cases of necessity such as when a soldier shoot a seriously wounded and dying colleague to prevent his capture and torture by the enemy.³²¹

In the case of non-voluntary euthanasia, Labuschagne writes that the previous wishes of the patient should be the determining factor, but in cases of doubt the decision must always be made in favour of life.³²²

Labuschagne also shortly looks at the sets of arguments for and against euthanasia (including both active and passive forms –Labuschagne considers the distinction to be morally and factually extremely artificial³²³) and gives his commentary. The first set of arguments against euthanasia is based on religious and moral considerations. Labuschagne quickly points out that people who do not share a certain religion or belief should not be bound by it, and therefore religious or moral arguments are by themselves not sufficient. A rule must be necessary for the “worldly welfare of society generally” before it should achieve legal status.³²⁴

The second set of arguments against euthanasia is based on the possibility that medical practitioners can give incorrect diagnoses and prognosis. Labuschagne admits that this risk cannot be completely eliminated, but argues that human fallacy is found in everything we do and to remember this only when dealing with voluntary euthanasia is arbitrary. As a means to reduce the risk, most suggestions for the legalization of euthanasia includes provisions to the effect

³²⁰ Labuschagne: anorexia nervosa (fn 245 above) p.222.

³²¹ Labuschagne: anorexia nervosa (fn 245 above) p. 222.

³²² Labuschagne "Beëindiging van mediese behandeling en toestemmingsonbekwames" 1995 *Obiter* (“Labuschagne: Toestemmingonbekwames”) p.178.

³²³ Labuschagne: die reg om waardig te sterf (fn 315 above) p.228.

³²⁴ Labuschagne: Toestemmingonbekwames (fn 322 above) p.185.

that a second medical practitioner, often a specialist, must confirm the first medical practitioner's conclusions before any euthanasia may be performed.³²⁵

The third set of arguments against euthanasia essentially boils down to saying that no disease or illness is inherently incurable, and medical technology may yet find cures where there are none today. To this Labuschagne replies with a quote from Matthews:³²⁶

“We cannot regulate our conduct at all unless we assume that we must be guided by the knowledge we have. We take for granted that known causes will be followed by known effects in the overwhelming majority of cases. Any other assumption would strike at the roots of sanity.”³²⁷

The fourth set of arguments against euthanasia is the so-called “slippery slope” or “thin end of the wedge” arguments. In essence, these arguments are that euthanasia is only the “thin end of the wedge”, or will start us down a “slippery slope”, reducing the value of human life and ultimately leading to abuse and foul play. To this Labuschagne answers that there is no human behaviour from which such evil cannot flow. He then quotes Tooley's analogy³²⁸ with approval:

“If someone were to advocate sexual activity, and a critic were to object that while only voluntary sexual activity is being advocated at present, the proposal will soon be extended to cover compulsory sexual activity, ie, rape, the critic would hardly be taken seriously.”³²⁹

The fifth set of arguments against euthanasia are of a medical-ethical nature: That euthanasia is in conflict with the Hippocratic oath, that people's faith in the medical profession will be scarred by people seeing medical practitioners as executioners and that euthanasia would allow for easier organ transplants. Labuschagne answers that the Hippocratic Oath is interpreted progressively and not exactly as when it came into being; a doctor's duty is not merely to cure, but also to eliminate suffering. Concerning people's faith in the medical profession,

³²⁵ Labuschagne: Toestemmingonbekwames (fn 322 above) p.187.

³²⁶ Matthews “Voluntary euthanasia: the ethical aspect” in Downing (ed) *Euthanasia and the right to death* (1969) (“Matthews”) p.28.

³²⁷ Labuschagne: Toestemmingonbekwames (fn 322 above) p.187

³²⁸ Tooley “Decisions to terminate life and the concept of person” in Ladd (ed) *Ethical issues relating to life and death* (1979) (“Tooley”) p.69.

³²⁹ Labuschagne: Toestemmingonbekwames (fn 322 above) p.188.

proposed euthanasia legalisation includes safeguards and requires the patient's consent. Moreover, if a doctor wants to abuse his position he need not wait for a case of active euthanasia and the mere fact that euthanasia makes the transplantation of good organs easier can and should never serve as an argument in favour of euthanasia.³³⁰

The sixth set of arguments against euthanasia comes down to the question of whether a patient, who is in pain, anxious, possibly depressed, suffering and facing death has the capacity to make a decision in favour of euthanasia. Labuschagne answers that these conditions can fluctuate and patients can lose and re-gain their capacity to make decisions. For these reasons, periodic re-evaluations should be made. Consultation with and control by experts should also be compulsory and informed consent (where the patient is properly informed of his diagnoses and prognosis, understands the information and gives his / her consent voluntarily) would be a requirement for euthanasia.

While in South African law consent cannot generally be raised as a criminal defence in cases of serious bodily injury or killing, Labuschagne quotes and supports from *S v Nkwanyana*:³³¹

“our Courts have not failed to take a firm stand regarding the finding of extenuating factors on a murder charge where the deceased has consented to his or her own killing.”³³²

Another argument that Labuschagne addressed in a different article is the argument raised in *S v Robinson*³³³ that one of the reasons murder is a crime is because it infringes the state's interest in the lives of all those within its jurisdiction. Labuschagne states that this view is of a paternalistic nature and

³³⁰ Labuschagne: Toestemmingonbekwames (fn 322 above) p.188.

³³¹ *S v Nkwanyana* (fn 243 above).

³³² Labuschagne: anorexia nervosa (fn 245 above) p.222.

³³³ *S v Robinson* (fn 244 above).

cannot always, like in the case of euthanasia, be supported in a liberal state where individual autonomy enjoys high status.³³⁴

The legalization of euthanasia brings with it tremendous and sometimes even scary responsibilities.³³⁵ Labuschagne writes that he supports the decriminalisation of both active and passive euthanasia subject to the following requirements:

- a) The patient must suffer from an incurable disease or illness;
- b) The suffering must be subjectively unbearable;
- c) The patient must give informed consent to the act of euthanasia;
- d) At least two medical practitioners must certify to the above,³³⁶
- e) A declaratory order from the High Court to the effect that the above has been complied with must be obtained.³³⁷

Should the above be complied with, Labuschagne asserts that, in the light of human autonomy and dignity and the fading of community paternalism, people should have a so-called right to die. Labuschagne also elsewhere quotes John Stuart Mill³³⁸ for the “classic approach” to personal autonomy:

“That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. Over himself, over his own body and mind the individual is sovereign.”³³⁹

With informed consent as a requirement for euthanasia, those people like children, the mentally ill, unconscious or comatose, who cannot legally give consent, are inadvertently discriminated against. In such cases Labuschagne submits that the courts would have to make a decision based on several factors, including the value system of the patient (what his / her wishes would have

³³⁴ Labuschagne: anorexia nervosa (fn 245 above) p.222.

³³⁵ Labuschagne: professionele hulpverlening (fn 318 above) p.229.

³³⁶ Labuschagne: Toestemmingonbekwames (fn 322 above) p.190.

³³⁷ Labuschagne: professionele hulpverlening (fn 318 above) p.229.

³³⁸ Mill (fn 118 above).

³³⁹ Labuschagne “Die strafregtelike verbod op hulpverlening by selfdoding” 1998 *Obiter* 58.

been), the recommendations of doctors and family and the quality of life, which should be the determining factor when there is doubt.

2.6.6 Van Oosten

Van Oosten writes about the situations, in medical law, where a medical practitioner would be liable for an omission.

Firstly, where the medical practitioner (or hospital) assumes control over a potentially dangerous situation and/or object, for example where treatment of a patient is initiated, but not followed through properly.³⁴⁰

Secondly, where there is a statutory duty to act, for example where a medical practitioner or hospital fails to provide a patient (who presents himself) with compulsory vaccination against a communicable disease.³⁴¹

Thirdly, where there is a contractual duty on a medical practitioner or hospital to perform certain actions and they fail to do so.³⁴²

Fourthly, in emergency situations like traffic accidents, where medical practitioners have a duty to intervene.³⁴³

Fifthly, where a doctor or hospital has taken charge of a patient and then fails to complete treatment or abandons the patient (with some exceptions).³⁴⁴

Lastly, Van Oosten remarks that the above five categories do not constitute a closed list and that the courts are free at any time to extend the list in accordance with the *boni mores*.³⁴⁵

³⁴⁰ Van Oosten (fn 13 above) p.59.

³⁴¹ Van Oosten (fn 13 above) p.59.

³⁴² Van Oosten (fn 13 above) p.60.

³⁴³ Van Oosten (fn 13 above) p.60.

³⁴⁴ Van Oosten (fn 13 above) p.60.

In a later chapter, Van Oosten recognizes authority for the view that deaths as a result of the “double effect” would not lead to the medical practitioner’s conduct being regarded as wrongful, but as justified by society’s convictions.³⁴⁶

With regards to euthanasia, Van Oosten starts off his writings on euthanasia by stating that

“[u]ntil recently, active involuntary euthanasia was treated by the courts as the intentional and unlawful killing of a human being and, hence, as murder as the most serious crime in law”³⁴⁷

and, after an extensive discussion of the case of *Clarke v Hurst*,³⁴⁸ concludes “[h]ence, in the instant case voluntary active euthanasia was afforded judicial recognition and acceptance.”³⁴⁹

It should be noted here that Van Oosten based this on a definition of “active euthanasia” that included the withdrawal of life-sustaining naso-gastric feeding (or treatment). Under the definitions used in this dissertation, such actions would be classified as passive euthanasia.

Van Oosten recognized a patient’s right to refuse treatment or medical intervention,³⁵⁰ which supports an argument in favour of passive euthanasia. Active euthanasia, as the term is used in this dissertation, is however not discussed.

2.6.7 Carstens

Carstens writes that many older persons who suffer from terminal illnesses or debilitating diseases often express a wish to die as a “logical developmental

³⁴⁵ Van Oosten (fn 13 above) p.61.

³⁴⁶ Van Oosten (fn 13 above) p.109.

³⁴⁷ Van Oosten (fn 13 above) p.109.

³⁴⁸ *Clarke v Hurst* (fn 98 above).

³⁴⁹ Van Oosten (fn 13 above) p.113.

³⁵⁰ Van Oosten (fn 13 above) p.63.

reality of a life that is no longer ‘worth living’[...],³⁵¹ and physicians are increasingly urged, in certain circumstances, to help their patients to end their lives in the name of compassion and dignity. Here, according to Carstens, the concepts of thanatology – the study of the experience of death, dying and bereavement – and palliative medicine are relevant.³⁵²

According to Carstens, end of life refers to all those issues involved in caring for the terminally ill. He further states that end of life begins when curative therapy ceases and it encompasses communication of the prognosis to the patient and his / her family; “defining the patient’s understanding of his / her illness”; advance directives; the need for hospitalization and hospice care; legal and ethical matters; bereavement support; psychiatric care and palliative care to relieve pain and suffering.³⁵³ Carstens does not indicate euthanasia directly, but it would presumably form part of the categories regarding legal / ethical matters and pain relief.

Carstens does, however, define euthanasia as “a physician’s intentional act to cause a patient’s death by directly administering a lethal dose of medication or other agent”,³⁵⁴ adding that such patients are thought to be terminally ill or injured. He then proceeds to list several forms of euthanasia:

“*Active euthanasia*, in which a physician intentionally kills a patient to alleviate or prevent uncontrollable suffering; *passive euthanasia*, in which a physician withholds artificial life-sustaining measures; *voluntary euthanasia*, in which a person who is to die is competent to give consent and does so; and *involuntary euthanasia*, in which the person who is to die is incompetent or incapable of giving consent. Euthanasia assumes that the intent of the physician is to aid and abet a patient’s wish to die.”³⁵⁵

³⁵¹ Carstens “The Law and Older Persons” in Clarke (ed) *Family Law Service* (2006) (“Carstens”) p.50.

³⁵² Carstens (fn 351 above) p.50.

³⁵³ Carstens (fn 351 above) p 50.

³⁵⁴ Carstens (fn 351 above) p 51.

³⁵⁵ Carstens (fn 351 above) p 51.

In considering voluntary passive euthanasia, Carstens shortly discusses advance directives, which usually takes the form of living wills, health care proxies (power of attorneys), or orders not to intubate or not to resuscitate.

A living will comprises specific instructions (which may include the rejection of artificial feeding or hydration or other life-prolonging measures) left by a mentally competent patient regarding his / her choices for health care when he / she cannot communicate them because of illness. Carstens states that, in the sense that every person of sound mind is, in principle, legally entitled to refuse medical treatment, such person has a “right to die”. If such a refusal by a person in a concrete situation is legally valid, “there is no reason why he would not be entitled at an earlier stage to express a standing refusal of any treatment at all.”³⁵⁶

Carstens describes a “health care proxy” as empowering another person to make the patient’s medical decisions if the patient cannot. Such decisions are then to be based on what he / she thinks the patient would want.³⁵⁷

While noting that, under current South African Law, most forms of euthanasia are unlawful and constitutes the crime of murder, Carstens submits that South Africa’s progressive Constitution seems supportive of a regulated regime of euthanasia in South Africa (even though public opinion might differ).³⁵⁸ Additionally, patient autonomy is a fundamental right and the ultimate decision to undergo or refuse a medical intervention does not lie with the doctor, but with the patient.³⁵⁹

2.6.8 Burchell

Burchell writes that, in South African law, murder is the unlawful, intentional killing of another person. When exactly a person is dead has traditionally been

³⁵⁶ Carstens (fn 351 above) p 50.

³⁵⁷ Carstens (fn 351 above) p 50.

³⁵⁸ Carstens (fn 351 above) p 51.

³⁵⁹ Carstens (fn 351 above) p 48.

determined with reference to the absence of breathing or heartbeat, but medical science now places the focus on irreversible brain stem damage – a criterion of death that the courts may well adopt.³⁶⁰

Regarding euthanasia, Burchell, with reference to case law, makes the distinction between cases involving positive conduct (the *Grotjohn*³⁶¹ and *Hartman*³⁶² cases) and the case of *Clarke v Hurst*,³⁶³ which involved an omission (the withholding of treatment) in a controlled medical environment.³⁶⁴

In the case of the latter, it is “considered ethically and legally permissible for artificial naso-gastric feeding to be withheld from a patient whose brain has ‘permanently lost the capacity to induce a physical and mental existence at a level which qualifies as human life’³⁶⁵ and the legal convictions of the community did not, according to the Court, require that the patient should be kept alive in these circumstances.³⁶⁶

Regarding the former two cases, a compassionate motive did not defeat a charge of murder³⁶⁷ and knowingly assisting another to commit suicide constitutes the factual and legal cause of death and could result in someone being found guilty of murder (if the assistance was intentional) or culpable homicide (if the killing was merely negligent). The role of the assistant in another’s suicide has been described by the Court as “accessory”, and “by emphasizing that the conduct must be both intentional and *unlawful*, it has left open the door for a future court to take account of changing attitudes to death and dying”.³⁶⁸

³⁶⁰ Burchell (fn. 13 above) p. 159.

³⁶¹ *S v Grotjohn* (fn 212 above).

³⁶² *S v Hartmann* (fn. 216 above).

³⁶³ *Clarke v Hurst* (fn 98 above).

³⁶⁴ Burchell (fn. 13 above) p. 159.

³⁶⁵ Burchell (fn. 13 above) p. 159.

³⁶⁶ Burchell (fn. 13 above) p. 159.

³⁶⁷ Burchell (fn. 13 above) p. 159.

³⁶⁸ Burchell (fn. 13 above) p. 159.

Burchell notes that South African courts have “consistently emphasized the sanctity of human life and the state’s interest in the preservation of life”,³⁶⁹ but that

“it appears to be both ethically and legally acceptable for a medical practitioner to administer drugs or other medicines intended to *alleviate pain* to a terminally-ill person, even if in the process the death of the patient is hastened.”³⁷⁰

Consent of the victim cannot generally excuse crimes (unless consent plays a part in the definition of the crime), as a crime is considered not so much harm against a victim as a harm to the community as a whole. For consent to succeed as a defence, the victim’s consent must, in the circumstances, be recognized by law as a possible defence; it must be real consent; and the person giving the consent must in law be capable of consenting.³⁷¹

Consent can only be a defence where it is in the interest of public policy that the consent of the victim renders the act of the offender not unlawful. Burchell writes on this that:

“The extent to which public policy puts a brake on the type of conduct to which we can consent is not only a reflection on the legal limits placed on individual autonomy but also a gauge of the degree of paternalism accepted at a certain time in a particular society.”³⁷²

Burchell submits that societal attitudes to death and dying are not static and points out - with reference to *Clarke v Hurst*³⁷³ - that it is “certainly arguable that a person who is in a persistent vegetative state should be permitted to die with dignity.”³⁷⁴

³⁶⁹ Burchell (fn. 13 above) p. 158.

³⁷⁰ Burchell (fn. 13 above) p. 159.

³⁷¹ Burchell (fn. 13 above) p. 324.

³⁷² Burchell (fn. 13 above) p. 324.

³⁷³ *Clarke v Hurst* (fn 98 above).

³⁷⁴ Burchell (fn. 13 above) p. 326.

Regarding living wills, Burchell writes that it's validity in South African law has not yet been judicially examined, but notes the Law Commission's recommendation that such documents be legally recognized and submits that this recommendation

“gains even more substance in the light of the emphasis in the South African Constitution on one of the central aspects of human dignity or individual autonomy in s 10 and control over one's body (s12).”³⁷⁵

He continues by submitting that:

“[i]t is arguable that a refusal to grant A, who has no reasonable prospect of recovering from a severely debilitating, life-threatening disease, the lawful right to agree to the withholding of life support systems (or to enlist the lawful help of others to end the suffering) is conduct that unreasonably and unjustifiably infringes A's Constitutional rights. It is submitted that the rights to dignity, freedom of the person and equal treatment would appear to be the central rights of A that are being unjustifiably and unreasonably infringed.”³⁷⁶

Acknowledging that the legal convictions of the community is informed by constitutional norms, Burchell show that not all forms of euthanasia would be against the legal convictions of society. He then gives the following examples of circumstances that might have to be present to justify or excuse assisting another to die with dignity:

- 1.) evidence of the *boni fide* medical context of the procedure
- 2.) at least two reliable medical assessments indicating that the quality of life of the sufferer is nil or minimal, that there is no reasonable chance of his / her recovery and that two medical professionals and perhaps also an ethical review committee approve the process whereby the sufferer will die
- 3.) approval of the procedure by close family and a court.³⁷⁷

³⁷⁵ Burchell (fn. 13 above) p. 328.

³⁷⁶ Burchell (fn. 13 above) p. 328.

³⁷⁷ Burchell (fn. 13 above) p. 329.

While acknowledging that the distinction between act and omission in the context of life-sustaining treatment was considered unjustifiable by Thirion J in the case of *Clarke v Hurst*,³⁷⁸ Burchell also lists the existence of a living will which has been properly made and the fact that death was caused by an omission rather than a positive act and the fact that the sufferer was sufficiently *compos mentis* to indicate his / her wishes at the time when the wish to die was made, as factors that will add weight to the legality of the decision to allow someone to die.³⁷⁹

³⁷⁸ *Clarke v Hurst* (fn 98 above).

³⁷⁹ Burchell (fn. 13 above) p. 329.

Chapter 3: Overview of the South African Law Commission Report

3.1 *Background*

The South African Law Commission report addresses the question of active euthanasia, even though this was not initially part of the proposed research project.

Beginning in October 1991 SAVES (“The South African Voluntary Euthanasia Society”, now known as “SAVES The Living Will Society”) approached the South African Law Commission with regard to possible legislation regarding “Living Wills”.

In January 1992, the South African Law Commission approved this as part of a research project, but expanded the project to include other issues relating to the termination of life under the heading “Euthanasia and the artificial preservation of life.”

Initially, as far as euthanasia goes, the Commission concerned itself only with passive euthanasia or the cessation of treatment. It soon became clear, however, that international developments as well as enquiries by respondents necessitated that the Commission further expand the project to include the question of active euthanasia.

A question that was apparently often raised during the investigation was whether there was truly a need for legislation – a minority felt that the law was not the appropriate instrument to deal with these end of life decisions. The Commission eventually agreed with the majority and decided, due to various reasons, that legislation would enhance the treatment of terminally ill and dying patients and recommended that formal legislation be implemented on all end of life issues.

This was only the first step, though, as there was little agreement as to what such legislation should be.³⁸⁰

The Commission did research, drafted suggestions, invited feedback thereon and redrafted certain aspects. This accumulated in a Final Draft Bill on End of Life Decisions (hereafter “Final Draft Bill”), contained in the South African Law Commission’s report addressing several end of life decision scenarios under separate headings.

3.2 The artificial preservation of life of a patient who is already clinically dead

The Commission essentially recommended that the present legal position regarding brain dead patients should be formalised in law, and made a suggestion for such formalisation, which is incorporated into the Final Draft Bill.

3.3 Cessation of the life-sustaining medical treatment of a competent person

Again, the present legal position was maintained, noting that in the case of *Castell v De Greeff*³⁸¹ the “unambiguous recognition and acceptance of the right of the patient, who need not be terminal, to refuse life-saving medical intervention was emphasised” and that “[t]his is an explicit rejection of medical paternalism and an endorsement of patient autonomy as a fundamental right”.³⁸²

It is, however, important that the person that refuses treatment be a “competent” person. Certain limitations were laid down regarding age and special provisions were made to facilitate communication in certain cases. The Commission’s suggestions are incorporated into the Final Draft Bill.

³⁸⁰ 1.21 – 1.30.

³⁸¹ *Castell v De Greeff* 1994 (1) SA 408 (C) (“*Castell v De Greeff*”).

³⁸² 4.22.

3.4 *Double effect*

The Commission noted that there is authority³⁸³ in South African law to the effect that the unlawful and intentional hastening of a person's death constitutes murder.

Regarding the intentional hastening of a person's death, intent in the form of *dolus eventualis* could still be present even if a person's actions were informed by a pure intent, but the death of another was foreseen as a result of such actions.

Regarding the unlawfulness, however, the Commission took note of Strauss' opinion³⁸⁴ that the administration of drugs to a terminally ill patient, where the secondary effect is the hastening of death, would be lawful if the doctor, acting in good faith, used normal drugs in reasonable quantities with the object of relieving pain and without the intention to cause death.

The Commission found support for this opinion in the Report of the British House of Lords. It should be noted that in this Report, great emphasis was placed on the medical practitioner's intent.

Furthermore, submissions received by the Commission indicated "overwhelming support for the principle that doctors should be able to administer treatment to prevent pain even if the secondary effect of the painkillers may be the shortening of life."³⁸⁵

According to one commentator, medical evidence suggests that a person's desire to terminate his / her life is greatly diminished by adequate pain relief and

³⁸³ *R v Makali* 1950 1 SA 340 (N) ("*R v Makali*").

³⁸⁴ Strauss (fn 8 above) p.345.

³⁸⁵ 4.41.

emotional support. A minority expressed concern that the principle of double-effect could lead to abuse that would not be easy to detect, control or prove.³⁸⁶

Commentators also indicated that the validity of the distinction between euthanasia and pain management relying on double effect is called into question by the link between pain management and the double effect.³⁸⁷

Here commentators again stressed that the intention of the medical practitioner is of prime importance and he / she must have no intent to kill the patient; if the medical practitioner's intention is to mitigate pain and suffering, "he or she is acting rightly even though such action may hasten the patient's death."³⁸⁸

One of the reasons for this approach seems to be the belief that, while palliative care fosters respect for life and people, euthanasia fosters the idea that "people become obstacles to be 'removed' as quickly and as quietly as possible."³⁸⁹

The South African Law Commission's suggestion recognizes the double-effect principle and it is incorporated into the Final Draft Bill.

3.5 Assisted suicide and active euthanasia

The South African Law Commission suggested that, in discussing these two options, any application will be limited to the "relatively small percentage of mentally competent patients who are terminally ill or can be identified as having an intractable and unbearable illness ie no effective curative medical treatment is available and palliative medical skills are not adequate or acceptable."³⁹⁰

³⁸⁶ 4.46.

³⁸⁷ 4.47.

³⁸⁸ 4.48.

³⁸⁹ 4.48.

³⁹⁰ 4.56.

Concerning any distinction between assisted suicide and active euthanasia, the Commission concluded that they should be treated the same, as assisted suicide is, legally speaking, just a different manifestation of active euthanasia, and the term “active euthanasia” is used in referring to either one or both of these.³⁹¹ The only value a distinction between the two might have is evidentiary: with assisted suicide, the final act is performed by the patient himself / herself, which is at least an indication of the voluntary choice of the patient.

Noting that there seems to be no moral consensus on the issue and the subject matter is highly controversial with strongly held views on both sides, the Commission turned to the decisions of the Constitutional Court for guidance.

In *S v Makwanyane*, the Court held that

“[P]ublic opinion may have some relevance to the enquiry, but, in itself, it is no substitute for the duty vested in the courts to interpret the Constitution and to uphold its provisions without fear or favour. If public opinion were to be decisive there would be no need for constitutional adjudication.”

The Commission concluded that “the only way in which an answer will present itself is if the discussion could be conducted with total objectivity in terms of the constitutional principles.”³⁹²

The Commission did not, however, make any specific recommendation with regards to voluntary active euthanasia. Instead, three different options were set out.

These options are discussed in the Report under the following headings:

- Option 1: Confirmation of the present legal position;
- Option 2: Decision making by the medical practitioner;
- Option 3: Decision making by a panel or committee.

³⁹¹ 4.109.

³⁹² 4.202.

Option 1 embodies the idea that it, if euthanasia were to be legalized, it would be impossible to establish sufficient safeguards to prevent abuse. The prohibition against intentional killing is one of the cornerstones of our law and social relationships and, whilst acknowledging that there may be individual cases in which euthanasia may seem appropriate, these are not sufficient reason to weaken this prohibition. In effect, “hard cases make bad law”. Furthermore, the issue of euthanasia is one in which the rights of the individual and the rights of society as a whole cannot be separated. The Commission notes that, should this approach be taken, it has to be a two-way street, so to speak:

“[T]he rejection of voluntary euthanasia as an option for an individual entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled. This responsibility exists despite the inevitable constraints on health care resources. High-quality palliative care should be made more widely available and the training of health care professionals should be given greater priority”³⁹³

Options 2 and 3 both embody a belief that the legalization of controlled active voluntary euthanasia is the appropriate response, but they take different approaches as to how such control is to be implemented. Option 2 provides that a medical practitioner, adhering to strict safeguards (to prevent abuse), may give effect to the request of a qualifying patient by administering or providing a lethal agent to the patient. Option 3 provides that requests for euthanasia must rather be considered according to set criteria by a multi-disciplinary panel or committee, instituted through legislation. This is similar to the committees that were instituted in The Netherlands, except that here it is proposed that they be approached before euthanasia is performed, rather than forming a part of the review process, as in The Netherlands.

All three of these options are incorporated into the Final Draft Bill, allowing for the appropriate option to be chosen and the remaining two options to be deleted if the Bill were to be enacted.

³⁹³ 4.206.

3.6 *Involuntary active euthanasia*

The South African Law Commission's view, to which commentators unanimously agreed, was that this kind of conduct would not be tolerated by any legal system, especially seen in the light of the tremendous risk of abuse legalizing involuntary active euthanasia would entail. The South African Law Commission recommended that the current legal position be maintained with regard to involuntary active euthanasia.

3.7 *Medical practitioners' convictions*

It was emphasised that a doctor should never be obliged to act in a certain way if such action is contrary to his / her religious or moral convictions.³⁹⁴

³⁹⁴ 4.48.

Chapter 4: Short analysis of South African Law

Commission Final Draft Bill

The provisions of the South African Law Commission's draft bill will be briefly analysed in this chapter. The Draft Bill will be used as the foundation for the recommended framework in chapter 6.³⁹⁵

Definitions

“1. (1) In this Act, unless the context otherwise indicates-

'competent witness' means a person of the age of 18 years or over who at the time he witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no benefit;

'court' means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;

'family member' in relation to any person, means that person's spouse, parent, child, brother or sister;

'intractable and unbearable illness' means an illness, injury or other physical or mental condition, but excluding a terminal illness, that-

- (a) offers no reasonable prospect of being cured; and
- (b) causes severe physical or mental suffering of a nature and degree not reasonable to be endured.

'lawyer' means an attorney as defined in section 1 of the Attorney's Act, 1979 (Act 53 of 1979) and an advocate as defined in section 1 of the Admission of Advocates Act, 1964 (Act 74 of 1964);

³⁹⁵ See p.146 below.

'life-sustaining medical treatment' includes the maintenance of artificial feeding;

'medical practitioner' means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

'nurse' means a nurse registered as such in terms of the Nursing Act 50 of 1978 and authorised as a prescriber in terms of section 31(14)(b) of the proposed [South African Medicines and Medical Devices Regulatory Authority Bill];

'palliative care' means treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene;

'spouse' includes a person with whom one lives as if they were married or with whom one habitually cohabits;

'terminal illness' means an illness, injury or other physical or mental condition that-

- (a) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or
- (b) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.”

Upon reading section 1, it is immediately apparent that, despite the “confusion with regard to terminology used”,³⁹⁶ no definitions for euthanasia or the different manifestations thereof are provided. Some meaning can fortunately be gleaned from the provisions of the Final Draft Bill. In this analysis of the Final Draft Bill, headings were replaced with ones that correspond to the terminology provided on page 8 above.

³⁹⁶ 1.5.

In the definition of “palliative care”, neither “treatment” nor “care” is defined, and it is merely indicated that “life-sustaining medical treatment” includes the maintenance of artificial feeding. Conceivably, therefore, an argument can be made that palliative care as defined here could include euthanasia. There is little doubt that those people providing palliative care would strongly object to such a reading, and it seems highly unlikely that such “treatment and care” were intended by the South African Law Commission to include euthanasia. It is submitted that this definition should be revisited, or at the very least that “treatment” and “care” should be defined appropriately.

Another definition which has great importance for the interpretation of the Final Draft Act is that of “intractable and unbearable illness”. This definition is clearly very wide and it would seem that the term “intractable and unbearable condition” would more accurately have matched provided definition.

4.2 Provisions

4.2.1 Where a person is already dead

“2.(1) For the purposes of this Act, a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely -

- (a) the irreversible absence of spontaneous respiratory and circulatory functions; or
- (b) the persistent clinical absence of brain-stem function.

(2) Should a person be considered to be dead according to the provisions of sub-section (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment.”

This section provides a definition of death for purposes of the act and then proscribes when a person may be considered dead. It would have been more consistent to include a definition of death in section 1 and then merely provide

later that two medical practitioners have to agree and confirm in writing that a person is dead before the person may be considered dead for purposes of whatever provision is in question.

In the light of the definitions provided, it would not make sense to refer to the type of case as referred to in section 2 as euthanasia, as that which is already dead cannot logically be killed or allowed to die.

It is important to note that in this scenario, all that is needed is the opinion of two medical practitioners, on criteria that requires a judgement call as to when certain conditions become “irreversible”. There is no requirement that the family or any other person be consulted.

4.2.2 Passive euthanasia

“3. (1) Every person -

- (a) above the age of 18 years and of sound mind, or
- (b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian,

is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

(2) Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.

(3) Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.

(4) Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made.”

Here again there is a reference to “illness”. Given the context, as well as the manner in which the word is used in the Final Draft Bill as a whole, it would at first seem that the intended meaning is much wider than would normally be attributed to it. The inclusion of the word “specific”, however, complicates the matter as it forces a more restricted interpretation.

Despite the specific reference to life-sustaining treatment, a patient would of course still have his / her normal right to refuse any treatment. If the treatment is not life-sustaining, it would apparently fall outside of the scope of end of life decisions – if treatment does not sustain life, its refusal would not bring about the end of life, even though it might strongly influence the patient’s end of life experience.

A logical consequence which is also expressly provided for in the Final Draft Bill, is that such a refusal by a person is valid despite the fact that giving effect to such refusal may cause or hasten that person’s death, provided that it is clear to the medical practitioner under whose care or treatment the person is that the refusal is based on the free and considered exercise of such person’s own will. Importantly, the Final Draft Bill then also directs said medical practitioner to give effect to such refusal.

Special care is taken not to unnecessarily exclude people due to communication difficulties or disabilities, thereby protecting their right to equality.

4.2.3 Double effect

“4.(1) Should it be clear to a medical practitioner or a nurse responsible for the treatment of a patient who has been diagnosed by a medical practitioner as suffering from a terminal illness that the dosage of medication that the

patient is currently receiving is not adequately alleviating the patient's pain or distress, he or she shall -

- (a) with the object to provide relief of severe pain or distress; and
- (b) with no intention to kill

increase the dosage of medication (whether analgesics or sedatives) to be given to the patient until relief is obtained, even if the secondary effect of this action may be to shorten the life of the patient.

(2) A medical practitioner or nurse who treats a patient as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his or her conduct in treating the patient, which record will be documented and filed in and become part of the medical record of the patient concerned.”

It is curious that the working of the double effect is limited to “terminal illness”, not including “intractable and unbearable illness”. Moreover, the medical practitioner is again directed to act in a way that may shorten the patient’s life without any mention of consultation with the patient or any other person. While a patient’s right to refuse the treatment is protected, this section in effect places the onus on the patient to refuse the life-shortening treatment, in a situation where the patient may not be in a position to make such decisions.

The only safeguard provided for here is that the medical practitioner’s findings and his / her conduct in treating the patient be recorded. Because the act provides elsewhere that no treatment may be administered without informed consent, there is some form of protection here, but it is submitted that such protection be incorporated into these provisions much more prominently.

4.2.4 Active voluntary euthanasia

“Option 1:

No legislative enactment”

The first merely maintains the *status quo*. This is not an acceptable option, due to the problems and legal uncertainty inherent in the current system, as discussed earlier in this dissertation.³⁹⁷

“Option 2:

5.(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request if he or she is satisfied that-

- (a) the patient is suffering from a terminal or intractable and unbearable illness;
- (b) the patient is over the age of 18 years and mentally competent;
- (c) the patient has been adequately informed in regard to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;
- (d) the request of the patient is based on a free and considered decision;

- (e) the request has been repeated without self-contradiction by the patient on two separate occasions at least seven days apart, the last of which is no more than 72 hours before the medical practitioner gives effect to the request;
- (f) the patient, or a person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;
- (g) the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;
- (h) an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner as contemplated in

³⁹⁷ Strauss (fn 8 above) p.342.

this section does not share or understand the first language of the patient;

(i) ending the life of the patient or assisting the patient to end his or her life is the only way for the patient to be released from his or her suffering.

(2) No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (i).

(3) A medical practitioner who gives effect to a request as contemplated in sub-section (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.

(5) A medical practitioner who gives effect to a patient's request to be released from suffering as contemplated in this section shall not suffer any civil, criminal or disciplinary liability with regard to such an act provided that all due procedural measures have been complied with.

(6) If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above

may, at the patient's request and in the presence of the patient and both the medical practitioners, sign the certificate on behalf of the patient.

(7)(a) Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state.

(b) Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.

(8) The following shall be documented and filed in and become part of the medical record of the patient who has been assisted under this Act:

(a) a note of the oral request of the patient for such assistance;

(b) the certificate of request;

(c) a record of the opinion of the patient's medical practitioner that the patient's decision to end his or her life was made freely, voluntarily and after due consideration;

(d) the report of the medical practitioner referred to in subsection (2) above;

(e) a note by the patient's medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the substance prescribed.”

In line with the approach taken by the South African Law Commission in the Report, physician-assisted suicide and active voluntary euthanasia are treated as one and the same thing in the Final Draft Bill.

The use of terminology with regard to “terminal illness” and “intractable and unbearable illness” is once again problematic. In section 5(1)(a) of Option 2, the intention seems to be that both people suffering from terminal illnesses and people suffering from intractable and unbearable illnesses would qualify for active voluntary euthanasia, yet section 5(2) of Option 2 then proceeds to implicitly provide that neither active voluntary euthanasia nor assisted suicide may be performed if the second medical practitioner conferred with is not

knowledgeable with regard to the terminal illness from which the patient is suffering. No mention is made of intractable and unbearable illness, effectively leaving the referral thereto in section 5(1) (a) meaningless.

It is also not clear why the last request by the patient has to be no more than 72 hours before the request is given effect to. The most obvious reason would be that this is to act as a safeguard against the possibility that a request that no longer represents the wishes of the patient is given effect to.

If this is the rationale, it would seem appropriate to make the last request very shortly before the request is given effect to, which would be in line with the (correct) approach that the patient may rescind his / her request at any time and in any manner without regard to his or her mental state.

This would have several benefits. It mitigates slightly the pressure a patient might feel not to change his / her mind after he / she made a request and arrangement have been made. In this sense, it would be rather similar to a wedding ceremony where, right at the end, both parties again have to express their consent.

A shorter period also seems to accomplish the apparent goal of the provision better than merely having a 72-hour limit.

On the other hand, the 72-hour limit creates the likelihood that a patient will have to reiterate his / her request at an earlier time when less arrangement have been made and the pressure to not change his / her mind would be less. If this is a consideration, it would make sense to have both a minimum period between the second to last request and the time it is given effect to and a much shorter maximum period between the last request and the time it is given effect to.

This maximum period should be kept as short as possible, with due regard to the patient's other needs, for example dignity and an opportunity to say goodbye to loved ones in peace.

Unfortunately any such provisions, even those already in the Final Draft Bill, raises the question why such a relatively higher burden is placed on someone where they are actively requesting physician-assisted suicide or voluntary active euthanasia than where passive euthanasia is requested in an advance directive or living will.

The provisions regarding a “certificate of request” and the destruction thereof where a patient rescinds his / her request is clearly intended to help prevent active voluntary euthanasia or physician-assisted suicide being performed erroneously. An extra provision that the original certificate has to be inspected by the medical practitioner giving effect to a request just before giving effect to said request would not place an undue burden on the practitioner, while augmenting the safeguarding-function provided by the other provisions.

Furthermore, the pattern of compelling the medical practitioner to comply with a request, provided that the correct procedure is followed, is maintained.

“Option 3: Decision by panel or committee

5.(1) Euthanasia may be performed by a medical practitioner only, and then only where the request for the euthanasia of the patient has been approved by an ethics committee constituted for that purpose and consisting of five persons as follows:

- a) two medical practitioners other than the practitioner attending to the patient;
- b) one lawyer;
- c) one member sharing the home language of the patient;
- d) one member from the multi-disciplinary team; and
- e) one family member.

(2) In considering and in order to approve a request as contemplated in subsection (1) the Committee has to certify in writing that:

- a) in its opinion the request for euthanasia by the patient is a free, considered and sustained request;

- b) the patient is suffering from a terminal or intractable and unbearable illness;
- c) euthanasia is the only way for the patient to be released from his or her suffering.

(3) A request for euthanasia must be heard within three weeks of it being received by the Committee.

(4)(a) The Committee which, under subsection (2), grants authority for euthanasia must, in the prescribed manner and within the prescribed period after euthanasia has been performed, report confidentially to the Director-General of Health, by registered post, the granting of such authority and set forth -

- (i) the personal particulars of the patient concerned;
- (ii) the place and date where the euthanasia was performed and the reasons therefore;
- (iii) the names and qualifications of the members of the committee who issued the certificates in terms of the above sections; and
- (iv) the name of the medical practitioner who performed the euthanasia.

(b) The Director-General may call upon the members of the Committee required to make a report in terms of subsection (4) or a medical practitioner referred to in subsection (1) to furnish such additional information as he may require.

(5) The following shall be documented and filed and become part of the medical record of the patient who has been assisted under this Act:

- (a) full particulars regarding the request made by the patient;
- (b) a copy of the certificate issued in terms of subsection (2);
- (c) a copy of the report made in terms of subsection (4).”

Option 3 replaced many of the safeguards in Option 2 with an “ethics committee”, and then provides for the composition and working of such committee.

In contrast to Option 2, Option 3 provides consistently for both “terminal illness” and “intractable and unbearable illness” as qualifying criteria. The synonymous use of “euthanasia” and “physician-assisted suicide” is also much less clear, especially in light of the fact that neither of these are defined in the Final Draft Bill.

Option 3 then also introduces a system of reporting cases of euthanasia, rather than merely requiring a proper record in the patient’s medical record.

It is not at all clear why these different approaches are followed in Option 2 and Option 3, but it seems that a hybrid of the two approaches could actually serve better than either one.

4.2.5 Advance directive / living will / power of attorney

“6. (1) Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted or any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.

(2) A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result is unable to make or communicate decisions concerning his or her medical treatment or the cessation thereof.

(3) A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof, shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.

(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator.”

Section 6(1) provides for the making of so-called “living wills” or “advance directives” by competent people.³⁹⁸ Unless the definition is changed, the reference to “palliative care”, as defined in the Final Draft Bill could be interpreted to include active euthanasia in certain cases, as was indicated earlier.³⁹⁹ That being said, it seems that the intention here were to restrict this section to passive euthanasia and to “terminally ill” patients.

It is unclear how the medical facility or practitioner would be aware of such living will or advance directive. In practice, these documents are often carried on the person on a card about the size of a credit card. With the power of attorney referred to in section 6(2), the problem is slightly lessened, as the patient’s agent in terms of the power of attorney will hopefully come forward.

The power of attorney referred to in this section might seem to be the same as a normal power of attorney, except that here medical treatment or non-treatment may be decided upon and special procedural formalities are created (it must be signed in the same manner as a will, in the presence of two competent witnesses who must also sign in each other’s presence). The differences, however, go further than that.

It is proposed that the Final Draft Bill be read with due regard to the context of the interests being protected and the document as a whole. Consequently, the

³⁹⁸ There is a difference of opinion amongst writers regarding the legality of a living will. Compare for example the views expressed in Strauss (fn 8 above) p.344 and Leonard-Taitz: euthanasia and the legal convictions of society (fn 235 above) p.445.

³⁹⁹ See p.107 above.

power of attorney referred to in the Final Draft Bill will only be in force while the patient is unable to make or communicate decisions regarding his / her medical treatment or non-treatment. This is in line with the idea, in the case of active euthanasia, that a patient may rescind his decision to forsake life at any time, without regard to his / her mental state.

The result, if the Final Draft Bill is read as proposed, is that the power of attorney will lose force the moment the patient regains the ability to make and communicate such decisions, also regardless of his / her mental state. This gives “the ability to make a decision” a different meaning from what one would encounter normally. Here it is not legal capacity, or even informed consent that we are talking about, but the mere ability to make a decision at the most basic level.

The thing that would probably cause people to opt for a living will, rather than a power of attorney, is that with the latter the agent might not act in accordance with the patient’s wishes, unless the power of attorney was carefully worded, empowering the agent, for example, only to refuse treatment in certain circumstances. This does not really solve the problem; besides the fact that the agent might simply choose not to accept the power of attorney or decide to not even come forward, there is very little in the way of the “decision-making” the Final Draft Bill speaks about involved in such a scenario. We are, in effect, again dealing with a living will.

It might have helped to provide that the fact that a patient made a living will shall be recorded in his medical record. While not nearly solving the problem - many people do not have “family doctors” and do not have a medical record to speak of, except the record at that specific facility / medical practitioner – it will at least have a positive effect in some cases. Of course, a medical practitioner should then not be allowed to act on the medical record alone, but must still inspect the actual living will. Additionally, provision must be made for the necessary amendments to the patient’s medical record in cases where a patient destroys or recalls a living will.

Section 6(4) provides that where a patient is terminally ill and there is no contrary court order, statutory provision, power of attorney, living will or advance directive, the decision-making regarding treatment or the cessation thereof shall vest in the patient's guardian or curator, if applicable. The guardian or curator is then basically in the same position as a person appointed as the patient's agent in terms of an enduring power of attorney.

“7.(1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-

(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and is therefore unable to make or communicate considered decisions concerning his or her medical treatment or the cessation thereof; and

(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition because of his expert knowledge of the patient's illness and his or her examination of the patient concerned.

(2) Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.

(3) Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested family members of the patient of his or her findings, that of the other medical practitioner contemplated in paragraph (b) of subsection (1), and of the existence and content of the directive of the patient concerned.

(4) If a medical practitioner is uncertain as to the authenticity as regard to the directive or its legality, he

shall treat the patient concerned in accordance with the provisions set out in section 8 below.

(5)(a) A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and the manner in which he or she implemented the directive.

(b) A medical practitioner as contemplated in paragraph (b) of subsection (1) shall record in writing his or her findings regarding the condition of the patient concerned.

(6) A directive concerning the refusal or cessation of medical treatment as contemplated in sub-section (1) and (2) shall not be invalid and the withholding or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might hasten the moment of death of the patient concerned.”

The “double effect” is encountered in the context of an advance directive or living will for the first time in section 7(1). It must be assumed that the reference to “palliative care” in section 6 was intended to include “which may contribute to the hastening of the patient’s death”. This is, however, not at all clear from section 6 alone, and to infer this from the definition makes it even more difficult to exclude euthanasia from the definition of “palliative care” as provided in the Final Draft Bill.

Section 7(1) (a) contains a very dangerous equation: “the patient is suffering from a terminal illness and is *therefore* unable to make or communicate considered decisions concerning his or her medical treatment or cessation thereof” (emphasis added).

It is submitted that the intention could never have been to imply that terminally ill patients are inherently unable to make or communicate such decisions. It is also unlikely that the intention was to exclude from this section patients who are terminally ill and unable to make or communicate such decisions, but where the latter is not the result of the former.

The more likely intention would have been to require both that the patient must be terminally ill and that the patient must be unable to make or communicate such decisions. It is suggested that, should this be the intention, the section be worded accordingly.

Section 7(1) (b) provides some form of safeguard in that an independent medical practitioner with expert knowledge of the patient's illness must examine the patient and confirm the patient's condition as determined by the medical practitioner that will give effect to the living will or advance directive.

Section 7(2) provides a safeguard in that the medical practitioner must satisfy himself as far as reasonably possible that the advance directive / living will is authentic and that the patient, at the time of making the living will or issuing the directive, was competent to do so. Should the medical practitioner not be so satisfied, section 7(4) then provides that the patient is to be treated in accordance with section 8.

The inclusion of the words "or its legality" in section 7(4) implies that this could also be read into section 7(2). For example, if two competent witnesses do not sign the living will or advance directive, section 7(4) provides that the patient be treated in accordance with section 8. It follows logically that a medical practitioner has to satisfy himself, as far as reasonably possible, of the legality of the living will or advance directive before giving effect thereto.

Section 7(3) compels the medical practitioner to, before giving effect to an advance directive or living will, inform the interested family members of the advance directive / living will, its contents and the two medical practitioners' findings.

This seems to be a deviation from the normal approach regarding the patient's right to confidentiality, even when it comes to spouses or issues like abortion. There is, however, a clear interest being served here: it is possible that the "interested family members" have access to information the medical practitioner

does not. An example would be that the patient could have verbally rescinded his living will or advance directive, but the actual document could not be destroyed for some reason. This section would then allow for such information to be taken into account.

In practice, this could have the unintended side-effect that the “interested family members” has *de facto* power to have the patient treated against his will. This problem is neither new nor unique to the Final Draft Bill and is in fact also present in the current legal position.

Section 7(5) provides that, where an advance directive or living will is given effect to, both medical practitioners shall record their findings with regard to the patient’s condition, and the medical practitioner who gives effect to the advance directive or living will shall record the manner in which this was done. Unfortunately, there is no indication as to where such recording should be made.

Finally, it is interesting to note that, in contrast to some of the other sections of the Final Draft Bill, no directive is given to a medical practitioner to give effect to an advance directive or living will; it is merely provided in section 7(6) that such action, if performed in accordance with the Final Draft Bill, shall not be unlawful.

4.2.6 Non-voluntary euthanasia

“8.(1) If a medical practitioner responsible for the treatment of a patient in a hospital, clinic or similar institution where a patient is being cared for, is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his or her opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him or her and who is competent to submit a professional opinion regarding the patient's condition on account of his or her expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any

directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.

(2) A medical practitioner as contemplated in subsection (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the interested family members of the patient, unless authorised thereto by a court order.

(3) A medical practitioner as contemplated in subsection (1) shall record in writing his or her findings regarding the patient's condition and any steps taken by him or her in respect thereof.

(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.”

Section 8 provides for the situations where there is no advance directive or living will. The provisions in section 8(1) are substantially the same as those that are at play with a living will or advance directive in the sense that it requires terminal illness, unableness on the patient's part to make or communicate decisions regarding his or her medical treatment or its cessation and the provisions regarding the second independent medical practitioner, who must be an expert on the relevant illness, who must confirm the patient's condition.

The differences between the two scenarios mainly concern the first medical practitioner.

Where there is an advance directive or living will, section 7 provides that the medical practitioner who will give effect to the living will or advance directive is the one who must satisfy all the criteria set out.

Where there is no advance directive or living will, section 8 provides that the medical practitioner who is responsible for the treatment of a patient in a

hospital, clinic or similar institution where a patient is being cared for is the one who must satisfy all the criteria set out. This medical practitioner may then grant written authorization for the “cessation of all further life-sustaining medical treatment and the administering of palliative care only”.

It is not clear what is meant by the addition of the word “only” at the end. At first glance, this would exclude the application of the “double effect” in such a case as the words “palliative care which may contribute to the hastening of a patient’s death” is replaced in section 8 by “palliative care only.” That this is, however, not the intention is made clear by section 8(4) (as well as the conflict it would create with section 4).

In all probability, the word “only” is intended to emphasize the exclusion of either active euthanasia or any form of treatment that is not purely palliative in nature from the working of this section. It is submitted that consistent wording would in such a case create less uncertainty and opportunity for abuse.

Section 8(2) provides that the medical practitioner shall not act as above if it “would be contrary to the wishes of the interested family members of the patient, unless authorized by a court order”. This effectively and positively gives the “interested family members” some decision-making authority. It is important to bear in mind here that where a patient has a guardian or curator, the Final Draft Bill seems to treat it as tantamount to an enduring power of attorney in terms of section 6(4), so section 8 would not be applicable in such a case.

Section 8(3) requires that the medical practitioner responsible for the treatment of the patient in a hospital, clinic or similar institution record his or her findings regarding the patient’s condition and any steps he or she took in respect thereof. It is curious that there is no requirement that the second medical practitioner, who has to confirm the patient’s condition, is required to record his or her findings, as is required in section 7(5)(b). The result seems to be that there are more safeguards in the cases where there is a living will or advance directive

than in the cases where there is not. It is submitted that such an approach is unjustified.

4.2.7 Powers of the court

“9. (1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.

(2) A court shall not make an order as contemplated in subsection (1) without the interested family members having been given the opportunity to be heard by the court.

(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who have expert knowledge of the patient's condition and who have treated the patient personally or have informed themselves of the patient's medical history and have personally examined the patient.

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not thereby incur any civil, criminal or other liability whatsoever.”

Section 9 seems to bestow certain powers upon the court. In truth, it limits the power of the court, which is defined in the Final Draft Bill to refer to the High Court. As the High Court has inherent jurisdiction, the only effect this section can have is to limit that jurisdiction.

The court may now only order cessation of medical treatment if an application is made by an interested person and the patient, who must be a terminally ill person as contemplated in section 6, left no power of attorney, living will or advance directive. Moreover, the court must be satisfied, on the evidence of at least two medical practitioners who are experts on the patient's condition and who have

treated the patient personally or examined the patient and informed themselves of the patient's medical history, that the patient is in a state of terminal illness and unable to make or communicate decisions regarding his or her medical treatment or cessation thereof.

The safeguards in this case are somewhat different than is the case in section 8. In section 8, one independent expert is required to examine the patient. In section 9, two experts (who need not necessarily be independent) are required to not only examine the patient, but also to inform themselves of the patient's medical history, alternatively they should have treated the patient personally. The reason for this distinction is not overtly clear.

Section 9(4) finally provides that a medical practitioner (who need evidently not be one of the experts giving evidence in the court) that gives effect to such a court order shall not incur any civil, criminal or other liability whatsoever.

Interpretation

“10. The provisions of this Act shall not be interpreted so as to oblige a medical practitioner to do anything that would be in conflict with his or her conscience or any ethical code to which he or she feels himself or herself bound.“

Section 10 finally protects the medical practitioner. The intent seems to be that a medical practitioner will not be forced to participate or discriminated against for not participating in euthanasia, if such participation is in conflict with the medical practitioner's beliefs, conscience, moral or ethical codes.

This is a very important provision, protecting amongst others the medical practitioner's freedom of belief. Unfortunately, incorporating it into an interpretation clause creates some difficulties, for example the fact that no provision is made for the situation where the medical practitioner refuses to participate. Is there then a duty on such practitioner to refer the patient to another practitioner who might participate? Such eventualities are easily foreseeable and should have been addressed.

Chapter 5: Legal comparison – The Netherlands

5.1 Introduction

Where South Africa has only common law prohibitions on assisting another to die, The Netherlands also have statutory prohibitions:⁴⁰⁰

Section 293 of the Dutch Criminal Code provided that anyone that takes someone else's life on such person's serious and explicit request may be punished with twelve years imprisonment.

Section 294 of the Dutch Criminal Code provided that anyone that incites another to commit suicide, assists another in committing suicide or provided another with the means to commit suicide may, if suicide ensues, be sentenced to a maximum of three years imprisonment or a fourth-category fine.

Despite these express prohibitions, the Dutch courts have, in suitable cases, accepted necessity as a defence to euthanasia or assisted suicide since 1973.⁴⁰¹ Necessity is provided for in section 40 of the Dutch Criminal Code as one of two forms of "overmacht", the other being *force majeure*.

In The Netherlands necessity can not only be used as a ground of justification, as in South Africa, but also to exclude culpability. A type of proportionality test is

⁴⁰⁰ For a more general overview, see Griffiths "The regulation of euthanasia and related medical procedures that shorten life in The Netherlands" 1994 *Medical Law Journal* p.137; Sheldon "Holland decriminalized voluntary euthanasia" 2001 *British Medical Journal* p.947; Jochemson "Legalization of euthanasia in The Netherlands" 2001 *Issues in Law and Medicine* p.285; Cohen "Netherlands legalise euthanasia" 2002 *Student British Medical Law Journal* Vol. 10 p.138 and Emanuel "Euthanasia: where The Netherlands leads will the world follow?" 2001 *British Medical Journal* p.1376 as well as the summaries provided at www.minvws.nl/infotheek.html?folder=4&page=13887 (accessed 14 October 2006) and www.minvws.nl/infotheek.html?folder=4&page=14361 (accessed 14 October 2006)

⁴⁰¹ Griffiths "Assisted suicide in The Netherlands: the Chabot case" 1995 *Modern Law Review* ("Griffiths") p.232; Griffiths "Assisted suicide in The Netherlands: postscript to Chabot" 1995 *Modern Law Review* ("Griffiths: postscript") p.895; Keown "Physician assisted suicide and the Dutch Supreme Court" 1995 *The Law Quarterly Review* ("Keown: Physician assisted suicide") p.394.

applied, and necessity can be raised where that which is protected is more worthy of protection than that which was sacrificed, provided that it was protected in the least punishable manner possible.⁴⁰² In the context of euthanasia, the life of the patient is sacrificed to protect the patient from his / her unbearable situation.

In 1982 the Dutch government established a committee to investigate euthanasia, medical practice and the resulting court decisions which were no longer in accordance with the spirit of the legislation and different courts were applying different criteria, leading to legal uncertainty.

In 1985 the committee recommended a bill in which sections 293 and 294 of the Dutch Criminal Code be amended so that a doctor would be allowed, in specific circumstances, to perform euthanasia. Due to political opposition, the bill was not passed.

In 1987 a compromise was reached which entailed that the provisions of sections 293 and 294 of the Dutch Criminal Code would remain unchanged, but the *de facto* situation would be given legal foundation.

In 1988, the Royal Dutch Medical Association, following on a previous publication in 1984, published a report entitled “Guidelines for Euthanasia”. These guidelines were very similar to the criteria laid down by the Dutch Court in determining the applicability of the defence of necessity, as summarised in 1989:⁴⁰³

(a) the request for euthanasia must come only from the patient and must be entirely free and voluntary;

⁴⁰² Dörfling “‘Genadedood’ in die strafreg - 'n regsfilosofiese en regsvergelykende perspektief’ 1991 (Unpublished thesis submitted in partial fulfilment of the degree Magister Legum) Faculty of Law Rand Afrikaans University (“Dörfling”) p.20 fn 19.

⁴⁰³ Borst-Eilers “The status of physician administered active euthanasia in The Netherlands” (paper delivered at the Second International Conference on health law and ethics, London, July 1989) as quoted by Keown “The law and practice of euthanasia in The Netherlands” 1992 *The Law Quarterly Review* (“Keown”) p.51.

- (b) it must be a well-considered, durable and persistent request;
- (c) the patient must be experiencing intolerable suffering with no prospect of improvement;
- (d) euthanasia must be a last resort;
- (e) euthanasia must be performed by a physician;
- (f) the physician must consult with a second independent physician who has experience in this field.

In November 1990 the Minister of Justice and the Royal Dutch Medical Association reached an agreement: After practising euthanasia, a doctor would submit a report to the coroner. The coroner would then inform the public prosecutor, who would only ask the police to investigate the matter if the Guidelines for Euthanasia had not been complied with. In theory, the Attorney-General made the final decision on whether to prosecute or not, but in practise the decision of the prosecutor was in most cases simply approved.⁴⁰⁴

The findings of an independent commission of doctors and jurists led to the introduction of a proposed Bill that would provide such legal foundation in September 1991. The Bill was not passed, as it made provision for non-voluntary euthanasia.⁴⁰⁵ The Bill was accordingly amended so that non-voluntary euthanasia would as a rule be regarded as punishable. It further stated that the verifying of a doctor's actions would under no circumstances be excluded and no form of euthanasia would automatically be exempted from punishment.

In 1994, in the Chabot case, the Dutch Supreme Court held that there was in principle no reason why the defence of necessity could not apply where a patient's suffering was purely psychological.

⁴⁰⁴ Keown (fn 403 above) p.60. In a subsequent submission received from Keown he indicated that the "Procureurs-Generaal" do, albeit infrequently, disagree with a decision of the local prosecutionutor.

⁴⁰⁵ Telegraaf, 12 May 1993.

In November 1997 a proposal to change the procedure for dealing with end of life decisions in The Netherlands was made to the Dutch Parliament by the Dutch Cabinet.⁴⁰⁶ The proposed changes would not alter the formal status of euthanasia in Dutch law, and mainly amounted to the creation of separate procedures for dealing with voluntary and non-voluntary euthanasia.⁴⁰⁷

Regional Committees, each consisting of a doctor, jurist and ethicist, would be created to deal with voluntary euthanasia and assisted suicide, reviewing a case to determine whether a doctor had acted with due medical care, making a preliminary judgement and then communicating their opinion to the Public Prosecutions Service. A separate national committee would deal with non-voluntary euthanasia.

5.2 Statutory law

After a few more years, the “Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001) was finally passed. This act represents the current position in The Netherlands. The most relevant sections are shortly discussed below.

Article 1 provides definitions of the terms used in the act.

As is the case in the South African Law Commission’s Final Draft Bill, no definition of euthanasia is provided, but “assisted suicide” is defined as: “intentionally assisting in a suicide of another person or procuring for that other person the means referred to in Article 294 second paragraph second sentence of the Penal Code”.

⁴⁰⁶ Joint Press Release of the Dutch Ministry of Justice and the Ministry of Health, Welfare and Sport dated 24/11/97 (“Joint Press Release”).

⁴⁰⁷ Here it should be noted that the Dutch do not use the term “non-voluntary euthanasia” - from their point of view, it would be a *contradictio in terminis*. They refer to “end of life decisions without a specific request”.

The act amended other acts in article 20. Specifically, articles 293 and 294 of the Dutch Penal Code were amended as follows:

“A

Article 293 shall read:

Article 293

1. A person who terminates the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.
2. The offence referred to in the first paragraph shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act and who informs the municipal autopsist of this in accordance with Article 7 second paragraph of the Burial and Cremation Act.

B

Article 294 shall read:

Article 294

1. A person who intentionally incites another to commit suicide is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues.
2. A person who intentionally assist in the suicide of another or procures for that other person the means to commit suicide, is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues. Article 293 second paragraph applies mutatis mutandis.”

Here we see that both euthanasia and assisted suicide are still offences in the Dutch law, but are not punishable in the situation where the person who committed the offence:

- Is a physician; and
- Has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act; and

- Informs the municipal autopsist of this in accordance with Article 7 second paragraph of the Burial and Cremation Act.

Article 2(1) determines the meaning of the “requirements of due care” referred to above:

- “1. The requirements of due care, referred to in Article 293 second paragraph Penal Code mean that the physician:
- a. holds the conviction that the request by the patient was voluntary and well-considered,
 - b. holds the conviction that the patient's suffering was lasting and unbearable,
 - c. has informed the patient about the situation he was in and about his prospects,
 - d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in,
 - e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a-d, and
 - f. has terminated a life or assisted in a suicide with due care.”

These requirements correspond to some extent to the requirements laid down in the South African Law Commission’s Final Draft Bill under Option 2 regarding active euthanasia. The Dutch act, however, makes no mention of terminal illness, merely “lasting and unbearable suffering”. This is in line with the approach adopted by the Dutch courts already in 1985.⁴⁰⁸ Furthermore, the age requirements are moved to a separate section,⁴⁰⁹ no overt reference is made to informing the patient about the treatment options available (although it is most probably implied as part of informing the patient about his prospects), there are no requirements for the request to have been repeated, no certificate signed by the patient and the requirement in the Dutch law is that both the medical practitioner and the patient hold the conviction that there is no other reasonable

⁴⁰⁸ www.pregnantpause.org/euth/nethhist.htm accessed 8 December 2006.

⁴⁰⁹ See discussion of Articles 2(3) and 2(4) on p.134 below.

solution for the situation, as opposed to the Final Draft Bill, where it needs only be the conviction of the medical practitioner. The provision made in the Final Draft Bill has no equivalent in the Dutch law, but that is easily attributable to the fact that the Dutch are a relatively homogenous society, whereas in South Africa we already have eleven official languages.

It is clear that that Option 2 of the Final Draft Bill provides substantially more safeguards than is provided for in the Dutch law.

Comparing the “due care” provisions in the Dutch law with Option 3 for active euthanasia in the South African Law Commission’s Final Draft Bill, we find quite a different situation. The only requirements in the latter case is that the committee must hold the opinion that the request for euthanasia is free, considered and sustained, the patient is suffering from terminal or intractable and unbearable illness and euthanasia is the only way for the patient to be released from his suffering.

Considering Option 3 then, and with the exception of the requirement that the request must be sustained, the safeguards seem to be substantially less than provided for in the Dutch law.

Article 2(2) of the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act very briefly regulates the situation with regard to living wills or advance directives:

“2. If the patient aged sixteen years or older is no longer capable of expressing his will, but prior to reaching this condition was deemed to have a reasonable understanding of his interests and has made a written statement containing a request for termination of life, the physician may carry out this request. The requirements of due care, referred to in the first paragraph, apply *mutatis mutandis*.”

This provision seems extremely open to abuse. The “due care” requirements will in all probability have been watered down substantially at this point (for example, it might be difficult for the doctor to inform the patient about the

situation he is in and about his or her prospects before the patient is actually in or on his or her way to such condition).

Articles 2(3) and 2(4) regulates the situation in as far as it concerns minors:

“3. If the minor patient has attained an age between sixteen and eighteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request for termination of life or assisted suicide, after the parent or the parents exercising parental authority and/or his guardian have been involved in the decision process.

4. If the minor patient is aged between twelve and sixteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request, provided always that the parent or the parents exercising parental authority and/or his guardian agree with the termination of life or the assisted suicide. The second paragraph applies *mutatis mutandis*.”

Where the Final Draft Bill provides for a single minimum age for active euthanasia (18 years), the Dutch law creates three categories of people deemed to have a reasonable understanding of his / her interests: Those above eighteen years of age, those between sixteen and eighteen years of age and those aged between twelve and sixteen years.

Articles 3 to 16 provide for the establishment of regional review committees and the working of and matters relating to such committees. The committee must consist of an uneven number of members, including a legal specialist (who must be the chairman), one physician, one expert on ethical or philosophical issues and deputy members of each of these categories. Such committee must review cases of euthanasia or assisted suicide for compliance with the act and on the basis of the report referred to in Article 7 of the Burial and Cremation Act, record the information, inform the physician of their findings and provide the public prosecutor with all the information he or she may need. The committee has a duty to keep the information otherwise confidential, except where required to divulge such information by law or the necessity to divulge the information ensues from their duties.

Further provision is made for the appointment, dismissal, remuneration, and similar matters regarding the members of the committee.

Articles 17 and 18 provides for reporting (and *de facto* monitoring) of the activities in terms of this act, with due regard to confidentiality:

“Article 17

1. Not later than 1 April, the committees issue a joint annual report to Our Ministers on the activities of the past calendar year. Our Ministers shall lay down a model for this by means of a ministerial regulation.
2. The report on the activities referred to in the first paragraph shall at any rate include the following:
 - a. the number of reported cases of termination of life on request and assisted suicide on which the committee has rendered an opinion;
 - b. the nature of these cases;
 - c. the opinions and the considerations involved.

Article 18

Annually, at the occasion of the submission of the budget to the states General, Our Ministers shall issue a report with respect to the performance of the committees further to the report on the activities as referred to in Article 17 first paragraph.”

No provision is made for similar national reporting in the Final Draft Bill. Such a provision is useful, as it allows for better monitoring of euthanasia and the effect that legalization has in practise.

The remainder of the act provides for the date the act will come in effect, the citation of the act, and amendment to other acts in the Dutch legal system. The amendments to the Dutch Burial and Cremation Act are of interest here, as it essentially regulates reporting of individual cases:

“The Burial and Cremation Act shall be amended as follows:

A

Article 7 shall read:

Article 7

1. A person who has performed a postmortem shall issue a death certificate if he is convinced that death has occurred as a result of a natural cause.
2. If the death was the result of the application of termination of life on request or assisted suicide as referred to in Article 293 second paragraph or Article 294 second paragraph second sentence, respectively, of the Penal Code, the attending physician shall not issue a death certificate and shall promptly notify the municipal autopsist or one of the municipal autopsists of the cause of death by completing a form. The physician shall supplement this form with a reasoned report with respect to the due observance of the requirements of due care referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.
3. If the attending physician in other cases than referred to in the second paragraph believes that he may not issue a death certificate, he must promptly notify the municipal autopsist or one of the municipal autopsists of this by completing a form.

B

Article 9 shall read:

Article 9

1. The form and the set-up of the models of the death certificate to be issued by the attending physician and by the municipal autopsist shall be laid down by order in council.
2. The form and the set-up of the models of the notification and the report referred to in Article 7 second paragraph, of the notification referred to in Article 7 third paragraph and of the forms referred to in Article 10 first and second paragraph shall be laid down by order in council on the recommendation of Our Minister of Justice and Our Minister of Health, Welfare and Sports.

C

Article 10 shall read:

Article 10

1. If the municipal autopsist is of the opinion that he cannot issue a death certificate, he shall promptly report this to the public prosecutor by completing a form and he

shall promptly notify the registrar of births, deaths and marriages.

2. In the event of a notification as referred to in Article 7 second paragraph and without prejudice to the first paragraph, the municipal autopsist shall promptly report to the regional review committee referred to in Article 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act by completing a form. He shall enclose a reasoned report as referred to in Article 7 second paragraph.

D

The following sentence shall be added to Article 12, reading: If the public prosecutor, in the cases referred to in Article 7 second paragraph, is of the opinion that he cannot issue a certificate of no objection against the burial or cremation, he shall promptly inform the municipal autopsist and the regional review committee referred to in Article 3 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act of this.”

The most important aspect here is that provision is made for a system where certain cases must automatically be brought under the attention of the public prosecutor. This is a very important safeguard with regard to reviewing procedures, but has less value in a system such as the one proposed in the Final Draft Bill. Nonetheless, a system requiring a medical practitioner to report any case he or she comes across where the law has apparently not been complied with might serve a similar purpose in such a system.

5.3 Dutch case law

5.3.1 The *Stinissen* Case

5.4.1.1 Facts

In 1974 Ms. Stinissen became comatose and entered a permanent vegetative state as a result of mistakes made during a caesarean. For 10 years her condition did not change. Her husband (who was also her appointed guardian) requested that the nursing home remove Ms. Stinissen’s feeding tube.

5.4.1.1 Decision

The Court (and later Appeals Court) did not direct the discontinuation of feeding, but held that it would not be illegal to do so, as the feeding of a persistent vegetative patient is mainly a medical procedure.⁴¹⁰

5.4.1.1 Application

The most important element here was the establishment of the principle that feeding and hydration in such cases constitute medical treatment, because nutrition and hydration take place under strict medical control. This opened the way for “passive euthanasia” where a patient refuses “treatment” in the form of feeding and hydration.

5.3.2 The *Postma* Case

5.3.2.1 Facts

The deceased in this case suffered a brain haemorrhage, after which she could hardly sit up and communicate verbally. On numerous occasions the deceased asked her daughter, Dr Postma to end her life. Dr. Postma, the accused, gave her mother an injection that resulted in her death. This led to the accused being charged under article 293 of the Dutch Penal Code.

5.3.2.2 Decision

The Court indicated that a doctor could provide pain-relieving medication without incurring legal liability, even if the effect thereof is to hasten death of the patient concerned, provided that the primary goal was to relieve physical or psychological pain arising from an incurable terminal illness. In this case, however, the Court found that the primary intention was to cause the death of the deceased. The Court found the accused guilty, but gave her only a one-week suspended sentence and one year’s probation.

⁴¹⁰ Gevers “Withdrawing life support from patients in a persistent vegetative state: the law in The Netherlands” 2005 *European Journal of Health Law* (“Gevers”) p.348.

5.3.2.3 Application

This case bears a remarkable similarity to the South African case of *S v Hartman*.⁴¹¹

5.3.3 The *Schoonheim* Case

Contrary to the common impression, legislation recently enacted by the Dutch parliament does not affect the legality of euthanasia but only the procedure for reporting it. The legal acceptance of euthanasia was based on jurisprudence, in particular, the acquittal that took place in 1983 and that was upheld by the Dutch Supreme Court in the *Schoonheim* case in 1984.⁴¹²

5.3.3.1 Facts

Schoonheim, a general practitioner, “euthanized” a 95-year-old woman on her repeated and explicit request. The woman was “in a very bad medical condition”.

5.3.3.2 Decision

The Court opened the door for the use of necessity as a ground of justification in such cases by holding that a doctor could invoke necessity if confronted by a conflict between exercising the duty of care required of a medical professional, his duty to his patient (who is suffering unbearably and hopelessly) and the requirements of the Criminal Code. Schoonheim was found not guilty of a contravention of the Criminal Code.

5.3.3.3 Application

Judicial decisions flowing from this gradually worked out the conditions and limitations for such a defence. Eventually, the prosecution policy in The Netherlands fell in line with these decisions and doctors who keep within the accepted limits enjoy a high degree of safety from prosecution.

⁴¹¹ See page 58 above.

⁴¹² De Haan “The New Dutch Law on Euthanasia” 2002 *Medical Law Review* (“De Haan”) p.59.

5.3.4 The Ross Case

5.3.4.1 Facts

Baby Ross was born with Down-syndrome and other fatal defects of the digestive system that could only be remedied through surgery. Baby Ross' parents gave consent for the surgery, but the consent for surgery was later withdrawn. The child was then placed in the care of the child protection council, but the secretary of the council also refused to let the operation be carried out. Baby Ross eventually died and the child's medical practitioner as well as the secretary of the council were prosecuted and acquitted. The attorney-general appealed.

5.3.4.2 Decision

The appeal was unsuccessful. The Court found that the probability of the child living a life of suffering, and the concomitant suffering of the parents, had to be borne in mind. The medical practitioner acted reasonably after the parents withdrew consent to surgery and, importantly, that the medical practitioner's actions, if the surgery was performed, would only have been of a death-delaying nature that added suffering.

5.3.4.3 Application

While this was an important case in the sense that it involved a baby,⁴¹³ the most important factor for purposes of this dissertation was that the suffering of those close to the patient were recognized as an important consideration.

5.3.5 The Chabot Case

5.3.5.1 Facts

The deceased in this case was B, a 50 year old woman. B married early in her life, at the age of 22, but the marriage was never really a happy one and the

⁴¹³ Cases involving babies fall outside of the scope of this dissertation. See in general Dorscheidt "Assessment procedures regarding end of life decisions in neonatology in The Netherlands" 2005 *Medicine and Law* ("Dorscheidt") p.803 with regard to such cases in The Netherlands.

situation deteriorated further over time. Nevertheless, two sons were born from the marriage.

The eldest son, aged twenty at the time, committed suicide in 1986 while serving military duty in Germany. Already then, B indicated that she only wants to live so long as her second son still needs her. In October 1986 B was committed to hospital for eighteen days for psychiatric treatment as she could not cope with the death of her eldest son. Two years and two months later her father died, two years and two months after that she was divorced and one year and one month later, in May 1991, B's second son died of cancer. Like his older brother, he was also twenty years old at the time of his death.⁴¹⁴

The same night that her second son died, B attempted to commit suicide by overdosing on medication that she stockpiled from her prescriptions from her psychiatrist. Her suicide attempt was unsuccessful. B started stockpiling her medication again and at the same time started discussing suicide methods with others. This led to her getting into contact with the accused, the psychiatrist Chabot, through the Dutch Voluntary Euthanasia Society.⁴¹⁵

Between 2 August 1991 and 7 September 1991, Chabot had four discussions with B, adding up to a total of between 24 and 30 hours. B's sister and brother-in-law were sometimes present. According to Chabot's judgement B suffered from a depressive disorder without signs of psychosis. She was still battling with a complicated mourning process. B also refused therapeutic treatment for depression.⁴¹⁶ Chabot made a written summary of her case and asked several experts for their opinion. Most agreed that Chabot should go ahead. Being unable to persuade the deceased to change or postpone her decision, Chabot agreed to help her with her suicide, and he subsequently assisted her with obtaining the

⁴¹⁴ Canady "Physician-assisted suicide and euthanasia in The Netherlands: A report to the House Judiciary subcommittee on the constitution" 1998 *Issues in Law & Medicine* ("Canady") p.309

⁴¹⁵ Labuschagne: professionele hulpverlening (fn 318 above) p.277.

⁴¹⁶ Canady (fn. 414 above) p.302.

needed pills.⁴¹⁷ On 28 September 1991, in the presence of Chabot, a house doctor and a friend, B took lethal drugs that Chabot “prescribed” to her and died. Chabot then followed the prescribed procedure for reporting an unnatural death.

Chabot was charged of a contravention of section 294 of the Dutch Criminal Code. In 1993 in the city of Assen, a court of three judges acquitted Chabot.⁴¹⁸ The Ministry of Justice appealed.

5.3.5.2 Decision

According to Griffiths, the Dutch Supreme Court had to determine four important questions:

“(a) Can assistance with suicide be legally justifiable in the case of a patient whose suffering does not have a somatic basis and who is not in the terminal phase? The Court holds that it can be.

(b) Can the right to die of a person suffering from a psychiatric sickness or disorder legally be considered the result of an autonomous (competent and voluntary) judgement? The Court holds that it can be.

(c) Can the suffering of such a person legally be considered ‘lacking any prospect for improvement’ if he or she has refused a realistic (therapeutic) alternative? The Court holds that in principle it cannot be.

(d) What are the legal requirements of consultation in such a case, as far as the defence of necessity is concerned? The Court holds that an ‘independent colleague’ must himself have examined the patient.”

He then explains that:

“I have purposely included the term ‘legal’ in each case to emphasise something that non-lawyers tend to forget: the decision of the Court concerns a number of legal terms and norms (in particular, those of the criminal law), not psychiatric or other terms or theories... Holdings (a) and (b) depend essentially on the Court’s position that the defence of necessity cannot be bound by general

⁴¹⁷ Hendin “Assisted suicide and euthanasia: the Dutch experience” in Uhlman (ed) *Last Rights – Assisted suicide and euthanasia debated* (1998) (“Hendin”) p.378.

⁴¹⁸ Hendin (fn 417 above) p.372.

limitation, as a consequence of which the case is largely decided not on normative, but on factual grounds. Otherwise, the only direct support for holding (a) is the bare assertion (invoking the support of ‘medical ethics’) that suffering, not the cause of suffering, is determinative. Direct support for holding (b) is limited to the dogmatic observation that the suggestion that the request of a psychiatric patient cannot be voluntary ‘is as a general proposition incorrect.’⁴¹⁹

Chabot was found guilty because he failed to have a psychiatric consultant see B. “Although the court expressed the belief that such consultation was necessary in the absence of physical illness, it imposed no punishment, because it felt that in all other regards Chabot had behaved responsibly.”⁴²⁰

Application

The Chabot case thus created the precedent that the patient need not be in the terminal phase of his / her illness. In this sense it is comparable to the South African case of *Clarke v Hurst*.⁴²¹ In fact, the patient’s suffering need not even be physical.⁴²² The approach taken by the Court has, however, been heavily criticized by some Dutch jurists:

“The Court’s fundamental point of departure – that there can be no general limitations on the defence of necessity – cannot, it is respectfully submitted, stand up to critical examination. It is, of course, true that the whole point of a general defence of necessity is to deal with unforeseen circumstances in which application of the strict term of a prohibition would lead to unjust results. In that sense it would defeat the point of the defence to try to specify in advance when it will and will not be available. In effect, the fence allows for future judicial legislation. Once it is invoked in a concrete case, the quasi-legislative process begins: the court has to decide whether the circumstances of the case require – in the name of substantive justice – a qualification on the coverage of the prohibition. A court does so, necessarily, on the basis of general normative considerations. This is precisely what the prosecution invited the Dutch Supreme Court to do. The Court

⁴¹⁹ Griffiths (fn 401 above) p.239.

⁴²⁰ Hendin (fn 417 above) p.379.

⁴²¹ *Clarke v Hurst* (fn 98 above).

⁴²² De Haan (fn 412 above) p.62.

apparently did not agree with the proposed normative considerations but, instead of saying this, it suggested that *any* normative limitations are unacceptable, thereby confusing the situation *before* a concrete set of facts is first presented for adjudication with the situation when the court is considering whether those facts, in light of the relevant normative considerations, amount to a state of necessity. And, of course, *after* a court has made a decision on the scope of the defence, its decision governs future similar cases as well. In fact, having rejected the idea of general limitations on the defence of necessity, the Supreme Court itself imposed one: the special consolation requirement in the case of non-somatic suffering [...] The idea invoked in the Court's decision in the *Chabot* case, that in each case the fate of the defence of necessity has depended on 'the trial judge's weighing and evaluation after the fact of the particular circumstances of the case' is, it is submitted, impossible as a matter of legal theory and of social practice, and inaccurate as a matter of history"⁴²³

5.3.6 The *Brongersma* Case

5.3.6.1 Facts

Mr. Brongersma,⁴²⁴ an 86-year old person who felt that his life had become meaningless and too heavy a burden and therefore sought help in committing suicide, was assisted with said suicide by the accused in this case, a medical doctor. The question raised by this is whether the test for unbearable and hopeless suffering is subjective or objective, ie whether it is totally up to the patient to decide if he is suffering unbearably or not.⁴²⁵

5.3.6.2 Decision

On 30 October 2000 the Haarlem District Court acquitted the doctor.

5.3.6.3 Application

This case highlighted the very broad interpretation that could be given to the Dutch requirement of unbearable suffering.

⁴²³ Griffiths (fn 401 above) p.240.

⁴²⁴ De Haan (fn 412 above) p.63 fn 24.

⁴²⁵ De Haan (fn 412 above) p.63 fn 24 .

Chapter 6: Recommended changes to the South African Law Commission's Final Draft Bill

The following are recommendations for amendments to the South African Law Commission's Final Draft Bill. The suggested changes are discussed here, without re-quoting the Final Draft Bill. The amended Final Draft Bill, with the recommended changes incorporated falls outside of the scope of this dissertation, but a suggestion that can be used as a starting point for discourse is nonetheless included as annexure A.

It is suggested that voluntary euthanasia be incorporated into the South African health system in a controlled, phased process. During the initial phase, the focus must be on the least problematic cases. All relevant activities must be recorded in sufficient detail to enable a more informed investigation into the real-world consequences, dangers and solutions and to ultimately enable the creation of a system where all the rights in the Bill of Rights are given the fullest possible protection, while the risk of abuse is kept to a minimum.

6.1 Preamble

It is suggested that the preamble include an acknowledgement of the positive obligation the Constitution imposes on the state to promote and protect the rights of dignity; life; security of the person; equality; privacy; access to health care and freedom of religion, belief and opinion.

6.2 Definitions

In the first section, provision should be made for death to be defined as brain death, as in the National Health Act.⁴²⁶ This helps to integrate health law into a coherent system and aids legal certainty.

Despite much criticism and dubious defensibility, the distinction between active and passive euthanasia should be retained, at least at this early stage. Not only do highly respected experts like Strauss stress the importance of the distinction, but it also carries a very practical benefit. It allows for controlled integration of active euthanasia into the legal system, as well as the removal of it, if needed, without unnecessary contamination of our common law. The distinction is to be incorporated through the provision of definitions similar to that provided earlier in this dissertation,⁴²⁷ and the different terms should then be used clearly in provisions where it is appropriate. Both “treatment and care” and “intractable and unbearable illness” must be redefined, as argued above, but also to better reflect the intended meanings in the context of the legalization of active voluntary euthanasia.⁴²⁸

Provisions

6.3.1 Integration into existing legal system

Again taking guidance from the National Health Act,⁴²⁹ the patient’s right to participate in decisions and the necessity of informed consent (and informed refusal where applicable) should specifically be made provision for. This should be explicitly extended to cases of “double effect”, which should in turn be expressly recognized in the Bill. “Double effect” should be recognized as a form of active euthanasia and informed consent and all other requirements for euthanasia should be required in all cases.

⁴²⁶ National Health Act 61 of 2003.

⁴²⁷ See page 8 above.

⁴²⁸ See page “intractable and unbearable illness”. 107 above.

⁴²⁹ National Health Act 61 of 2003.

The Inspectorates of Health Establishments and Office of Standards Compliance from the National Health Act should also be used to monitor compliance with the letter and spirit of the Bill. This again aids in providing “a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith”,⁴³⁰ one of the stated objective of the National Health Act.

6.4 Specific provisions

There are some criteria that should be included or maintained, at least initially, to facilitate controlled integration into the health system and early detection of, for lack of a better description, “abuse-loopholes”. The groups or individuals so excluded all represent special cases accompanied with special problems, where the Bill proposed here would in all probability not provide sufficient safeguards given our current level of experience with euthanasia practised openly. While deeply aware of the very real difficulties this presents from a constitutional equality perspective, especially in the light of decisions like *Minister of Health v Treatment Action Campaign*,⁴³¹ it is submitted that such exclusion can be distinguished from previous cases. Firstly, the risk of abuse of euthanasia is real, the consequences of such abuse permanent and exclusions are not based on geography or convenience, but on the relative size of the risk involved. Secondly, a statutory time-limit is set for the implementation of further measures to accommodate the excluded groups or, if the risk of abuse proves to be unmanageable, all forms of euthanasia where the risk is unmanageable will have to be excluded, based on real-world experience and monitoring. Thirdly, relative to the case of *Minister of Health v Treatment Action Campaign*,⁴³² where the

⁴³⁰ National Health Act 61 of 2003 Prelude.

⁴³¹ *Minister of Health v Treatment Action Campaign* (fn 170 above).

⁴³² *Minister of Health v Treatment Action Campaign* (fn 170 above).

drug was available to the state free of charge, implementation of active euthanasia will, at least initially, entail much more of a resource-balancing exercise. It is submitted, while the proposals made here undoubtedly treats certain groups of people unequally, that the above contributes to making the limitation one that qualifies under section 36 of the Bill of Rights.

It is suggested that the initial criteria exclude anyone that:

- does not have a terminal or incurable disease;⁴³³
- does not suffer unbearably;⁴³⁴
- is not an adult (eighteen years of age or older);⁴³⁵
- is not a South African citizen or permanent resident.⁴³⁶

In all cases, the requirement that at least two medical practitioners should concur on any diagnoses relevant to euthanasia should be maintained, as it represents an important safeguard without seriously compromising the availability of euthanasia. This should include cases of “double effect”.

Time limits must be imposed on the requests for euthanasia. The last request must be shortly before the euthanasia is performed, and at least one other request must be no less than a few days before euthanasia is performed. Directly before euthanasia is performed, the medical practitioner performing the euthanasia must

⁴³³ This requirement eliminates all sorts of problematic cases, for example that of a heart-broken teenager from a failed relationship requesting euthanasia, or that of a person serving a life sentence in prison requesting euthanasia. At the same time, the definition of “terminal” is highly problematic in its own right.

⁴³⁴ This requirement incorporates a strong predilection in favour of life and enforces the requirement of compassion or mercy as motive for euthanasia. It also indirectly incorporates the element of “quality of life”.

⁴³⁵ This keeps the legislation in line with the rest of the health law system, where one can only consent to serious operations (with the exception of abortion) from the age of 18. Eventually, this requirement may fall away and the situation with regard to children may evolve around similar lines as that of any other person who cannot give informed consent (or informed refusal) at the relevant time.

⁴³⁶ This requirement is intended to prevent “euthanasia tourism”, at least during the initial phases when South African citizens are already being excluded and where the potential of a relatively large influx of “euthanasia tourists” could overwhelm the health system and defeat the purpose of this initial phase.

again inspect the signature on the original certificate of request. If the original certificate is missing or destroyed, euthanasia may not be performed.

A certain type of document, sometimes called a “passport of life”, is essentially an advance directive with content almost opposite to that of a living will. In such a document, a request is typically made that the person concerned be kept alive by whatever means possible. Living wills and passports of life are the preferred mediums for communicating end of life decisions, rather than enduring powers of attorney alone, as the advance directives provide the most direct insight into the patients previous wishes. A combination of the advance directives and enduring power of attorneys can, however, be employed with good result.

Any medical practitioner that has access to a patient’s medical record and has knowledge that a patient has made an advance directive must record this fact on the patient’s medical record. Such record cannot be used to prove the patient’s intentions, but is merely intended to create an awareness of the existence of such advance directive.

Where a person is already legally dead, but still retains some form of biological life, interested family members must be given the opportunity to have such life maintained, provided that this falls within the ascertainable will of the patient and the persons concerned can provide the necessary resources.

Very clear provision should be made that nobody, including the medical practitioner and the patient, may be forced to act against his / her religion, beliefs or opinion nor may any person be disadvantaged, directly or indirectly, due to his / her beliefs and participation or non-participation in euthanasia. Furthermore, a provision should be included that regulates the disciplinary measures that professional bodies may take against practitioners in euthanasia cases where there is full compliance with the law.

6.5 New considerations

It is submitted that a reporting procedure, similar to that found in articles 17 and 18 of the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2001), but more comprehensive, form part of any implementation of euthanasia. Autopsies should automatically be required in all cases and there must be a legal duty on all medical practitioners to report anything suspicious that they may come across at any stage of an euthanasia case, or even thereafter. All records should be kept for at least five years at the premises where the euthanasia request was given effect to, with copies held at the head office of the of medical institution concerned. Copies should also be sent to the Inspectorates of Health Establishments and Office of Standards Compliance, where the necessary statistics reports must be compiled for submission to a committee that must be formed by Ministerial decree in the Government Gazette. This committee must then report in the Government Gazette every year on the euthanasia-related acts in the Republic during that year.

Provisions relating to health and life insurance⁴³⁷ must be included, ensuring that no disadvantage or victimization result from euthanasia requests. All cases of euthanasia must be treated as confidential and may not in any way, directly or indirectly, be treated as suicide for insurance purposes.

⁴³⁷ Similar provisions are found in other instruments internationally, for example the Oregon “Death with Dignity” act.

Chapter 7: Conclusion

The current legal position in South Africa is that active euthanasia (excluding the “double effect” in this case) is illegal and constitutes the crime of murder. Passive euthanasia will in certain limited circumstances be allowed, as discussed in the case of *Clarke v Hurst*.⁴³⁸ Living wills have never been given judicial consideration, and enduring powers of attorney in this context are not currently recognized in South African law. Most of these principles have, however, been laid down in a time when society and the law looked much different from today.

The current situation in South Africa and the way forward was considered by several authors.

Strauss considers respect for life the “hallmark of western civilization”, but qualifies the statement. While South African courts consistently emphasize the sanctity of human life and the state’s interest in the preservation of life, Strauss indicates that the emphasis has shifted from sheer preservation of life to the quality of life.

Concerning passive euthanasia, McQuoid-Mason (with reference to case law) comes to the conclusion that it may not be regarded as murder, as the patient is regarded as having been killed by the underlying illness or injury. Van Oosten comes to the same conclusion, but while he refers to the same case law as McQuoid-Mason, he (incorrectly) refers to it as active euthanasia. Burchell states that passive euthanasia is considered both legally and ethically permissible.

From the South African case law it appears that, while active euthanasia is prohibited by South African law, those who commit it are consistently treated with the utmost - almost absurd - leniency by our courts. There is apparently

⁴³⁸ *Clarke v Hurst* (fn 98 above).

wide support for this approach (rather than formal legalization of active euthanasia). This leads Strauss to ask whether we have not transformed criminal law into criminal “non-law”, where we recognize a class of murderers (who commit our most serious crime) that we do not want to punish at all.

In 1977, Strauss came to the conclusion that, while the *boni mores* supported passive euthanasia, most South Africans at the time were opposed to any suggestion of active euthanasia being legalized. Carstens indicates that public opinion may still differ today, but South Africa’s Constitution seems to be supportive of a regulated regime of euthanasia in South Africa, similar to that found in The Netherlands. Burchell submits that constitutional norms inform the legal convictions of society and that not all forms of euthanasia would be against the legal convictions of society. While consent to murder (including euthanasia) is no defence against a charge of murder, Burchell writes that societal attitudes are not static and a court can still take into account the changing *boni mores*, allowing courts to deviate from the old precedents and to allow some previously prohibited forms of euthanasia.

The so-called “double effect” is generally considered to not be unlawful by the authors. Van Oosten recognized authority for the view that a medical practitioner’s conduct in cases of double effect would not lead to the medical practitioner’s conduct being regarded as wrongful, but as justified by society’s convictions. According to Burchell, the double effect appears to be both legally and ethically acceptable for a medical practitioner. Strauss writes that the medical practitioner’s conduct would not be unlawful, but emphasizes the intention of the medical practitioner in distinguishing this from active euthanasia. It is submitted that, as the true intention behind euthanasia proper is always to relieve unbearable pain and suffering, and the death of the patient is merely the only means to that end, this distinction is artificial. Active euthanasia and the double effect are different manifestations of the same thing.

In discussing cases where a patient is not able to communicate their desires, McQuoid-Mason notes that enduring powers of attorney are not currently

recognized in South African law, but argues that living wills and advance directives should be respected, provided that it is reasonably clear that they reflect the patient's wishes. Carstens, Labuschagne, Strauss and Burchell agree that living wills should be recognized, with Strauss adding that such a living will can be revoked at any time, but involved a risk that life insurers should be informed about. Additionally, Labuschagne submitting that where there is doubt as to the wishes of the patient, a decision has to be made in favour of life.

In conclusion, Strauss apparently agrees with Hillel Shapiro that it may be best to simply maintain the *status quo* and avoid the dangers involved in trying to create a statutory framework.

McQuoid-Mason postulates that the converse to a right to life must be that every person will have the right to, if they so wish, take his / her own life - a mentally competent patient, who is terminally ill or suffering unbearably, may rely on his / her constitutional rights to respect and protection of dignity, privacy and freedom and security of the person.

Labuschagne appreciates the recognition that the law in The Netherlands gives to patient autonomy and argues that a patient should have a right to die, if they comply with the following criteria:

- The patient must suffer from an incurable disease or illness;
- The suffering must be subjectively unbearable;
- The patient must give informed consent to the act of euthanasia;
- At least two medical practitioners must certify to the above;
- A declaratory order from the High Court to the effect that the above have been complied with must be obtained.

Carstens also recognizes patient autonomy as a fundamental right and writes that the ultimate decision to refuse or undergo medical intervention does not lie with the medical practitioner, but with the patient. He argues that the Constitution supports the implementation of euthanasia that is regulated in a way similar to

that found in the Netherlands, and he seems to advocate limiting (at least for the time being) the application thereof to the terminally ill.

Burchell concludes that some forms of euthanasia might be allowed, if the following criteria are complied with:

- There is evidence of the *bona fide* medical context of the procedure;
- There are at least two reliable medical assessments indicating that:
 - The quality of life of the sufferer is nil or minimal;
 - There is no reasonable chance of the sufferer's recovery;
- At least two medical professionals, and perhaps also an ethical review committee, approve the process whereby the sufferer will die;
- Approval of the procedure by close family and a court.

In short, the authors all seem to be in favour of some form of euthanasia being recognized in law. The most conservative of the above is Strauss, who does not support the legalization of active euthanasia, and the most liberal is Labuschagne, who argues for a "right to die". Most of the authors seem to support the legalization of active euthanasia, provided that sufficient safeguards are created to prevent abuse.

Internationally, the potential legalization of euthanasia and the problem of effective safeguards against abuse are being debated in several countries throughout the world. Sociologically, technologically and legally speaking, the world has changed much in the past few decades and legal principles that were formulated centuries ago naturally do not take account of such changes.

The law in The Netherlands were to a large extent, *de facto*, written by the courts. The cases that came before the Dutch courts bear a striking resemblance to those that came before the South African courts. A similar degree of compassion for the accused can be found in the jurisprudence of both countries and even though the verdicts were different, the effectual results were similar, to the extent that the different systems allowed for it. The Netherlands eventually reached a situation where the written letter and the real-world practise of the law

were almost alien to one another, and it can be argued that the legislator was almost forced to enter the arena. Even then, there was opposition to the legalization of euthanasia, and a compromise was reached that resulted in the shielding from punishment of a medical practitioner that performs euthanasia in accordance with certain criteria.

In January 1992, the South African Law Commission approved a research project which was later expanded to include most issues relating to the termination of life under the heading “Euthanasia and artificial preservation of life”. The project invited much debate and input from various interest groups and individuals. The final Draft Bill recommended by the Law Commission, which, if enacted, would have been called the “End of Life Decisions Act, 1999”, has still not been enacted or clearly rejected by the Minister and calls are again being made (from both sides) for a re-opening of the debate and for the regulation of end of life decisions.

The question of euthanasia, in essence, raises again the same questions and arguments that were in play during the abortion debates. Any discussion on euthanasia normally invokes deeply held personal, moral and religious views, and the only manner in which an answer will present itself is by conducting the discussion with total objectivity in terms of the constitutional principles.

Constitutionally, the rights to equality, dignity, access to health care, privacy, life, freedom and security of the person and the right to freedom of religion, thought, belief and opinion are especially relevant, further informed by constitutional values:

- The right to dignity protects individuals from dying in a manner that they consider undignified, and may in fact create an obligation on the state to provide for accessible legal remedies in appropriate cases
- The right to life arguably protects not any life, but only certain types of life. Even should it protect all life, it is submitted that human rights instruments are not drafted to restrict the freedom of the individual

concerned, but rather to protect the individual from arbitrary deprivation or limitation of such rights.

- The right to freedom and security of the person encompasses the right to be left alone, to be protected from violations of one's physical integrity and, in the context of euthanasia, represents the value of individual autonomy, leading to a right to bodily self-determination which is more concerned with an individual's integrity than his / her welfare. This clearly includes the right to choose what medical treatment one is willing to receive or not receive.
- The right to equality as interpreted in South African constitutional jurisprudence embraces the concept of substantive equality. In the case of euthanasia, the unequal treatment of people with disabilities may be especially relevant. Such disabled individuals do not have access to the same options in relieving their suffering as non-disabled individuals may have.
- The right to freedom of religion, belief and opinion protects individuals from being forced to participate in a procedure that it goes against his / her beliefs.
- The right to access to health care is a socio-economic right that also incorporates a positive dimension, requiring action from the state. Health is not limited to physical health, but may also include the psychological health of an individual requesting euthanasia. Furthermore, it is submitted, this right places a duty on the state to not force life upon those who do not wish to live, especially if in the process resources are irrationally spent that could have been used to provide access to health care to those who need it to live and who desperately want to live.

These rights may be limited in terms of section 36 of the Constitution, provided that such limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. For our legal system and constitutional framework to remain consistent and retain any meaning, it is imperative and unavoidable that voluntary euthanasia be legalized. Ultimately, it is a matter of personal choice. The only clear exception would be if the risk of

abuse were so great that the limitation would be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.

It is submitted that, while the risk of abuse cannot be eliminated, it can be limited sufficiently by a process of controlled integration of voluntary euthanasia with proper monitoring and review, as proposed in this dissertation. Ultimately then, it is submitted that there is a constitutional duty on the state to legalize voluntary euthanasia of this or a similar nature.

The South African Law Commission's report includes more safeguards than the Dutch law. This is to be expected, as the challenges faced by the two countries from practical and infrastructural points of view are different. The reporting system in The Netherlands can however be used in a modified form to facilitate the design of a system that is appropriate in South Africa. As the Law Commission's suggestions have apparently been ignored for so long, one has to conclude that the suggestion was not fully satisfactory. This creates the imperative to re-open the debate and design a system to give effect to the rights guaranteed in our Constitution.

The Law Commission's report has been analyzed and, bearing in mind the writings of the authors, the position in the Netherlands and changes in South African law (specifically the introduction of a Bill of Rights), some suggestions have been made for changes to the Law Commission's Draft Bill.

Debate or criticism invited by this proposal will further improve the (arguably inevitable) eventual legislation – it allows for fine-tuning and improvement of the framework. This type of discourse is beneficial to all parties concerned and should be encouraged as much as possible. To this end, an amended version of the Law Commission's suggestion is included as annexure A, which represents a suggested starting point for further debate.

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Annexure A: Suggested Bill

(Note: This annexure includes definitions not used therein; this is designed to provide a common terminology to be used in such debate.)

Recognizing the obligation imposed by the Constitution on the state to promote and protect the rights to dignity, life, security of the person, equality, privacy, access to health care and freedom of religion, belief and opinion;

AND *recognizing* that the the answer to end of life decisions must be found as far as possible through total objectivity in terms of constitutional principles;

AND *recognizing* the risk of abuse inherent in such matters and the concurrent responsibility to oppose such abuse;

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:

Definitions

1. (1) In this Act, unless the context otherwise indicates-

‘active euthanasia’ means any euthanasia that is not passive euthanasia.

‘adult’ means anyone at or above the age of 18 years.

‘competent witness’ means a person of the age of 18 years or over who at the time he / she witnesses the directive or power of attorney is not incompetent to give evidence in a court of law and for whom the death of the maker of the directive or power of attorney holds no benefit;

‘court’ means a provincial or local division of the High Court of South Africa within whose jurisdiction the matter falls;

‘death’ means brain death;

‘euthanasia’ means the killing or allowing to die of another person with mercy or compassion for that person as primary motive.

‘family member’ in relation to any person, means that person's spouse, parent, child, brother or sister;

‘lawyer’ means an attorney as defined in section 1 of the Attorney's Act, 1979 (Act 53 of 1979) and an advocate as defined in section 1 of the Admission of Advocates Act, 1964 (Act 74 of 1964);

‘life-sustaining medical treatment’ includes the maintenance of artificial feeding and / or hydration;

‘medical practitioner’ means a medical practitioner registered as such in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

‘non-voluntary euthanasia’ means any euthanasia where the wishes of the person to be euthanized is unknown and unascertainable.

‘nurse’ means a nurse registered as such in terms of the Nursing Act 50 of 1978 and authorised as a prescriber in terms of section 31(14)(b) of the South African Medicines and Medical Devices Regulatory Authority Bill;

‘palliative care’ means treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-social suffering and of maintaining personal hygiene, but excluding any active measures that may be considered life-shortening;

‘passive euthanasia’ means euthanasia by means of non-interference or non-intervention in the death of another person.

‘physician-assisted suicide’ – means that a medically-trained person assists another person in some way to commit suicide by use of medical knowledge or technology.

'spouse' includes a person with whom one lives as if they were married or with whom one habitually cohabits;

'terminal illness' means an illness, injury or other physical or mental condition that-

(a) in reasonable medical judgement, will inevitably cause the untimely death of the patient concerned and which is causing the patient extreme suffering; or

(b) causes a persistent and irreversible vegetative condition with the result that no meaningful existence is possible for the patient.

'voluntary euthanasia' means euthanasia performed as a result of the real and informed wishes of the person to be euthanized.

Conduct of a medical practitioner in the event of clinical death

2.(1) For the purposes of this Act, a person may only be considered to be dead when two medical practitioners agree and confirm in writing that the person is brain dead.

2.(2) Should a person be considered to be dead according to the provisions of sub-section (1), the medical practitioner responsible for the treatment of such person may withdraw or order the withdrawal of all forms of treatment, but only after providing interested family members with reasonable opportunity to arrange for the biological life of the person to be maintained at their expense, unless the patient has indicated by way of advance directive that he or she does not want his or her biological life to be maintained in such a manner.

Mentally competent person may refuse treatment

3.(1) Every person -

- (a) above the age of 18 years and of sound mind, or
- (b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian,

is competent to refuse any life-sustaining medical treatment or the continuation of such treatment.

(2) Should it be clear to the medical practitioner under whose treatment or care the person who is refusing treatment as contemplated in subsection (1) is, that such a person's refusal is based on the free and considered exercise of his or her own will, he or she shall give effect to such a person's refusal even though it may cause the death or the hastening of death of such a person.

(3) Care should be taken when taking a decision as to the competency of a person, that an individual who is not able to express him or herself verbally or adequately, should not be classified as incompetent unless expert attempts have been made to communicate with that person whose responses may be by means other than verbal.

(4) Where a medical practitioner as contemplated in subsection (2) does not share or understand the first language of the patient, an interpreter fluent in the language used by the patient must be present in order to facilitate discussion when decisions regarding the treatment of the patient are made.

Conduct of medical practitioner in relieving distress

4.(1) Should it be clear to a medical practitioner or a nurse responsible for the treatment of a patient who has been diagnosed by a medical practitioner as suffering from a terminal illness, that the dosage of medication that the patient is currently receiving is not adequately alleviating the patient's pain or distress, he or she may, with the object to provide relief of severe pain or distress, increase the dosage of medication (whether analgesics or sedatives) to be given to the patient until relief is obtained, even if the secondary effect of this action may be to shorten the life of the patient, provided that all the requirements for active

euthanasia, and informed consent, with the exception of the requirement of terminal illness, are complied with.

(2) A medical practitioner or nurse who treats a patient as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and his or her conduct in treating the patient, which record will be documented and filed in and become part of the medical record of the patient concerned. Such record must also be stored in terms of section 17.

Active voluntary euthanasia

5.(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall give effect to the request if he or she is satisfied that-

- (a) the patient is suffering from a terminal illness;
- (b) the patient is over the age of 18 years and mentally competent;
- (c) the patient has been adequately informed with regard to the illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;
- (d) the request of the patient is based on a free and considered decision;
- (e) the request has been repeated without self-contradiction by the patient on two separate occasions, of which one must be no less than 72 hours before the medical practitioner gives effect to the request and another may be no more than 30 minutes before the medical practitioner gives effect to the request;
- (f) there is a period of at least seven days between the original request and the time the request is given effect to;

- (g) the patient, or a person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;
 - (h) the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;
 - (i) the medical practitioner has the signed original certificate of request on his / her person directly prior to and at the time of giving effect to the request;
 - (j) an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner as contemplated in this section does not share or understand the first language of the patient;
 - (k) ending the life of the patient or assisting the patient to end his or her life is the only way for the patient to be released from his or her suffering.
- (2) No medical practitioner to whom the request to make an end to a patient's suffering is addressed as contemplated in subsection (1), shall give effect to such a request, even though he or she may be convinced of the facts as stated in that subsection, unless he or she has conferred with an independent medical practitioner who is knowledgeable with regard to the terminal illness from which the patient is suffering and who has personally checked the patient's medical history and examined the patient and who has confirmed the facts as contemplated in subsection (1)(a), (b) and (i).
- (3) A medical practitioner who gives effect to a request as contemplated in sub-section (1), shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

(4) The termination of a patient's life on his or her request in order to release him or her from suffering may not be effected by any person other than a medical practitioner.

(5) If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above may, at the patient's request and in the presence of the patient and both the medical practitioners, sign the certificate on behalf of the patient.

(7)(a) Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state.

(b) Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.

(8) The following shall be documented and filed in and become part of the medical record of the patient who has been assisted under this Act:

(a) a note of the oral request of the patient for such assistance;

(b) the certificate of request;

(c) a record of the opinion of the patient's medical practitioner that the patient's decision to end his or her life was made freely, voluntarily and after due consideration;

(d) the report of the medical practitioner referred to in subsection (2) above;

(e) a note by the patient's medical practitioner indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the substance prescribed.

Directives as to the treatment of a terminally ill person

6.(1) Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would as a result be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted or any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.

(2) A directive contemplated in subsection (1) and any amendment thereof, shall be signed by the person giving the directive in the presence of two competent witnesses, who shall sign the document in the presence of the said person and in each other's presence.

(3) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator. The guardian or curator must have due regard to the wishes of interested family members and the ascertainable wishes of the patient, and proof of compliance must accompany any certificate of request made by the guardian or curator.

Conduct in compliance with directives by or on behalf of terminally ill persons

7.(1) No medical practitioner shall give effect to a directive regarding the refusal or cessation of medical treatment or the administering of palliative care which may contribute to the hastening of a patient's death, unless-

(a) the medical practitioner is satisfied that the patient concerned is suffering from a terminal illness and is, as a result thereof, unable to make or

communicate considered decisions concerning his or her medical treatment or the cessation thereof; and

(b) the condition of the patient concerned, as contemplated in paragraph (a), has been confirmed by at least one other medical practitioner who is not directly involved in the treatment of the patient concerned, but who is competent to express a professional opinion on the patient's condition because of his expert knowledge of the patient's illness and his or her examination of the patient concerned.

(2) Before a medical practitioner gives effect to a directive as contemplated in subsection (1) he shall satisfy himself, in so far as this is reasonably possible, of the authenticity of the directive and of the competency of the person issuing the directive.

(3) Before giving effect to a directive as contemplated in subsection (1), a medical practitioner shall inform the interested family members of the patient of his or her findings, that of the other medical practitioner contemplated in paragraph (b) of subsection (1), and of the existence and content of the directive of the patient concerned.

(4) If a medical practitioner is uncertain as to the authenticity as regard to the directive or its legality, he shall treat the patient concerned in accordance with the provisions set out in section 8 below.

(5)(a) A medical practitioner who gives effect to a directive as contemplated in subsection (1) shall record in writing his or her findings regarding the condition of the patient and the manner in which he or she implemented the directive. Such record must be stored in terms of section 17.

(b) A medical practitioner as contemplated in paragraph (b) of subsection (1) shall record in writing his or her findings regarding the condition of the patient concerned. Such record must be stored in terms of section 17.

(6) A directive concerning the refusal or cessation of medical treatment as contemplated in sub-section (1) and (2) shall not be invalid and the withholding

or cessation of medical treatment in accordance with such a directive, shall, in so far as it is performed in accordance with this Act, not be unlawful even though performance of the directive might hasten the moment of death of the patient concerned.

Conduct of a medical practitioner in the absence of a directive

8.(1) If a medical practitioner responsible for the treatment of a patient in a hospital, clinic or similar institution where a patient is being cared for, is of the opinion that the patient is in a state of terminal illness as contemplated in this Act and unable to make or communicate decisions concerning his or her medical treatment or its cessation, and his or her opinion is confirmed in writing by at least one other medical practitioner who has not treated the person concerned as a patient, but who has examined him or her and who is competent to submit a professional opinion regarding the patient's condition on account of his or her expertise regarding the illness of the patient concerned, the first-mentioned medical practitioner may, in the absence of any directive as contemplated in section 6(1) and (2) or a court order as contemplated in section 9, grant written authorisation for the cessation of all further life-sustaining medical treatment and the administering of palliative care only.

(2) A medical practitioner as contemplated in subsection (1) shall not act as contemplated in subsection (1) if such conduct would be contrary to the wishes of the interested family members of the patient, unless authorised thereto by a court order.

(3) Both medical practitioners as contemplated in subsection (1) shall record in writing his or her findings regarding the patient's condition and any steps taken by him or her in respect thereof. Such record, together with the written findings of the second medical practitioner, must be stored in terms of section 17.

(4) The cessation of medical treatment as contemplated in subsection (1) shall not be unlawful merely because it contributes to causing the patient's death.

Powers of the court

9.(1) In the absence of a directive by or on behalf of a terminally ill person as contemplated in section 6, a court may, if satisfied that a patient is in a state of terminal illness and unable to make or communicate decisions concerning his or her medical treatment or its cessation, on application by any interested person, order the cessation of medical treatment.

(2) A court shall not make an order as contemplated in subsection (1) without the interested family members having been given the opportunity to be heard by the court.

(3) A court shall not make an order as contemplated in subsection (1) unless it is convinced of the facts as contemplated in that subsection on the evidence of at least two medical practitioners who have expert knowledge of the patient's condition and who have treated the patient personally or have informed themselves of the patient's medical history and have personally examined the patient.

(4) A medical practitioner who gives effect to an order of court as contemplated in this section shall not thereby incur any civil, criminal or other liability whatsoever, provided that all due procedural measures have been complied with in a manner as can be expected of a professional medical practitioner.

General provisions

10. Nothing in this Act shall be interpreted so as to oblige a medical practitioner to partake in any end of life action that would be in conflict with his or her conscience or any ethical or religious code to which he or she feels himself or herself bound, even should such practitioner be the only available practitioner.

11. A medical practitioner who, based on personal beliefs, opinions or religious considerations, gives effect to a patient's request to be released from suffering; or refuses to give effect to a patient's request to be released from suffering shall not suffer any civil, criminal or disciplinary liability with regard to such an act provided that all due procedural measures have been complied with in a manner as can be expected of a professional medical practitioner.
12. No provision in a will, contract, insurance policy, annuity or other contract shall be valid to the extent that it affects whether or not or when a person may make or rescind an advance directive or request for euthanasia in accordance with this Act.
13. The condition, sale or rate of any insurance or medical aid or annuity may not be affected by the making or rescinding of an advance directive or request for euthanasia in accordance with this Act.
14. Any person who intentionally exerts undue influence on or coerces another person to make or rescind an advance directive or request for euthanasia shall be guilty of an offence, punishable as though it constitutes attempted murder.
15. Whenever any request for euthanasia is received, the medical practitioner receiving the request shall
- (1) counsel the patient to inform interested family members of the request. A patient's refusal to inform interested family members shall not disqualify him or her as a candidate for euthanasia;
 - (2) inform the patient of the palliative care options and counsel the patient to consider such options;
 - (3) inform the patient of his or her right to rescind the request at any time and in any manner that clearly communicates such intention.
16. Any medical practitioner who has reason to suspect that the law has not been complied with in any given case, has a duty to report the matter to the national committee as envisioned in section 17.(2).

Public record

17.(1) Copies of all records relating to euthanasia must be held at the premises where the euthanasia was performed and / or requested, as well as the head office of any institution that performed and / or received a request for euthanasia and the relevant Inspectorate of Health Establishments and Office of Standards Compliance, as defined in the National Health Act 61 of 2003, for a period of at least five years.

(2) The Minister of Health must establish, by way of Government Gazette, a national committee to annually report on euthanasia activities on a national level. These reports must be published in the Government Gazette annually. Such committee must include at least two experienced medical practitioners, two experienced legal practitioners and two ethicists.

(3) The Inspectorates of Health Establishments must compile annual reports concerning the records received by the establishment during the year. These reports must be sent to the national committee on an annual basis.

(4) The national committee may refer any matter where the law has apparently not been complied with to the police for investigation and prosecution.

Limitation on application of act

20. Regardless of any other provision in this act, this act does not apply to any person who is not:

20.(1) mentally competent;

20.(2) suffering unbearably and where palliative medical skills are not adequate or acceptable;

20.(3) an adult;

20.(4) A South African citizen or permanent resident.

Review of the Act

19.(1) Two years after this Act comes into effect, the national committee's report must include a recommendation for amendments to the Act. Such recommendations must include the possibility of expanding the group of persons that qualify for euthanasia to people who are presently being excluded in terms of section 20 or otherwise purely on grounds of present difficulty in controlling the risk of abuse, as well as recommendations regarding safeguards to prevent abuse in said cases.

(2) The legislature has to take positive steps to implement the suggestions with any necessary amendments, or alternatively publish a report in the Government Gazette indicating why such proposals are not implemented, within six months of receiving the report referred to in subsection (1).

Short title

20. This Act shall be called the End of Life Decisions Act, 2007