The Bounds of Compassion? Medical Ethics and the Politics of Medical Mercy Killings in South Africa, 1930s to 1976

Julie Parle
University of KwaZulu-Natal and University of Pretoria
Email: julie.parle@up.ac.za

Abstract

The 1975 trial of Dr Alby Hartman for the killing of his father, in September the previous year at the small hospital at Ceres just over 100 kms from Cape Town, galvanised South African debates about medical euthanasia. After the trial, the obligations and duties of doctors faced with extreme suffering, profound disability, or inevitable death were widely discussed. The first study of medical mercy killings in South Africa, this article provides context, from the 1930s to the 1970s, for the Hartman trial and its controversial sentence. I consider why Dr Hartman admitted to ending his father's life, but also entered the plea of not guilty to murder. 'Compassion was my motive', he said. Several complexities of compassion and medical ethics in South Africa before 1976 are explored through attention to the role of Dr Guy A. Elliott. Through attention to South African medical politics under apartheid, I explain the contradictory positions on censuring Dr Hartman taken in 1976 by the South African Medical and Dental Council (SAMDC). Finally, I point to how the sentence passed on Dr Hartman – which made him a criminal 'non-law'- has had a complex legacy for the issue of doctor-assisted dying in South Africa.

Keywords: Compassion; doctors; medical ethics; euthanasia; dying; doctor/physician-assisted death; mercy killing; *State vs Hartmann*; South African Medical and Dental Council; medical authority

Introduction: A crime of compassion

On 19 March 1975, at the Cape Division of the Supreme Court of South Africa, Dr Alby Hartman freely admitted that in September of the previous year he had administered a lethal dose of sodium pentothal, an anaesthetic, to his 87-year-old father. His intention had been to put him into a coma 'from which he would never come out again'. Yet, to the charge that he did 'wrongfully, unlawfully and maliciously kill and murder Glen Frederick Alby Hartman', his lawyers entered the plea 'not guilty'.[1] 'Compassion was my motive', Dr Hartman told the court.[2] For months, it had been clear that the cancer with which Mr Hartman had been diagnosed had spread and that his death was inevitable. For hastening his father's death, perhaps only by minutes, Dr Hartman now technically faced the possibility of the death sentence, then mandatory in South Africa for 'intentional murder, in the absence of a finding of extenuating circumstances'.[3]

On 20 March, Justice Louis de Villiers van Winsen passed the only verdict possible in law – that of guilty of murder. Yet, the next day, in handing down sentence, he expressed the view that Dr Hartman's care for his father had been 'close, compassionate and correct'. Identifying the irreconcilable demands on medical professionals, Van Winsen said that Hartman had acted because, as a 'medical man […] *in the course of his profession*', he had been 'exposed to the lonely dilemma of whether or not actively to assist or refrain from preventing his

already doomed and suffering patient's demise'.[4] Van Winsen added that, in his view, Dr Hartman had carried out a mercy killing and had acted only because 'his compassion knew no legal bounds [and this] is a case which calls for the total suspension of the sentence'. That, however, could not 'be achieved in law'.[5]

The prosecutor, Mr Frank Khan, put the suggestion that the court postpone its sentence until Dr Hartman had been censured by the South African Medical and Dental Council (SAMDC).[6] Alert to the judicial perils that this precedent would create, however, Van Winsen decided that the court could not allow its sentence to be seen to be influenced by another body.[7] Even though he was openly sympathetic to Hartman, Van Winsen was careful to explain that, to allow for lawful medical mercy killings, *legislative* change would be necessary. For, as historian of bioethics Sarah Ferber explains: 'Most governments which have, in broad terms, "legalized euthanasia" by doctors have created special laws which effectively provide a degree of protection for medical practitioners, to separate medical from other forms of mercy killing'.[8]

With regard to lawful active euthanasia, this did not take place until as recently as the 1990s, and it is still rejected by the World Medical Association.[9] Indeed, and as historian Roger Cooter points out, it was and is not uncommon for the formal representative bodies of the medical profession to resist state legislation on a range of fronts, including medically assisted euthanasia.[10] Like their American and British counterparts, in the 1970s the SAMDC often exercised 'anti-state paternalism' and strove to preserve a large degree of autonomy over 'the "special doctor–patient relationship"', including at the end of life.[11]

Turning to the matter of sentencing Dr Hartman, Justice van Winsen noted 'the courts cannot legislate, but they can mitigate'.[12] After stating that 'without having to be unfair to society, full measure can be given to the element of mercy', he delivered an unusual and controversial sentence to someone found guilty of murder: Dr Hartman was to receive a year's imprisonment, suspended for three years. Moreover, this suspension was itself suspended until the court adjourned. Since court rose almost immediately, 'Dr Hartman was technically in custody for less than a minute', as one commentator observed, possibly 'the shortest detention any convicted murderer has ever served'.[13]

Interest in the 'Ceres Euthanasia Case', the arguments made at trial, and the sentence passed was extensive, both in South Africa and internationally, with reports published in newspapers from Cape Town to New York.[14] Given Dr Hartman's candid testimony, the court's verdict was inevitable. As this article will outline, the Hartman trial highlighted an intensifying set of dilemmas in post-World War II medicine concerning the duties and responsibilities of doctors in preserving the life of their patients, despite sometimes possibly prolonging their suffering. As an astute report noted, the token sentence passed on Hartman reflected a 'fundamental change in medical and legal thinking [at a time] when enormous advances have been made in medicine, when there is new thinking about the definition of death and when the climate of public opinion is beginning to accept the principle of euthanasia'.[15]

Though reported as an almost unprecedented crime, being only the third mercy killing to be tried at the Supreme Court in South Africa and the first of a doctor, it soon became clear that the 'lonely dilemma' Hartman had faced was not at all unusual. Indeed, in the days following the sentencing, several high-profile South African doctors said that they often felt under great pressure to carry out mercy killings. According to heart surgeon Marius Barnard: 'All doctors are faced by this problem sometime during their careers'.[16]Another prominent specialist went

much further: he told the press that 'he had deliberately ended the lives of 11 patients during his 40 years of practising medicine'. He added that he believed that 'in each case, it was his clear *duty* to end life with a minimum of suffering to those concerned'. Of these patients, three had terminal cancer but, shockingly, eight had been profoundly disabled newborns. 'My conscience would have worried me if I had let those babies live. It is better to end the child's life at the beginning and let the mother think the child was stillborn', he said.[17]

This article, the first to address the topic of medical mercy killings in South Africa directly, provides historical context from the 1930s to the 1970s for the Hartman trial and its verdict. I argue that Dr Hartman admitted to ending his father's life, but entered a plea of not guilty to murder, because he – like many doctors at the time – did not see these as contradictory propositions. As the article shows, this particular act of mercy killing was propelled into the public realm and to the attention of a South African judiciary reluctant to punish Dr Hartman. The SAMDC's vacillating responses to the Hartman trial require explanation. These, I will suggest, can be understood both as a consequence of the profound ambivalence with which many members of the medical professions have regarded mercy killing and as an effect of the influence of powerful political actors at a time when the apartheid state – most prominently spearheaded by new SAMDC chairman Professor Hendrik W. Snyman – was expanding its control over the South African medical profession. In this struggle, Dr Hartman became caught between three powerful institutions: the courts, the medical profession, and the state.

My sources for this article go beyond the oft-cited published legal summary case notes and include insights drawn from the full transcripts of Dr Hartman's trial and his father's associated medical records. In allowing Dr Hartman to 'speak for himself', these sources convey his navigation of duty, compassion, filial responsibility, and medical care. Throughout the article, I also draw attention to the role of Dr Guy A. Elliott, then a SAMDC member, who tried to bridge the law, compassion for Dr Hartman, and professional medical ethics. His intervention secured a sympathetic sentence for Dr Hartman but could not offer a way of addressing the broader issue faced by doctors presented with suffering that they could not relieve, except by ending life. Rather, the legal sentence passed on Dr Hartman – which made him a criminal 'non-law' – has had a complex legacy on the issue of doctor-assisted dying in South Africa. For, while the Hartman trial galvanised intense legal, medical, academic, personal, and popular debate about medical euthanasia, these remain unresolved in South Africa.

Towards a history of mercy killings and active euthanasia in modern South Africa

Euthanasia has long been translated as meaning a 'good' or 'easeful' death. Historian Michael Stolberg defines *active* euthanasia as the 'intentional hastening [of] the death of terminally-ill patients'.[18] Physician Michael Manning similarly describes it as 'a deliberate intervention, by someone other than whose life is at stake, solely to end his or her life'.[19] He distinguishes this from *passive* euthanasia, practices which may include 'the avoidance of extreme or heroic measures to prolong life in the case of incurable and painful terminal illness'.[20] In Southern Africa, practices that can be broadly glossed as 'euthanasia' have been studied by ethnographers, anthropologists, and legal scholars.[21] There has, however, been no account which has historicised doctors' debates about euthanasia in modern South Africa.

By the mid-twentieth century, South Africa's hybrid legal system was made up of an amalgam of Roman-Dutch law, British common law, and 'traditional' African customary law. No South African court had considered a proposal for legalising euthanasia, and

importantly therefore there was no law to 'expressly prohibit the practice of assisted dying'.[22] Instead, a cluster of cases provided legal principles which shaped the Hartman verdict and the sentence. In 1940, for example, 'assisting another to commit suicide' was found unlawful; and the defence of 'consenting to death' was also rejected.[23] Suicide and assisted suicide were considered again in a 1962 case, in which the Appellate Division determined that suicide was not a crime but confirmed that *assisting* another to commit suicide was unlawful. That left a 'somewhat anomalous' situation in that 'every person has the right to commit suicide, but the assistance thereof remains unlawful'.[24] This 'left the door wide open for future courts to take account of changing attitudes to death and dying'.[25]

As Rob Turrell has shown, in South Africa to the 1930s, judicial 'mercy' was routinely meted by reprieve from capital punishment, even in guilty verdicts for the crimes of suicide pacts, infanticide and child murder, and mercy killings. He explains that even if intent to kill was proven in law, 'the social and moral meaning of a murder' was significant.[26] In South Africa, this often translated into more lenient sentencing for white persons accused of capital crimes.[27] That Mr Hartman was recorded as being 'a European person' had no legal weight in this case and was not overtly noted in the records but, given South Africa's racist milieu, came freighted with social significance. Under Nationalist Party rule after 1948, the courts continued to reflect sympathy for mercy killings. They did so by accepting mental illness or temporary psychological aberration as grounds for acquittal of killing carried out for compassionate reasons. In 1955, for example, a son killed his mother after her repeated requests – by shooting her in her hospital bed – and was acquitted of murder on psychiatric grounds.[28]

Alternatively, the court recorded a verdict of guilt but then failed to impose the handed-down sentence, such as in a 'mercy killing' trial in 1968 when a mother confessed that she had intentionally drowned her profoundly disabled baby. Temporarily resident in the country, Mrs De Bellocq had had some medical training and, the court suggested, was fully aware that the prognosis for the child's life span and mental development were dire. The paediatrician expert witness was of the view that there 'was no reasonable chance that the child would live for any length of time' and 'that he would not have treated the child medically if it were his own child'.[29] In other words, he sanctioned (passive) euthanasia. In the light of De Bellocq's confession of active euthanasia, however, the 'court held that the law does not permit the killing of any person, irrespective of whether the person is very ill or an imbecile'. Mrs De Bellocq was found guilty of murder. However, she 'was never called upon to come up for sentence and thus no sentence was ever imposed'.

'I kill within the law, and within the limits of my conscience': Eugenics, ethics, and ending life, 1930s–1960s

As many scholars have shown, across human societies there is evidence that 'euthanasia as both a concept and a practice' has been performed since 'classical antiquity'.[30] Doctors have been on both sides of the debate about its practice, with some interpreting the Hippocratic Oath in rigid ways or expressing religious proscriptions against euthanasia. At other times, however, some doctors have openly endorsed a responsibility medically to alleviate terminal suffering or to end unviable lives. According to Ezekiel J. Emanuel, writing of the United States and other 'western' countries, the fundamental bases of modern pro- and anti-euthanasia arguments have not substantially changed since the 1800s.[31] In Ohio, for example, some medical doctors actively campaigned for the legalisation of active medical mercy killing as early as 1906.[32] They did not succeed, but even so, until 'World War One, the

overwhelming consensus […] was that physicians were justified in trying to provide their dying patients with an "easy death" by making them as comfortable and pain free as possible'.[33]

As several historians have shown, popular support for doctors' rights to carry out euthanasia often grows during times of economic hardship and political stress.[34] Along with Emanuel, Ian Dowbiggin argues that national debates over 'whether or not the state should permit painless killing of incurable patients' were associated with the growth of the 'popularity of social Darwinism, scientific naturalism, eugenics, positivism, and the ideology of Progressivism'.[35] One current of that support came from modernist advocates of the application of 'scientific theory to social problems […] by letting disabled babies die', regarding this as a 'humane way of curtailing human breeding, thus reducing the number of unfit individuals in society'.[36] It was during the Great Depression of the 1930s, in the United States and England, that societies in support of voluntary euthanasia were founded.

Debates about euthanasia, then, are entangled with concerns about those who are thought 'fit' to be born and to carry on living after birth, or deserving – or desirous – of death. In the South African historiography, these considerations have understandably been deeply shaped by concern with racial power. Eugenic thinking was strongest early in the twentieth century at the level of the state, in some branches of scientific medicine (especially psychiatry) and in some sectors of the white public.[37] Eugenicists, amongst them medical doctors, identified 'European' women for reproductive control in the service of the ideal of imperial and white nationhood. Some advocated the sterilisation of 'mental defects' as a 'cost effective eugenic measure'.[38] As Susanne M. Klausen has argued, however, eugenic policies were limited in practice because fostering a white (English and Afrikaans-speaking) nation largely meant rejecting negative eugenics.

On the issue of euthanasia, in 1933 the *South African Medical Record* published a debate in which members of the Cape branch of the Medical Association of South Africa (MASA) considered 'the right to kill by medical men'.[39] The 'main question […] revolved around the desirability or otherwise of hastening death in cases that are incurable and where there is prolonged suffering and pain'.[40] Three speakers represented the medical profession; the fourth was a judge. The first pointed to the 'duty imposed upon all medical men to relieve pain and suffering' but recognised that pain-killing medications could carry 'considerable risks […] of precipitating death'.[41] Foreshadowing the words of Justice van Winsen he went on to say that even if MASA sanctioned euthanasia, it would be unlawful in the absence of legislative changes.

In opposition, a second doctor posed the case for supporting 'the desirability of euthanasia under properly-controlled circumstances [such as when] dealing with terminal illness'.[42] In his view, this would not be murder because 'it was a question of the *acceleration of death* which would inevitably follow'.[43] Others returned to grounds for opposing even 'controlled euthanasia', mentioning the potential for the exploitation and abuse of the vulnerable; the desirability of a final opportunity for repentance of sin; and the example to society said to be set by encouraging the ill to continue living in the face of suffering. They also argued that life could be meaningfully extended by recourse to new narcotics.

The debaters noted that it was not only the elderly and the terminally ill who might be considered suitable subjects for euthanasia but also the 'defective' newly born. The continued lives of 'imbeciles', it was agreed, were a cause of suffering, not so much 'for the individual

but for the relatives and friends'.[44] Still, in 1933 the doctors agreed that the correct remedy for the suffering and pain such children represented for their parents lay not in euthanasia but rather that 'more be done by the state [in terms of] institutional treatment'.[45]

In 1937, MASA firmly distanced itself from euthanasia. In his address to the annual conference, its president dodged the issues of 'contraception, sterilization of the unfit etc.', but on the 'vexed question of euthanasia or voluntary death', he said:

> The business of a doctor, as such, is to save life and to prolong it. It is not for him to say whether this or that life is desirable, nor is it the doctor's business to do what he is asked, even to please his patient. It is his province to study and to cure disease if he can. If not, to relieve it. This is the beginning and the end of his duty […] Put bluntly, a doctor may not kill.[46]

Even so he prevaricated, acknowledging that doctors could 'ease the death of someone we care for and for whom we are responsible'.[47] These distinctions were more than semantic. Instead, they show how doctors understood the difference between a compassionate act at the end of life and killing a patient.

The appalling evidence of doctors' and nurses' widespread participation in murder, mis-named 'euthanasia', in Germany in the late 1930s and during World War II not surprisingly meant that popular support for the legalising of medical involvement in the ending of life waned in the 1940s. In 1950, the World Medical Association, of which MASA was a member, 'recommended to all national medical associations that euthanasia be condemned under any circumstances'.[48]

Post-World War II, the dying process was more extensively medicalised. As Caitlin Mahar has put it, the 'care of the dying [became] a branch of medicine requiring specialised knowledge and skills'.[49] These included modern therapeutics and pharmacology, which since the late nineteenth century had produced significantly more potent substances to which registered doctors, dentists, pharmacists, anaesthetists, and veterinarians had legitimated access. Morphine and cocaine were especially used for pain alleviation. In palliative care, these were combined with an alcoholic drink in the 'Brompton cocktail'.

From 1952, South Africa banned the importation of heroin, allegedly to 'no resulting inconvenience […] or unfavourable reaction on the part of the medical profession'.[50] Southern African doctors, therefore, relied for pain relief on prescriptions of morphine and a widening range of synthetic analgesics.[51] Some doctors, especially at remote hospitals, however, reported great difficulties in securing adequate supplies of effective painkilling drugs. In addition, as one doctor later recalled, at that time nurses were often reluctant to administer doses of morphine 'larger than (at the most) half a grain, because they had been taught that this was the maximum safe dose'.[52] He overcame the problem by omitting the per teaspoon opium dosage on the labels on the Brompton Cocktail bottles issued to the wards. Nurses, in his view, had not been sufficiently instructed in the need for escalating pain control; regarded suffering pain as inevitable; and were not always motivated to give medicines frequently since they were faced with burdensome administrative requirements, doses of morphine or 'allied drugs' having to be recorded every four to six hours.[53]

Organised faith systems, theologians, theoreticians of the emerging secular discipline of medical ethics, authors of fiction, and medical professionals all participated in twentieth-

century debates about euthanasia and compassion.[54] Published shortly before his own death during heart surgery in 1956, South African author, intellectual, and politician H.I.E. Dhlomo juxtaposed physician and priest in his short story 'Euthanasia by Prayer'. In it, he powerfully punctures the hubris of modern medical scientists in the face of the immanence of death.[55] Doctors, rather than family or religious officials, were, however, increasingly overseers of the dying patient. As the locus of death shifted from the home to the hospital, individual 'medical "assisting of death" became far less possible', and instead 'the management of the dying could be the work of many hands'.[56] These could include doctors of different specialities, but also nurses, all of whom were almost entirely untrained in end-of-life care until the 1970s, or even later, in South Africa.[57]

Our South African archival record and medical histories are largely silent on the many doctors and nurses, black and white, who, out of compassion, exhaustion, panic, feelings of medical impotence (alternatively grandiosity and hubris), lack of effective painkilling resources, or even callousness, intervened decisively to end life. A partial corrective can occasionally be glimpsed in autobiographies. Colin Froman's sardonic and sometimes harrowing account of his studentship at the University of the Witwatersrand (Wits) in the late 1950s and later career as a neurologist is one example. He describes 'the cancer ward' at the Johannesburg General Hospital, a 'whites-only' facility, in 1959:

> There were no euphemisms such as 'oncology'. There was no Hospice. So, the Professor of Medicine ran The Ward of Death. There was little to offer. Erythromycin, Digitalis, Mercurial diuretics. Morphia. The patients with disseminated cancer were admitted to die […] In the Medical Ward, everybody died.[58]

Sometimes, doctors and nurses collaborated in euthanasia. Froman writes that

> when the surgery failed [Sister Makiwane] established a ritual. She will screen the bed, summon [him, the doctor], and he would arrive, knowing that behind the screens, in an otherwise empty ward, she would be standing at the bedside of a man dying in agony […] The syringe and a substantial dose of morphine were lying on the tray […] Intravenous doses were given […] that were more than adequate for pain relief.[59]

Froman gives us further glimpses of the complicated and contradictory ways in which pity, compassion, and medical power could function. In the early 1960s, he was an obstetrics houseman at a maternity hospital. This was an 'era before […] prophylactic abortions and it was not uncommon to deliver encephalic and other severe deformations at full term'.[60] He worked with a senior doctor: 'When a patient produced a severely deformed infant, the infant was delivered, [he] would never let it breathe or cry. A bucket of water, or a swab down its throat sufficed […] The mother would get an immense dose of morphia'.[61] In such ways were disabled neonates were erased not only from life but also from the historical record.

Death as an uncertain consequence of necessary medical treatment, especially the administration of analgesics, was also a recognised risk. At Dr Hartman's trial, Professor Guy Elliott was questioned about Hartman's use of morphine. As he told a friend in private correspondence in late 1974, Elliott had been notified that he would be called by the prosecution as an expert witness on medical drugs at the trial. He did not however wish to regard himself as testifying *for* the state.[62] A respected senior advisor, Elliott had more than 40 years of medical practice experience and was chairman of the Drug Safety Committee of the Drugs and Medicines Control Council of South Africa.[63] He had been an elected member

of the SAMDC for quarter of a century. He testified that while increasing the dosage of powerful painkilling drugs was the accepted course of action, they could also asphyxiate the patient. Accordingly, he agreed that the course of treatment followed by Hartman in the hours before his father's death had carried an 'inherent risk involved albeit a calculated one, [in that] there is the risk of respiratory depression'.[64] Death would be an unintended side effect of necessary action. In other words, death would be the outcome no matter what, but its timing could not be precisely predicted. It was Hartman's decision to employ pentothal which would – as indeed it did – prove fatal within a 'precise moment of time'.

Elliott was fully aware of the directive advanced by Judge Devlin in *R* v. *Adams* in Britain in 1957, which 'rendered lawful the administration of pain-relieving drugs to the dying even when it is known they will accelerate death'.[65] The response of South African doctors to news of Adams' acquittal presaged those expressed by many physicians straight after the Hartman trial. According to the *Rand Daily Mail*, many doctors 'searched their conscience [and] pondered on the extent to which the law permits them to shorten life – to shorten it "incidentally"'. One doctor was quoted saying that if 'the actual administration of drugs brings about two distinct effects – the one the relief of pain, the other the shortening of life – the action is lawful'.[66]

Also referencing Pope Pius XII's endorsement of Devlin's direction not long before, a distinguished Johannesburg surgeon said:

> My conscience is at rest […] The Hippocratic oath made me swear 'I will give no deadly drug to any, that it be asked of me, nor will I counsel such […]' But I will give morphia or pethidine to a patient suffering agony with incurable cancer, though I know it may lead to deterioration in his condition.
>
> I know I may be shortening his life. But I am not killing him. The distinction is perilously fine, and involves one in an involved Socratic debate. If I shorten life, am I killing?
>
> In effect, I kill. But I kill within the law, and within the limits of my conscience.[67]

Another practitioner who debated the moral problem of 'mercy killing or pain palliatioń said bluntly:

> Doctors have mobile consciences – but they respect the law. Not one of us would agree to the recognition of euthanasia even if it was sanctioned by a panel of doctors, because of possible legal consequences […] In certain cases, doctors do […] 'put out' a patient where the prognosis is hopeless and he is suffering.
>
> It may be done with an overdose of morphia, or with an insulin injection. But no doctor will ever admit this happens.
>
> *I* do not admit it.[68]

If administered in high dosages, or to some patients, or in inappropriate circumstances, accidentally or intentionally, a range of medicinal substances could also result in death. Exogenous insulin inappropriately administered, for example, was the cause of death in dozens of murder cases, especially in Britain and the United States after 1946.[69] A 'perfect

weapon', at that time not subject to medical prescription and ostensibly undetectable after death, it was well publicised in popular detective fiction.[70] After the application of new forensic tests in 1957, the first case of 'murder by insulin' to be convicted was that of unemployed British staff nurse Kenneth Barlow. Even so, the evidence in the case was more heavily weighted towards circumstantial than toxicological proof, and only in the 1960s did scientific evidence become conclusive in 'insulin murder' trials.[71]

'A South African precedent to help Hartman'? Killing pain, medical ethics, and professional discipline

Insulin use for pain relief – or, possibly, to hasten the end of life – had also been central to a magistrate's court inquiry into the death of a hospital patient, Ramadimetja Tliane, a quarter of a century before Dr Hartman's trial. This 1950 case is recounted in some detail here to show how many doctors were convinced that extreme measures were justified in attempts to control patients' pain and to illustrate how difficult it could be to establish with certainty whether a medically induced death for a terminally ill patient had been accidental or the consequence of the deliberate intent to 'wrongfully, unlawfully and maliciously kill and murder'.[72] It also demonstrates that while it was commonly understood (but not openly stated) that medical misjudgements and transgressions would often be kept 'in house', there could be ambiguous interactions between doctor and attending nurse in which responsibility and decision-making could become confused. These factors were repeated at the Hartman trial in 1975, but with a very different outcome for the doctor.

In December 1950, a recently qualified doctor (Dr A.) faced an investigation into the death on 15 August of a patient under his care at the hospital in Pietersburg.[73] Following a train of action set in motion by the doubts expressed by a 'Native' staff nurse, a preliminary inquiry was conducted by the attorney general. On legal advice, the doctor surrendered himself for arrest at the Supreme Court in Pretoria but was released on bail to attend a preparatory hearing at the District Court at Pietersburg, in what according to *Rand Daily Mail* was the 'first case of mercy killing to come before a South African court'.[74]

At that hearing, part-time senior physician Dr Mackenzie told the court that some months earlier Tliane had been admitted with an incurable condition and that several treatments had been tried, to no avail. He had advised Dr A. 'not to spare the morphia […] She was in extreme pain, and we wanted her to die in reasonable ease'.[75] On 15 August, Dr A. saw Tliane at 11:40 pm, and he asked Staff Nurse Quono to fetch 'plain insulin'.[76] He administered no less than 200 units. Quono reminded him to enter the injection on the patient's chart, which he said he would do the next morning. (He did not.) Tliane was not at that time visibly in pain. Quono asked the doctor why he was using insulin, and he replied by asking her if she herself would 'like to be in Tliane's condition'. She said 'No', after which he said, 'Staff nurse, watch her carefully and you will see'. He left, and Tliane's condition deteriorated. Troubled, Quono reported to her superior, Sister Vorster, that an insulin injection had been given. Quono observed that the patient's pulse became weaker and that she 'was now really dying'. At 00:50 am, Tliane died.[77]

Members of the white and male-dominated medical profession and a senior woman nurse appear to have come together to shield the young doctor. In court, Dr Mackenzie testified that insulin would not usually be a treatment under the circumstances but commented that the houseman might have 'decided to try to improve a patient by insulin'.[78] He nonetheless agreed that the amount administered was excessive. Dr Lombard, the hospital superintendent,

testified that on the day after the patient's death he had been away, but said that the district surgeon had decided that a post-mortem would be 'no use' because insulin 'left no characteristic post-mortem signs'.[79] He also told the court that 'a medical man […] with a patient in extreme pain [might use almost anything that might relieve it]'. He himself had once used 'cobra venom to relieve the pain of a man who was having large quantities of morphia [and had also] resorted to the use of insulin'.[80]

Intentionally or otherwise, Sister Vorster cast aspersions on Quono, commenting that her relationship with Dr A. had not been as positive as it was with other doctors. Vorster denied that injections given at the hospital were always written up on the charts, saying there was no definite rule about this. Questioned, Quono conceded that, rather than seeking her condonation of an intentionally lethal action, perhaps the houseman had only meant for her to report any further change in Tliane's condition.[81]

Asked the rhetorical question of why the doctor would have asked Sister Quono to watch Tliane carefully after telling her that he was going to inject Tliane with insulin, Dr Lowen - appearing for Dr A - alleged that the doctor may have acted 'stupidly' and miscalculated the amount of insulin he believed would ease Tliane's pain. The possibility of Dr A. not wanting Tliane to die alone but abdicating the responsibility for staying with her while she did so was not raised by either the court or the witnesses.

The Pietersburg hospital dispenser was called to court during an adjournment requested by the prosecution. Lowen then resumed questioning Lombard – who had already given five hours of testimony over several days of the hearing – who explained that unless kept in a cool place, insulin could lose its 'potency', and testified that much of the hospital's insulin stock had passed its expiry date.[82] After this evidence, the chief magistrate agreed with Dr A.'s colleagues that he should not be put through the 'agony of a trial' and that it had not been proven that the patient's death was caused by an insulin injection. The case against Dr A. was dropped.[83]

From this distance of time, it cannot be known whether Dr A. had intentionally hastened his patient's death in an act of compassion or if he simply blundered. The case was well publicised at the time, yet no official record of it was available to Dr Hartman's defence in 1975, nor was it directly quoted at his trial. In fact, we know of its existence only through the archived correspondence of Guy Elliott, writing to a colleague in late 1974 while he was preparing for the Hartman trial. He wrote that he remembered the case and had searched for records of it but could find any that had been kept by the SAMDC. Over the next few months, he went to some considerable trouble to get copies of press clippings from 1950. These showed that he had correctly remembered that Dr A. had not been found guilty of murder. Elliott passed this information on to 'the local legal men', because he was 'trying to trace a S. African precedent maybe to help Hartman'.[84] Because of Dr A's acquittal, however, there was no legal precedent that allowed mercy killing. As discussed below, Elliott's expert testimony given in March 1975, therefore, had to take a different slant, one that highlighted the individual and psychological factors that had led to Dr Hartman's actions.

Elliott was called as an expert medical witness but was also motivated by his own personal and professional sympathies with Hartman, who had graduated from Wits in 1952. Although not mentioned at the trial, it is likely that Elliott had taught Hartman. Elliott had published a compilation of his lectures as the short book *Medical Ethics* in 1954. It reproduced the Hippocratic Oath, the Declaration of Geneva of 1948, the International Code of Medical

Ethics of 1949, and the declaration taken by Wits medical students.[85] The book also outlined the planes in which a medical practitioner operated, describing these as three axes: 'the relationship of the practitioner to the patient; […] to his colleagues [and to] the community'.[86]

In illustrations which reflect the white paternalistic medical profession of South Africa in the mid-twentieth century, he described a number of practical situations in which doctors might face ethical dilemmas. He nonetheless repeatedly underscored that the 'most important influence controlling a doctor's conduct [is his] *conscience*' and underlined that all medical practitioners should be familiar with the law. Above all, he said it was the doctor's duty to 'ensure the welfare of the patient' whose interests should always be placed before those of the doctor.[87] For Elliott, 'it is helpful to remember […] that it is the privilege of the doctor to cure sometimes, to relieve often, to comfort always'.[88]

As Roger Cooter has put it, critical studies of medicine have shown that, far from being a positivist story of progress, in practice 'medical ethics is about power, or struggles for authority in medical decision-making'.[89] Indeed, Solly Benatar and Trefor Jenkins noted that in the mid-1970s professional ethical codes, including those of South Africa,

> while viewed by most practitioners as designed to protect the interests of their patients […] were as (if not more) intimately concerned with protecting the interests of the profession itself and with relationships between members of the profession as with the welfare of individual patients.[90]

The professional interests of the doctors were the concern of MASA, an elective organisation. Especially from the 1950s, 'the language and the debates of the MASA increasingly came to reflect a conservative, white, male profession comfortable within a racist society'.[91] On the issue of euthanasia, it remained silent after 1937, and its members operated within the framework of physician-independence in deciding when and whether to end the life of a suffering patient or to extinguish that of a disabled neonate.

The statutory body, the SAMDC, had been established by the Medical, Dental, and Pharmacy Act of 1928 for the registration of medical practitioners. It had the authority to regulate doctors' conduct and to maintain standards of practice and training. The SAMDC also had quasi-judicial powers over the profession. These included the power to subpoena and investigate medical personnel against whom a [legal] charge had officially been made. Queries about misconduct were first heard at a gate-keeping preliminary inquiry. If it was decided that there was a *prima facie* case against a doctor, this was followed by referral to the SAMDC's Disciplinary Committee. The screening authority of those entrusted with preliminary inquiries was extensive. In 1954, Elliott noted that 'of those complaints that are laid before the [SAMDC], not more than 1 per cent go to the length of a formal enquiry; the remainder are dismissed as frivolous, baseless, or unprovable'.[92] When they were held, the *South African Medical Journal* (SAMJ) often published the details of these findings 'as a service to our readers and to keep them informed of and put them on guard against malpractices'.[93]

The SAMDC had the statutory right to direct that its hearings, either in full or partially, be held *in camera.* This option was apparently seldom exercised, however, since the intention of the hearings was to be seen to discipline doctors. One example of such a hearing that was open to the public was the high-profile case of Dr Anjini Singh and Professor Derk Creighton

in Durban in March 1973, charged with performing unlawful abortions. Elliott served as a member of that disciplinary committee.[94] Even so, the SAMDC was not obliged to act on the committee's recommendations and censure of a doctor – by temporary or permanent suspension from the medical register – would be ratified by a full meeting of its council.

Since the Pietersburg magistrate had decided to drop charges against Dr A. in the 1950 'mercy killing trial', the issue of his (at best unconventional) conduct was not reported to the SAMDC. Nor, apparently, were any of the cases of mercy killings owned to by doctors in the press in 1957. Rather, the medical profession, the SAMDC, and the courts tacitly avoided direct consideration of the reality of unlawful medical mercy killings. By the 1970s, this untenable situation became even more fraught as medical and legal opinions about the roles and responsibilities that 'good doctors' carried towards dying patients were shifting away from assisting dying towards providing 'heroic' life-extending measures.

Good doctor? Doctors defining and debating death, 1960s–1970s

Life expectancy rose in South Africa in the 1940s and 1950s, especially for whites; as elsewhere, this was accompanied by a greater prevalence of chronic illnesses, including cancers. In general, increasing numbers of people were dying in hospital facilities, and then, as now, South Africa's medical landscape accommodated both extreme privilege and the most rudimentarily equipped hospitals. Even where available, late-life home 'care' was gendered and primarily undertaken by untrained family members, often daughters, or poorly remunerated domestic workers.

By the 1960s, significant medical-scientific interventions in the extension of life for some terminal conditions had been achieved. New medico-legal challenges were most evident for doctors conducting high-risk surgical interventions, but also had a widening impact on general practitioners. These were addressed in a growing number of published articles, many first presented at South African medical conferences. These intensified in the years surrounding the world's first successful heart transplant in Cape Town. At the MASA annual congress in July 1967, several papers addressed definitions of life and death. One discussed the difficulties of precisely determining 'the moment of death', adding that,

> whereas doctors used to be concerned to avoid premature certification of death, they are now faced with pressing ethical problems [such as] when are they entitled to pronounce life extinct? Life in the sense of an independent vitality may cease, yet tissues and organs may be kept 'alive' or 'in a living state' by artificial means […] Legal issues are now pressing.[95]

There were notable South African successes in renal and cardiac surgery. Some have suggested that ethical laxity regarding the definition of death and a lack of professional accountability facilitated the timing of Christiaan Barnard's successful heart transplant surgeries in Cape Town, the first on 3 December 1967.[96] More directly, unlike other countries competing at the time for the medico-scientific breakthrough of human heart transplantation, South Africa did not have 'guidelines for the diagnosis of death of beating heart donors'. Only when Raymond Hoffenberg (the consultant on call to care for the heart donor during the second South African transplant) could no longer elicit neurological reflexes was he prepared to agree to the removal of a (still beating) heart.[97]

Specialists and legal authorities continued, across the world, to debate the terminus of life and the onset of death. In August 1968, the *Journal of the American Medical Association* published the report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. It defined 'irreversible coma' as a new criterion for death. According to the committee, these new criteria were needed because of the 'great burden that trying to revive irreversibly comatose patients put[s] on the patients themselves, their families, hospitals and the community'.[98] Perhaps it was that understanding of death which, spurred by desperation, helps explain Dr Hartman's later insistence that he was seeking to put his father 'into a coma from which he would never come out again' when he added pentothal to his father's drip.[99]

In the early 1970s, tending to the dying was frequently discussed in South Africa, as well as in international medical journals. Whereas in his book *Medical Ethics,* Elliott had prevaricated on the question of whether doctors should fully inform terminally ill patients of their prognosis, Dr Turner of Humansdorp argued in 1973 that, 'of all the ways of dealing with death, the one most surely doomed to failure is the attempt to ignore it. Part of the picture is ugly, and part of it is painful, but a great deal can be done to mitigate the suffering.'[100] Turner paid attention to the relationship between doctor and patient, and the need for the physician's own self-awareness so as to be a 'good doctor' with 'psychological balance and emotional stability'. He cautioned that the doctor 'dare not be caught in a web of emotions'. It was the responsibility of 'the doctor [to] do his duty towards the patient, even in these last moments, to prevent death if possible'. He concluded: 'We are all human, and all have our appointment with death. What will we expect from the doctors at our deathbeds? What we expect we must be prepared to give.' Turner baulked at euthanasia, however, concurring with the British Medical Association's 1970 statement that

> what was needed was not legislation but more resources for the care of the elderly and chronically sick and a change in attitude towards them. We cannot accept the responsibility of such legislation, as no adequate safeguards can be provided […] To be a trusted physician is one thing but to appear as a potential executioner is quite another.[101]

South African psychologists and psychiatrists were also increasingly mindful of the needs of the dying and the frequent inadequacies of doctors in the face of imminent death. Referencing medical, legal, and ethical studies, including those by Elisabeth Kübler-Ross and Cicely Saunders, as well as Solzhenitsyn's *Cancer Ward*, a 1972 paper presented by a senior psychiatrist to a Cape Town symposium on 'The Care of the Dying Patient' stated that 'the medical profession has failed in its obligation relating to the psychological care of the dying patient […] Doctors are abandoning their patients at a time when they are faced with the greatest emotional crisis of their lives.'[102]

The following year, a senior radiologist at Groote Schuur Hospital published a review essay in the *SAMJ* titled 'Care of the Dying'. The author considered the deathbed experience for both the physician and the dying patient. He defined the latter as one for whom 'all further active and supportive treatment is without avail, and whose death seems a matter of certainty within days or, at the most, a few weeks'.[103] Unlike Dr Turner, he was of the view that 'there should be no drama. No dialyses and no transfusions […] Above all this, [the patient] needs warm, human fellowship and support.' He wrote, idealistically, of the 'privilege of watching someone achieve perfect serenity [in death and that] the doctor cannot always be the great comfort and strength to his patients-sometimes strength flows the other way. To be able to

show himself as weak, fallible and human to his dying patient, may be just what the patient needs most.'[104]

By the 1970s, a profound new dilemma was therefore created: when ought doctors refrain from attempting to prolong life and delay death? Supreme Court Judge Victor G. Hiemstra addressed a medical congress in August 1974 on these issues. In his view, medical doctors were in danger of becoming not the 'saviour and friend of the patient, but his tormentor […] who [acts not to] save life but [instead who] prolongs it into meaningless agony [during which there were many] operations and medication which are technical triumphs but [that] are abominations when seen from the angle of human suffering'.[105]

Unlike the abortion law reform movement of the early 1970s, there was as of then no discernible South African civil, medical, or political lobby pressuring for legal reforms that would permit, let alone regulate, doctor-assisted dying.[106] Yet Hiemstra's address was widely reported in the English-language press and found a receptive audience amongst some. One was a retired and widowed nurse, Sylvia Kean, who in Hilton – outside Pietermaritzburg – formally established the Voluntary Euthanasia Society of South Africa on 14 September 1974. The organisation's aim was to have legislation passed that would permit passive euthanasia. For three months (notably before Mr Hartman's death), she canvassed support for the initiative. The society was soon renamed the South African Voluntary Euthanasia Society (SAVES), and Mrs Kean liaised with the Voluntary Euthanasia Society (VES) in England, which sent her 'advice and encouragement'.[107] Mrs Kean wrote directly to Judge Hiemstra, to the United Party's Dr Ephraim Fisher, and Dr Marius Barnard. Harry Grant-Whyte, former professor of anaesthesiology at the University of Natal, immediately agreed to become the chairman of SAVES and was energetic in this role over the next decade.[108] Along with Guy Elliott, Grant-Whyte had been re-elected as a member of the SAMDC in 1973, for a five-year term.

In 1974, Judge Hiemstra could see no imminent need for a resolution to the conundrum posed by euthanasia. 'We', he wrote, 'shall have to take stock of our position in regard to the sustaining of life in circumstances where it has become meaningless and an intolerable burden'.[109] He predicted that 'gradually and silently, the solution will have to come in the minds of the doctor and of the dear ones of the patient […] A deep sense of responsibility will open the door to difficult decisions which depend upon moral judgement.'[110] A mere two weeks later, however, events were set in motion which would oblige the court to address the issue directly after Dr Alby Hartman exercised his moral judgement and intervened to end the suffering of his dying father. He did so in an act of desperation but also, as the trial transcripts clearly show, in the reasonable expectation that he was not committing murder and that his actions would be understood by other medical practitioners and witnesses.

'A lonely dilemma'?

Dr Alby Hartman moved to Ceres in 1973, where he joined a busy general medical practice with Dr Philip Conradie Basson. Both doctors were also assistant district surgeons. In August 1974, his father, Mr Glen Hartman, was discharged from the H.F. Verwoerd Hospital in Pretoria with the advice that he be 'removed to a hospital for the chronic sick'. Glen Hartman was fragile and in extreme pain because of disseminated cancer. He had repeatedly told his sons that he would 'never go to an old age home', and it was agreed that he would be admitted as a private patient at the hospital in Ceres.

In two statements given to the police after his father's death – the first on 13 September, the second 10 days later – Dr Hartman detailed the last weeks of his father's life. The distressing details were recounted at the trial and in the media coverage of the time, and some are repeated in this article to illustrate the enormous and conflicting demands on Dr Hartman as a physician and a son.[111] There was no disagreement that, technically and legally, Dr Hartman had actively ended his father's life by adding pentothal to his intravenous drip. What the trial transcripts show, however, is Dr Hartman's own calculus of compassion, which took into account the quality of his father's remaining life; the inability of medication to quell the pain in spite of his best efforts; the dignity of his patient; his responsibility as a doctor; and an understanding that the cause(s) of death was neither singular nor immediately proximate.[112]

The transcripts also show that decisions to end suffering in the final stages of life were often taken by a doctor within a small circle of witnesses, but not entirely alone. In the small hospital at Ceres, these witnesses were nurses. Communication between patient and doctor, between doctor and nurse, and between doctors was often unspoken – conveyed in bodily gestures, tones of voice, eye contact, touch, or even silences. Mediated by professional rank, gender, social class, and race, such vital transmissions of intent, emotion, consent (or refusal), and affect were of no formal interest to the court in reaching its verdict and do not appear in the law reports or summary case notes. What they make clear, however, is that Dr Hartman's decision became known to legal and medical authorities only because that small circle was breached by one of its members. Dr Hartman and the nursing sister on duty on 11 September 1974, Sister M.H., were sometimes at odds with each other, and she did not always follow Dr Hartman's instructions, possibly complicating his medical decisions.

Ten days after his admission, Mr Hartman experienced a marked deterioration. Dr Hartman was summoned and, initially diagnosing a pulmonary embolism, gave 'energetic treatment'. As he told the court: 'It was thought by all, including me, that he was dying. […] I lay on the bed next to him and at some time during the evening I asked [that the nursing sister on duty] administer 100 mg of Pethidine by injection. I waited for him to die'.[113] To everyone's surprise, the following morning Mr Hartman seemed revived, and Dr Hartman decided that 'it was not my father's time to die yet and I would do everything possible to keep him alive as long as he was *compos mentis* and able, at least, to understand what we were saying'. However, Mr Hartman worsened again, and he seemed to be 'just alive'.[114] Concerned that his father had habituated to the opiates with which he had been treated for years, sometimes beyond the prescribed dose, Dr Hartman changed the medication, and his father rallied a little. Mr Hartman's physical discomfort, however, did not abate and injections caused him 'agonizing pain'. Thereafter, Dr Hartman instructed that all his medication should be given intravenously. The initial dosage of 100 mgs of Pethidine per bottle of intravenous fluids was soon doubled. Dr Basson criticised Dr Hartman, saying that he was 'prolonging the agony'; and Sister M.H. asked him whether he 'was going to continue with it'. Dr Hartman explained that his 'attitude was that as long as my father was able to understand and talk to me, I was going to let him live'.[115]

On the evening of 11 September, the deferred but anticipated crisis occurred. Dr Hartman and his wife, Jan, arrived at the hospital to find Mr Hartman semi-conscious. There were multiple indications that he was now actively dying. Evidently still experiencing pain, he could only respond faintly. The Hartmans returned home briefly, but Dr Hartman decided to return to the hospital to be with his father, 'as I had made up my mind to stay with my father for the rest of the night'. Before he left his home, he telephoned the hospital and requested that Sister M.H., who had recently come on duty, give his father half a grain of morphine. He acknowledged

the dose was large but justified that it was clear that his father no longer benefited from lesser doses. Sister M.H. refused because she felt such a dose was 'a bit stronger than the normal […] [was] more than required […] [and] that she had never given a dose that big before'.[116] She told Dr Hartman that she required written instructions.

Under examination, it surfaced that there had been tension between 'Sister M.H. and Dr Hartman. When the doctor returned to the hospital, Sister M.H. had not yet seen Mr Hartman, being, she explained at the trial, first busy in the 'Non-European section'. After going back to her 'European office', she found visitors there: her husband, the local captain of police, and the hospital administrator, as well as another nurse. An irate Dr Hartman ordered them to leave. Friction escalated between them as she prepared Mr Hartman to receive the injection, as she seemed to have forgotten the doctor's earlier instructions as to how it ought to be done. She then gave the injection and left the room. She described that Dr Hartman was in 'an agitated state' at that point.[117] Ten minutes later, she met him in the corridor, and he gave her further instructions to put up a new infusion, which she understood to be for 200 mg of Pethidine. She did not follow Hartman's instruction, however; she also did not tell him that she did not do so but rather followed her own conviction that it would have been 'too much' in addition to the half grain of morphine.

Sister M.H. directed two junior nurse aides, classified as 'Coloured' under apartheid law, to check in again on Mr Hartman, but she herself attended to the next infusion (of dextrose and saline, still not adding Pethidine). She then went to the 'Non-European side' of the hospital, from which she was soon summoned to meet Dr Hartman in her 'European office'. This was at about 10:00 pm. There he instructed her to prepare a second injection of morphine. She showed reluctance, and he 'ordered' her to do so. She then fetched the drug from the designated dangerous drug cabinet. Asked about Dr Hartman's demeanour at that point, Sister M.H. said that he seemed somewhat calmer than previously and had embarked on a 'sort of conversation' with her and the two junior nurses who were present.

It was at this point that Dr Hartman signalled – by means of rhetorical questions reminiscent of those by Dr A. to Nurse Quono in 1950 – that he had made the decision to end his father's suffering. Sister M.H.'s testimony to the court were hazy about some of the details, but she stated that Dr Hartman said that 'if your father was screaming in agony if you could help him, wouldn't you help him?' She said she could not recall her reply or what further was said. Prompted, she recalled that Dr Hartman had said that 'his conscience was clear […] he had said goodbye to his father'.[118] She was shocked but followed the instruction to draw up the morphine into a syringe, which Dr Hartman injected into the drip.

Dr and Mrs Hartman 'waited for the end to come', but Mr Hartman did not die. Even so, the doctor and his wife (who had returned to the hospital) felt that his 'spirit had already left his body and there was no longer any case in prolonging the agony'.[119] Sister M.H. was again called, and this time Dr Hartman asked her to give his father two ampoules – totalling 500 mgs – of pentothal. These she gave, with a syringe, to Dr Hartman. Again, she recalled she had been shocked but had not openly remonstrated with him. Again, there were two junior nurses with her when she received the instructions. Dr Hartman 'mixed the injection and drew it into the syringe' himself. He was not as agitated as he had been earlier in the evening. She asked him if he was going to give the injection himself, and he replied that he would not ask anyone else to do what he himself was not prepared to do.[120]

According to his own statement, around 11 pm Dr Hartman leaned close to his father's ear and said, 'I am going to make you sleep. Do you mind?'[121] Mr Hartman vaguely nodded his head. Dr Hartman said that he was tormented by the thought that his father might yet emerge into sufficient consciousness and that his only remaining living experience would be that of pain that even two doses of morphine had failed to contain. 'It seemed as if morphia did not touch him […] All I could think of was a low dose of pentothal […] to put him more peacefully to sleep.' To a direct question of Judge van Winsen, he acknowledged that he had fully understood what the consequences of this action would be – that it would kill his father. Even so, he said: 'I took the decision […] I had a moral obligation towards my father and I was prepared to take that step.'[122] Slowly, he began to add the first ampoule to the drip and death followed in seconds.

The next day Dr Hartman filled in the death certificate. As the cause of death he entered, 'Prostraat Karsinoom met uitsaksels' (disseminated prostate cancer). Had he certified that death had not been due to natural causes, this would automatically have been referred to a magistrate. Struggling to explain this to the court, he said that he could and would not expect any other doctor to sign what was, he acknowledged, a false certificate. In a rationale that drew on a code of ethics that accorded him, a medical professional, the responsibility of acting in the best interests of his patient, he knew, he said, that 'someone would come and talk to me', but he 'hoped that somewhere along the line someone would have understood what the situation was'.[123] Drawing a fine, but important distinction, he denied that he had wished to avoid an inquest but was prepared to face an official enquiry.

To understand the difference, we should note that Dr Hartman believed he had made his intentions clear by asking the staff for pentothal. As he told the court: 'The circumstances to me were compassionate. Everyone in the hospital knew what my father's condition was. Everyone knew that he was dying.'[124] He expected that his actions would be understood and accepted, and expected that nothing would be said about the pentothal. Instead, at eight the next morning Sister M.H. reported to the hospital matron that, in front of her and the two nurse aides, Dr Hartman had made it clear that he was about to end his father's life. The procedures which would lead to his arrest were thus triggered, as was his later conviction for murder.

Had Dr Hartman not been so emotionally distraught and open about his intentions, and, especially, had he not put Sister M.H. in a compromised position in front of the nurse aides, Mr Hartman's death could well have gone unheeded by the police and legal authorities. Indeed, the post-mortem conducted on 16 September could not determine the cause of death. In fact, the clinical findings, an expert stated, would have indicated that death was caused by cancer, pneumonia, and 'general debility'.[125] However, with Dr Hartman's testimony to the police that he had administered pentothal, forensic tests identified a lethal amount of phenobarbitone (which derives from pentothal). As Judge van Winsen said in his summation:

> It 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 none the less 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.[126]

‘A peculiar crime … within a tight [medical] circle’?

The verdict of guilty being certain, grounds for extenuating circumstances in mitigation of sentence were presented to Van Winsen on 20 March 1975. In this, the defence, led by Mr Gerrit van Schalkwyk, drew extensively from Elliott’s testimony. Elliott did not endorse euthanasia and said that he could not envisage how euthanasia could be ‘controlled’ and agreed that ‘euthanasia would open the door to abuse’. Instead, focusing tightly on the particularities of the case, both Van Schalkwyk and Elliott advanced the view that Dr Hartman had experienced extreme stress and pressures unlikely to be encountered by most medical professionals, and which could not be duplicated. Elliott testified that it was not unlawful, although it was undesirable, for a medical doctor to treat his own family members. In this, Dr Hartman – a son treating his father – had been exposed to conflicting interests that had impaired his judgement. In Elliott’s view,

> there must [have been] a very considerable conflict […] where you have double interests and there is conflict between those interests. This in itself is a cause of stress and anxiety and may inhibit decision-making and judgement. So that is if you add up all these three forms of stress, the doctor/patient, father/son and the fact that there is conflict […] Very, very great stress, which influences what you are doing […] [and] the sentimental aspect of the relationship allows itself to obtrude on the professional.[127]

In effect, Elliott provided an acceptable compromise that would be agreed on by the court: Dr Hartman had committed a murder but had done so for compassionate reasons while under unbearable pressure, a pressure that could have been avoided had he not personally and almost solely tended to his dying father but had abrogated that responsibility to another doctor.

Van Schalkwyk also turned to Elliott’s evidence in arguing that, ‘in this case of mercy killing’, the legally and medically correct course of treatment for Dr Hartman could have only been in the administration of even more morphine, which itself was a ‘calculated risk’ and which, ‘on Professor Elliott’s evidence’, would come ‘perilously close to murder […] In circumstances such as these the lines become blurred.’ Instead, Dr Hartman had merely chosen ‘a more direct way’.[128] He also put forward the view that so unusual were the circumstances that there was no need for a harsh punishment to be handed to Dr Hartman to deter others. Mercy killings by doctors were almost unheard of in England and elsewhere, he said.

In response, the state’s prosecuting lawyer, Frank Khan, rehearsed the ‘slippery slope’ argument: permitting mercy killings would break the relationship of trust between doctor and patient, would undermine ‘respect for the sanctity of human life’, and could open the door to abuse.[129] In his view ‘medical men are morally tempted every day […] They feel a small pity for a man in this situation, they are tempted to do it, the temptation is there. Too lenient a view by the Court might make people follow through with this temptation.’[130] Van Winsen was unconvinced, however, that medical professionals, whom he termed ‘a responsible professional body of men’ [sic], would act irresponsibly. Finding certainty where in fact there could be none, he could ‘hardly see that one must assume that this is a widespread practice’.

Khan then turned to the role of the criminal law in ‘protecting society’ by curtailing the freedom of the individual, citing ‘the utilitarian theory which must be balanced with the

moral guilt […] of the accused. This Court [Khan said] must strike a fine balance in so far as what the accused has done and the effect based of his deed on society.' Yet both Khan and Van Schalkwyk, as prosecutor and defence, were in agreement that in pronouncing punishment the Court could be lenient towards Hartman because he would be 'dealt with by a Medical Tribunal'.

For Van Schalkwyk, 'the mere question of conviction, the fact of a conviction of murder, the stigma which that must carry for a brother, a sister, a son or a medical doctor […] is far the greatest deterrent than any punishment as such could ever be'. Indeed, the prosecution concurred, and it was Khan who suggested that Van Winsen 'might consider in this particular case of possibly postponing sentence and seeing what action is taken by the Profession'. In his view, 'the inevitable result, the worst punishment that anybody could impose would come inevitably from the Medical Council. The accused has suffered today, we have convicted him of a criminal offence, but his punishment is not complete'.

Khan added: 'This is a peculiar crime, it is peculiar to the medical profession, they live with this problem. This is a medical practitioner we are dealing with; this is not a member of the public who has committed this act of murder'. He agreed that Hartman had

> kept [his actions] within a very tight circle [hoping] he would receive sympathy from people. He spoke to the two nurses, he tried to make them understand […] He had the feeling that this matter would be hushed up within the confines of the hospital. He felt that the medical circle […] would form a ring around him, together with the nurses.

However, should Dr Hartman be 'struck off the medical register, either permanently or for a period of time, he would have received extreme punishment for his act'. In effect, Khan – for the state – was suggesting that the SAMDC should take responsibility for deciding the punishment of a special category of murder, a mercy killing.

Van Winsen was not persuaded, saying that he would not 'know who is leading under those circumstances'. Van Schalkwyk concurred that sentencing could not be delayed as, 'with respect to the Medical Council', in their deliberations 'all sorts of factors, hearsay evidence, irrelevancies' could influence their findings. We do not know precisely to what extent Elliott influenced this view, but, along with similar expressions of aversion to euthanasia by other senior medical-scientific experts who had testified on forensic matters, his status as a member of the SAMDC likely bolstered the court's confidence that there was no question that the council would express a strong censure against Hartman. The exact determination of the penalty could not be known, however, as the SAMDC had no recorded precedent on which to draw. As one lawyer commented: 'The sentence passed the buck to the Medical Council, which would have to do some quick thinking on how they were going to deal with Dr Hartman.'[131]

The bounds of compassion

This thinking had to take into account widespread popular support for Dr Hartman, as recorded in the daily press: one account described that, after the court had risen, for 'fully 15 minutes [Dr Hartman] was followed round the precincts of the court by people who wanted to congratulate him and pat him on the back'.[132] On his return to Ceres, he was welcomed with flowers and received dozens of messages of support from well-wishers, and was visited by 'six Coloured nurses from the nearby hospital'.[133] Moreover, many of the medical fraternity

were similarly well disposed to Hartman. Nor did the SAMDC appear to be immediately concerned with censuring him. He began a new practice in another small town, Montagu. It was almost a full year after his trial, on 3 March 1976, that the council's Disciplinary Committee met.[134] As expected, this body found that Hartman had indeed been guilty of 'disgraceful conduct', but it echoed the court's extreme lenience in the matter of penalty. It recommended that Hartman should have his medical license suspended only for a year, and, again, that even this punishment should be suspended for twelve months. Effectively, Dr Hartman was to pay no price despite being convicted for the killing of a patient.

In a rapid reversal, however, in June 1976, the Disciplinary Committee's recommendations were overridden by a full meeting of the SAMDC, chaired by its recently appointed head, Professor Hendrik Snyman.[135] Hartman had the right to apply for reinstatement, and his application was heard by the full Council, on 21 October.

In his motivation to the council, Dr Hartman dismissed the view that 'he had undermined the confidence of old people in the medical profession', and said that he had 'received hundreds of letters from old people and people with elderly parents who had pledged their faith in him'.[136] Indeed, he proved to be something of a hero in his predominantly white Afrikaans-speaking community, and, according to a press report, petitions in his favour were signed on behalf of 15,000 people and submitted to the SAMDC.[137] These supporters included the mayor and members of Montagu, residents of the town's whites-only old age home, Montagu's Coloured Management Committee, the Rapportryers, Lions International, the Nederduitse Gereformeerde Kerk, and the Langeberg Farmers' Society.[138]

The SAMDC's meeting lasted only 50 minutes. The *Rand Daily Mail* reported that, 'after considering the appeal *in camera* […] Snyman tersely told waiting Pressmen in Pretoria that his Council had decided not to grant Dr Alby Hartman's application'.[139] Hartman would receive the strongest penalty the council could mete out and was struck off the professional register.

Without extant records, and especially because these meetings were held *in camera*, the reasons for the council's at first slow response and its Disciplinary Committee's initial reprimand (but no more) of Hartman and its later sudden turn-around and decisive disciplining of Hartman by the full council are unclear. Changes in the composition of the SAMDC due to new legislation simply may have delayed the Disciplinary Committee's meeting. Even so its members, no matter how sympathetic towards Hartman, would not have openly endorsed active euthanasia, which was – and is not – sanctioned by the World Medical Association. The influence of Snyman was considerable. He had extremely close ties to the apartheid government and its military and was a powerful man.[140] He has been attributed with making a personally driven intervention in Dr Hartman's case.[141] Indeed, according to a journalist who had interviewed Dr Hartman at the time, there was 'speculation […] that the council had succumbed to pressure from conservative political bodies and churches'. Even so, 'nothing was ever proved'.[142]

Vice-president of the SAMDC from 1960 and president from 1974 to 1980, Snyman was a prolific contributor to the SAMJ, which regularly published his views on medical politics. On the topic of mercy killings, he had strong convictions on where the bounds of compassion should be drawn. For him, as he told a symposium held in 1978, Hartman had been a victim of an *excess* of compassion that could put the standing of the profession itself at stake.[143] Snyman stated that he had been long 'convinced of the need for discussion' and had sought

on several occasions to form a 'contact committee' of the legal and medical professions on this and other medical matters.[144] He held firmly with the World Medical Association that 'the calculated hastening of death is equal to the illegal, deliberate causing of death of another person and is, therefore, murder, irrespective of the period of time elapsed taken'.[145] This was not his view alone, he said: the SAMDC 'has also at the first opportunity at which it was pertinent [after the trial of Dr Hartman] disapproved of involuntary active euthanasia as ethically objectionable and as a crime which calls for the highest penalty'. For him,

> the approval of any such active behaviour by the doctor […] also creates the possibility of abuse by persons whose conscience are lacking or blunted. This is also the dangerous terrain where unbridled compassion on the part of the doctor makes him forget his professional objectivity and act in a manner that he would not consider in lucid moments.[146]

Moreover, he was, he wrote 'not in favour of a policy of euthanasia through legal determination'.[147]

Snyman's views regarding Dr Hartman's mercy killing were consistent with those of many doctors worldwide. Yet, influential members of the SAMDC at the time of the trial, in March 1975, included several who were – albeit in different ways – sympathetic to Dr Hartman's plight as well as being staunch defenders of the profession's autonomy in disciplining its own members. Among them were Guy Elliott and Harry Grant-Whyte, appointed (as noted above, for a five- year term) to the Council in early 1974. This term of office was prematurely terminated however when new legislation, from October 1974, stipulated a new structure for the Council, it being reconstituted in 1975. Now, the majority of the Council's members were nominated by the apartheid government, not the medical profession itself. Neither Elliott nor Grant-Whyte were members of the new SAMDC which met for the first time in August 1975. Even so, the body's Disciplinary Committee decided to show leniency to Dr Hartman when it discussed his case in early 1976.[148]

Strong currents in South African politics between March and October 1976 may have prompted Snyman to exercise his authority over the SAMDC and to intervene to make an example of Hartman by insisting that he be professionally and publicly punished. Notably, after the Soweto Uprising in June of that year, the apartheid government turned more aggressively against dissent from any quarter, including from within its usual reservoir of white voters. With this demonstration of state strength over the SAMDC, the body, already largely supine and complaisant in apartheid negations of human rights, was cowed and, arguably, reached its nadir soon afterwards when it remained silent in the face of the neglect by doctors of an injured and dying anti-apartheid activist Steve Biko in 1977.[149] It would also be another 17 years before even passive euthanasia was permitted under South African law.

Conclusion and epilogue: Conscience, the politics of compassion and the creation of a 'non-law'

Before 1975, the South African courts were able to avoid sentencing medical professionals who carried out mercy killings. In March 1975, Dr Alby Hartman pled not guilty to the charge of murdering his father because, in his view, he had acted within the bounds of his conscience and had ended Mr Hartman's suffering, his life being already lost in all meaningful senses. Dr Hartman consistently held that he had been solely motivated by

compassion for his father. Inasmuch as it was able, within the confines of the law, the court concurred.

At the time, the sentence handed down was an innovative compromise, one which in part was brokered by Hartman's former teacher, Dr Guy Elliott, who acted in ways consistent with his own conscience. Tracing Elliott's involvement in the Hartman case, including his private quest to find a legal precedent 'to help Hartman', has also enabled us to explore aspects of then accepted (within a small, largely male and white circle of professionals) personal and political workings of medical ethics in South Africa up to the mid-1970s.

Elliott, the Supreme Court, and the SAMDC's Disciplinary Committee were all disposed to compassion and decided on only a formal reprimand for Hartman, a symbolic punishment. In declining to sentence him to prison, however, the court made him a 'criminal non-law': as described by legal scholar S.A. Strauss, Hartman was consigned to belong to a 'class of murderer whom [the courts] do not want to punish at all'.[150] Even so, Dr Hartman was forced to pay a heavy price – professionally, personally, and financially – for following his conscience. Struck off the medical register, he had to find alternative employment. He lost his medical practice and his home.[151] Yet, Dr Hartman remained convinced that he had acted correctly, saying: 'If I had had my life over, I would certainly do what I did again. I have absolutely no [guilty] conscience. I can face the world and say I may be guilty of 101 sins but ending my father's life is not one of them.'[152]

To pin responsibility on Snyman alone for the punitive censure of Hartman by the SAMDC, as several critics have done, downplays the considerable differences of opinion within the medical profession, which was as unlikely in 1976 as it is now to be close to consensus on the question of medical euthanasia. Nonetheless, outside the SAMDC, Dr Hartman's trial opened wide South African debates about medical professionals and legal interventions in ending suffering, a debate that continues today. The trial facilitated the discussion of both passive and active euthanasia in ways not possible beforehand. Those discussions drew in medical practitioners and scientists, theologians, academics, legal experts, and hundreds of members of the South African publics, many of them elderly and voicing feelings of vulnerability. Some doctors – the most outspoken of whom were Marius and Christiaan Barnard – soon spoke out in favour of active euthanasia. In 1979, the latter said:

> The time has come for doctors to practise 'active euthanasia' to put hopeless and suffering patients out of misery. Merely withdrawing life-support systems and halting heroic efforts to save the dying was not sufficient in some cases […] I have never practised active euthanasia but I believe there is often a need for it. We should get the opinions of society and have those who make our laws draw the boundaries for us.[153]

SAVES, the organisation advocating the legalisation of voluntary, passive euthanasia, emerged at the same time as, but was independent of, the Hartman case. In 1983, it claimed 5000 members across South Africa, and its chairman for more than a decade was Harry Grant-Whyte.[154] By that time, a Synod of the Nederduitse Gereformeerde Kerk had resolved that passive euthanasia was permissible.[155] By the end of the decade, news reports were claiming that a strong majority of white South Africans also supported 'assisted suicide' – in fact, amongst English and Afrikaans speakers there was more enthusiasm for euthanasia than for either abortion or capital punishment.[156]

As elsewhere in the world, during the 1980s the South African pro-euthanasia movement had many constituencies, with a 'complex constellation of motives – some murky and some indisputably humane'.[157] In late 1991, SAVES succeeded in convincing the South African Law Commission (SALC) to begin researching legal reforms with regard to 'euthanasia'.[158] In 1992, after an application to the Supreme Court, passive euthanasia by the withdrawal of the artificial feeding tube of Dr Fred Clarke, who had been in a 'vegetative state' for four years, was permitted.[159] In the same year, and shifting focus away from individual doctor–patient interactions, progressive advocates of an equitable healthcare system, such as the multiracial South African Health and Social Services Organisation (SAHSSO), repurposed the term. They identified inequalities in healthcare as itself creating 'apartheid euthanasia, where people (including neonates), many of them black, were left to die because of structurally unequal medical services.[160] By 1994, along with abortion and capital punishment, euthanasia – it was not specified whether active or passive – was a named issue for consideration in choosing a political party in the country's first democratic elections.[161]

The SALC concluded its report in 1997, called for public comments, and published proposed drafts of the 'End of Life Decisions Bill', in 1999.[162] It submitted the report to Minister of Justice Dullah Omar, who referred it to Minister of Health Dr Nkosasana Dlamini Zuma.[163] Omar proposed that the parliamentary ad hoc select committee 'consider the issue of active euthanasia'. In the late 1990s, democratic South Africa had affirmed the right to abortion and disallowed capital punishment. It seemed poised to change its laws in favour of medical mercy killing, or at the very least to allow for parliamentary debate on the issue.

But, more than 45 years after Judge van Winsen called for legislative changes in respect of mercy killings, and after more than a quarter of a century of democratic rule, no South African parliament has debated the legalisation of active euthanasia. Doctors still may not legally assist terminally ill and suffering patients to end their lives.[164] At the time of writing (late 2021), a South African high court has before it a request, brought by two terminally ill people, Diethelm Harck and Dr Suzanne Walter, for the lawful medical assistance in their dying.[165] That Dr Walter is herself a palliative care specialist, seeking a medically assisted death, is both poignant and potentially significant. Their appeal, however, is opposed by the Health Professions Council of South Africa (the successor body to the SAMDC) and by the offices of the ministers of health, justice and correctional services, and the national prosecutor. It remains to be seen if, under a transformational judiciary tasked by a constitution that enshrines rights to dignity as well as to health, it will be possible to break the deadlock and determine that a compassionate death may be legally enacted by a willing medical professional.

Acknowledgements

For their sustained interest, personal compassion, intellectual input, and years of support in the research and writing of this difficult topic, I owe deep thanks to Simonne Horwitz, Nancy Jacobs, Susanne Klausen, Alice Morrison, Steve Terry, and, especially, Thembisa Waetjen. I am also grateful for the generosity of the reviewers, and the editorial team of the *SAHJ*.

Note on the contributor

Julie Parle is honorary professor of history at the School of Social Sciences, University of KwaZulu-Natal, and research associate in the Department of Historical and Heritage Studies, University of Pretoria.

Notes

1 Cape Town Archives Repository (KAB), Cape Supreme Court (CSC), 1/1/1/2358, Case No. KS. 100/75, 'Record of proceedings of criminal case. The state versus Alby Desmond Hartman. Murder, 19–21 March1975'. The full transcripts of the trial and associated documents are held at the KAB, Following a typographical error in the published Law Reports, the case is usually referred to as *S v Hartmann* 1975 (3) SA 532 (C). The correct spelling however is Hartman.

2 'Compassion Was My Motive: Doctor Found Guilty of Killing his Father', *Cape Times*, 21 March 1975.

3 *S* v. *Hartmann* 1975 (3) SA 532 (C) 1975 (3) SA, Van Winsen, J.

4 *Ibid*., emphasis added.

5 *Ibid*. Medical mercy killings are defined here as the intentional ending of a patient's life by a medical practitioner, motivated by compassion. This is today termed physician- (or doctor-) or medically assisted death/dying.

6 KAB, CSC, 1/1/1/2358, Case no. KS. 100/75, 'The state versus Alby Desmond Hartman. Murder', 21 March 1975.

7 *Ibid.*

8 S. Ferber, *Bioethics in Historical Perspective* (New York: Palgrave Macmillan, 2013, Kindle Edition), 52. Ferber notes that 'Australia's Northern Territory (Rights of the Terminally Ill Act 1995)' was the 'world's first enacted law allowing [active] euthanasia, which came into force in 1996'. 'The country's federal government overruled the Act in 1997'. Ferber, *Bioethics*, 51. In 2002, the Netherlands was the first country to legally permit active euthanasia. The modern history of *passive* euthanasia, or the lawful intentional withdrawal of medical life support technologies by a physician, is usually dated to the late 1970s, the most famous case being that of American Karen Ann Quinlan in March 1976. In South Africa it dates to 1992. See below.

9 World Medical Association, 'WMA Declaration on Euthanasia and Physician-Assisted Suicide: Adopted by the 70th WMA General Assembly, Tiblisi, Georgia, October 2019', https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/, accessed 1 June 2022.

10 R. Cooter, 'The Ethical Body', in R. Cooter and J. Pickstone, eds, *Medicine in the Twentieth Century* (Amsterdam: Harwood Academic, 2000, Kindle Edition), 14–15.

11 *Ibid*., 14.

12 S v Hartmann 1975.

13 Michael Simpson, 'SA Doctor Banned for Euthanasia of his Father', *Health 24*, 30 September 2014, http://www.health24.com/Columnists/SA-doctor-banned-for-euthanasia-of-his-father-20140930, accessed 20 August 2021.

14 'South African Free in Mercy Killing of Father', *New York Times*, 22 March 1975.

15 'Expressions of Relief: Pats on Back for Freed Doctor; Hartman Verdict Causes a Stir', *Cape Times*, 22 March 1975.

16 ‘Barnard Backs Euthanasia’, *Natal Witness*, 24 March 1975.

17 ‘I Killed 11 Sufferers, Says Doctor’, *Cape Times*, 31 March 1975, emphasis added. In this article, I am primarily concerned with debates about the role of medical doctors in interventions to bring an end to the life of very ill, usually elderly, adults in great pain. Histories of neonatal euthanasia are not central to this article and will be more fully explored elsewhere.

18 M. Stolberg, ‘Active Euthanasia in Pre-Modern Society, 1500–1800: Learned Debates and Popular Practices’, *Social History of Medicine*, 20, 2 (2007), 205.

19 M. Manning, *Euthanasia and Physician-Assisted Suicide: Killing or Caring?* (New York: Paulist Press, 1998), 2.

20 *Ibid*., 1.

21 See A.C. Myburgh, ‘Euthanasia among Indigenous African Peoples’, in A. Carmi, ed., *Euthanasia* (Berlin: Springer-Verlag, 1984), 71–82; S.A. Strauss, ‘Euthanasia: A South African View’, in A. Carmi, ed., *Euthanasia* (Berlin: Springer-Verlag, 1984), 83–90; M. Brindley, ‘The Role of Old Women in Zulu Culture, with Special Reference to Three Tribes in the District of Nkandla’ (PhD dissertation, University of Zululand, 1982). Brindley records that her informants defined death (the cessation of breathing) and described practices of both passive and active euthanasia.

22 K.L. Frances, ‘Implementing a Permissive Regime for Assisted Dying in South Africa: A Rights-Based Analysis’ (LLM thesis, University of KwaZulu-Natal, 2015), 97.

23 L.B. Gové, ‘Framework for the Implementation of Euthanasia in South Africa’ (LLM thesis, University of Pretoria, 2005), 51–53, cites *R* v. *Peverett* 1940 AD 213; *R* v. *Davidow*, unreported, June 1955; and *R* v. *Nbakwa* 1956 2 SA 557 (SR) 113. Even had he intentionally consented to his own death – which is uncertain – Mr Hartman could not have done so in law.

24 Frances, ‘Implementing a Permissive Regime’, 100.

25 *Ibid*., 98–99.

26 R. Turrell, ‘“It’s a Mystery”: The Royal Prerogative of Mercy in England, Canada, and South Africa’, *Crime, History and Societies*, 4, 1 (2000), esp. 87 n. 13.

27 R. Turrell, *White Mercy: A Study of the Death Penalty in South Africa* (Westport: Praeger, 2004). See also P. Badassy, ‘A Severed Umbilicus: Infanticide and the Concealment of Birth in Natal, 1860–1935’ (PhD dissertation, University of KwaZulu-Natal, 2011) for issues of mercy, compassion, race, and colonial law.

28 *R* v. *Davidow*, unreported, June 1955.

29 *S* v. *De Bellocq* 1975 (3) SA 538 (T); Frances, ‘Implementing a Permissive Regime’, 99.

30 I. Dowbiggin, *A Merciful End: The Euthanasia Movement in Modern America* (Oxford: Oxford University Press, 2003), xiv.

31 The literature is now extensive, but a most useful introduction is E.J. Emanuel, ‘The History of Euthanasia Debates in the United States and Britain’, *Annals of Internal Medicine*, 121 (1994), 793–802.

32 See Emanuel, ‘The History of Euthanasia Debates’, 796.

33 Dowbiggin, *A Merciful End*, xiv.

34 Emanuel, ‘The History of Euthanasia Debates’.

35 Dowbiggin, *A Merciful End*, xiv–xv.

36 *Ibid.*, xv.

37 See S. Dubow, *Scientific Racism in Modern South Africa* (Cambridge: Cambridge University Press, 1995); J. Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868–1916* (Pietermaritzburg: University of KwaZulu Natal Press, 2007).

38 For a detailed discussion of eugenics, race, gender, and ‘feeble-mindedness’, see S.M. Klausen, ‘“For the Sake of the Race”: Eugenic Discourses of Feeblemindedness and Motherhood in the South African Medical Records, 1903–1926’, *Journal of Southern African Studies*, 23, 1 (1997), 41. See also S.M. Klausen, ‘Eugenics and the Maintenance of White Supremacy in Modern South Africa’, in D.B. Paul, J. Stenhouse, and H.G. Spencer, eds, *Eugenics at the Edges of Empire: New Zealand, Australia, Canada and South Africa* (London: Palgrave Macmillan, 2018), 289–309.

39 *South African Medical Journal*, 7 (1933), Minutes of Ordinary Meeting of the Cape Town Division of the Cape Western Branch of the Medical Association of South Africa (B.M.A), 24 February 1933, 155.

40 *Ibid.*

41 *Ibid.*

42 *Ibid*.

43 *Ibid*., emphasis added.

44 *Ibid*.

45 *Ibid.*, 156.

46 Dr S.M. de Kock, ‘The President’s Address, The Public and Ourselves – Some Points of Contact’, *South African Medical Journal*, 11 (1937), 710.

47 *Ibid.*

48 For a snapshot of this history, which has a deep historiography, see M.A. Grodin, E.L. Miller, and J.I. Kelly, ‘The Nazi Physicians as Leaders in Eugenics and “Euthanasia”: Lessons for Today’, *American Journal of Public Health*, 108 (2018), 53–57. On the World Medical Association in 1950, see Dowbiggin, *A Merciful End*, 95. South Africa withdrew from the association in 1976 for issues unrelated to euthanasia.

49 C. Mahar, ‘Easing the Passing: *R v Adams* and Terminal Care in Post-war Britain’, *Social History of Medicine*, 28, 1 (2014), 155–171.

50 ‘Heroin and Its Substitutes’, Editorial, *South African Medical Journal*, 30 (1956), 557.

51 See J. Parle, ‘Obliv[i]on C: Sedatives, Schedules, and the Stresses of “Modern Times”: South African Pharmaceutical Politics, 1930s to 1960s’, *South African Historical Journal*, 71, 4 (2019), 614–643.

52 S.V. Humphries, ‘The Alternative to Euthanasia’, *Central African Journal of Medicine*, 22, 5 (1976), 99–102. He was writing of his long experience as a medical doctor.

53 The Dangerous Drugs Act, originally of 1920, required that a register be kept of certain categories of drugs, including morphine.

54 For succinct comments on these complex dynamics, see Cooter, ‘The Ethical Body’, 661–662. In South Africa, organised religious bodies engaged with the question of euthanasia most directly after the Hartman trial. For the Nederduitse Gereformeerde Kerk’s position on abortion in the early 1970s, see S.M. Klausen and J. Parle, ‘“Are We Going to Stand by and Let These Children Come into the World?”: The Impact of the “Thalidomide Disaster” in South Africa, 1960–1975’, *Journal of Southern African Studies*, 41, 4 (2015), 735–752.

55 H.I.E. Dhlomo, ‘Euthanasia by Prayer’, downloaded from http://pzacad.pitzer.edu/nam/newafrre/writers/hdhlomo/plays/plays.htm, accessed 23 September 2021. The precise date of writing and publication is not given.

56 R. Cooter, ‘The Dead Body’, in R. Cooter and J. Pickstone, eds, *Medicine in the Twentieth Century* (London: Routledge, 2000), 694–695.

57 K.R.L. Huddle, ‘Reflections of a Retiree: 40 Years in Public Service at Chris Hani Baragwanath Academic Hospital’, *South African Medical Journal*, 105, 6 (2015), 448.

58 C. Froman, *The Barbershop Quartet: A Satirical Surgical Saga* (Victoria BC: Trafford, 2005), 17–18. At the time Elliott was professor of medicine at Wits, but it is unclear whether Froman is referring to Elliott, who was not in South Africa for some of 1959.

59 *Ibid.*

60 *Ibid*., 29.

61 *Ibid.*

62 Adler Museum of Medicine (hereafter AMM), University of the Witwatersrand, ‘Guy Abercrombie Elliott, Biographical’, G.A. Elliott to T.H. Bothwell, 22 December 1974.

63 Established under the Drugs (later, Medicines) and Related Substances Control Act (101) of 1965, effective 1966, it was later simply named the Medicines Control Council; AMM, ‘Guy A. Elliott Biographical’; *South African Medical Journal* , 49, (1975), 1896–1897.

64 KAB, CSC, 1/1/1/2358, ‘Record of proceedings of criminal case. Criminal Session, The state versus Alby Desmond Hartman. Murder, 19–21 March1975’, Professor Guy Elliott called and examined by Mr van Schalkwyk (for the defence), 20 March 1975.

65 Mahar, ‘Easing the Passing’, 156.

66 ‘Pain, Drugs and the Doctors’, *Rand Daily Mail*, 11 April 1957, 15.

67 *Ibid*.

68 *Ibid*., emphasis in original.

69 See V. Marks, 'Murder by Insulin', *Medico-Legal Journal*, 67, 4 (1999), 147–163.

70 Perhaps most notably by Agatha Christie's *Crooked House*, first published in 1949.

71 V. Marks and C. Richmond, 'Kenneth Barlow: The First Documented Case of Murder by Insulin', *Journal of the Royal Society of Medicine*, 101 (2008), 19–21.

72 *S* v. *Hartmann* 1975 (3) SA 532 (C).

73 'Doctor in Court after Death of a Patient', *Rand Daily Mail*, 2 December 1950, 9.

74 '"Mercy Killing" by Insulin Alleged Against Doctor: Native Woman Said to Have Been Incurably Ill in Hospital', *Rand Daily Mail*, 5 December 1950. I have omitted the doctor's name, referring to him as Dr A, since he was not found guilty of any offence. It is possible that this doctor made a medical mistake; but it is also possible that he deliberately ended the life of his patient. Below, I have also redacted the name of the nursing sister (Sister M.H.) on duty at the Ceres hospital on the night of Mr Hartman's death, since one reading of the evidence possibly points to her professional neglect, now impossible to verify, but Elliott voiced oblique suspicions in his correspondence with Bothwell. I have, however, kept the other surnames and full references. This raises questions about historians' ethical codes and is an unsatisfactory compromise.

75 'Doctor in Court after Death of a Patient', *Rand Daily Mail*, 2 December 1950.

76 'Mercy Killing Case: Nurse Tells How Patient was Given Insulin Injection', *Rand Daily Mail*, 3 December 1950.

77 *Ibid.*

78 '"Mercy Killing" by Insulin Alleged Against Doctor', *Rand Daily Mail*, 5 December 1950.

79 'Mercy Killing Case: Nurse Tells How Patient Was Given Insulin Injection', *Rand Daily Mail*, 6 December 1950.

80 'Crown Drops Murder Allegations Against Doctor: No Proof Insulin Caused Woman's Death, Says Magistrate', *Rand Daily Mail*, 8 December 1950.

81 '"Mercy Killing Case"', *Rand Daily Mail*, 6 December 1950.

82 'Overdose of Insulin "Unlikely Cause" of Patient's Death - Hospital Superintendent', *Rand Daily Mail*, 7 December 1950.

83 'Crown Drops Murder Allegations Against Doctor: No Proof Insulin Caused Woman's Death, Says Magistrate', *Rand Daily Mail*, 8 December 1950.

84 AMM, Elliott to Bothwell, 22 December 1974.

85 G.A. Elliott, *Medical Ethics* (Johannesburg: Witwatersrand University Press, 1954), 1–5.

86 *Ibid*., v and 7.

87 Elliott, *Medical Ethics*, v.

88 *Ibid.*

89 Cooter, 'The Ethical Body', 661–662.

90 S. Benatar and T. Jenkins, 'Teaching Medical Ethics in South Africa', *South African Medical Journal*, 73 (1988), 450.

91 L. Baldwin-Ragaven, L. London, and J. de Gruchy, *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa* (Cape Town: Juta, 1999), 148.

92 In 1972, for example, medical practitioners were charged with improper or disgraceful conduct for 'Extraction for financial gain' – guilty, cautioned; charge of theft – suspended for 3 months; unreasonable delay of medical report and reply to letters – suspended for 3 months; charge of assault – guilty of disgraceful conduct, reprimanded and cautioned; excessive fees – guilty of improper conduct, cautioned. See 'Bulletin, Disciplinary Cases', *South African Medical Journal*, 46 (1972), 556.

93 *Ibid.*

94 S.M. Klausen, *Abortion under Apartheid: Nationalism, Sexuality and Women's Reproductive Rights in South Africa* (Oxford: Oxford University Press, 2015), 145.

95 K. Simpson, 'The Moment of Death: A New Medico-Legal Problem, Paper presented at the 46th South African Medical Congress, Durban, July 1967', *South African Medical Journal*, 41 (1967), 1189.

96 This is a complex issue, but see W. Beinart and S. Dubow, The Scientific Imagination in South Africa, 1700 to the Present (Cambridge: Cambridge University Press, 2021), 312; S. Horwitz, Baragwanath Hospital, Soweto: A History of Medical Care, 1941–1990 (Johannesburg: Wits University Press, 2013), 20–21; S. Horwitz, 'Race, Kidney Transplants, Immunosuppression Research, and White Supremacy under Apartheid, 1960–80', *Canadian Bulletin of Medical History*, 37, 2 (2020), 461–489, especially 468.

97 The donor for the second South African heart transplant was Clive Haupt. The transplant took place on 2 January 1968. R. Hoffenberg, 'Christiaan Barnard: His First Transplants and Their Impact on Concepts of Death', *British Medical Journal*, 323 (2001), 1478–1480.

98 On the same day, 5 August 1968, the 22nd World Medical Assembly announced the 'Declaration of Sydney', an often-overlooked pronouncement on death. According to Machado *et al.*, this declaration differed from the Harvard one in that it 'differentiated the meaning of death at the cellular and tissue levels from the death of the person. [It also] faced the main conceptual and philosophical issues on human death in a bold and forthright manner'. See C. Machado *et al.*, 'The Declaration of Sydney on Human Death', *Journal of Medical Ethics*, 33, 12 (2007), 699–703.

99 KAB, CSC, 1/1/1/2358, 'Record of proceedings of criminal case', 'Dr Albie [sic] Desmond Hartman Called by Mr van Schalkwyk', 19 March 1975.

100 P.J. Turner, 'The General Practitioner and the Care of the Dying Patient, Paper presented at the 49th South African Medical Congress, Cape Town, 23–27 July 1973', *South African Medical Journal*, 48 (1974), 708.

101 *Ibid.*

102 H. Cooper, 'The Psychological Needs and Care of the Dying Patient, Paper presented at a Symposium on the Care of the Dying Patient, University of Cape Town Medical School, 8 November 1972', *South African Medical Journal*, 47 (1973), 1711.

103 M.B. Bennett, 'Care of the Dying, GP Review Article, paper presented at the 49th South African Medical Congress, Cape Town, 23–27 July 1973', *South African Medical Journal*, 47 (1973), 1560.

104 *Ibid.*

105 Judge V.G. Hiemstra, 'Aspects of Medical Ethics, Opening address to the 20th Congress of the South African Orthopaedic Association (MASA), Pretoria, 26–30 August 1974', *South African Medical Journal*, 49 (1975), 47–49.

106 Klausen, *Abortion under Apartheid*, esp. 83–105. Also Klausen and Parle, '"Are We Going to Stand by'.

107 Historical Papers Research Archive, University of the Witwatersrand, Papers of Ephraim L. Fisher (hereafter Fisher Papers), ZA HPRA A1135-B-Bc-Bc9, 'Euthanasia, 1974–1976', Mrs Sylvia Kean, 'For broadcasting on radio – was broadcast on 22 December 1974'; Fisher Papers, ZA HPRA A1135-B-Bc-Bc9, 'Euthanasia, 1974–1976', Mrs Sylvia Kean, letter to Dr E. Fisher, United Party, Member of Parliament, 5 February 1975; *Natal Witness*, 'Euthanasia Meeting at Hilton', 10 September 1974.

108 'SAMDC: Candidates for Election', *South African Medical Journal*, 47 (1973), 2197–2198.

109 Hiemstra, 'Aspects of Medical Ethics', 49.

110 *Ibid.*

111 KAB, CSC, 1/1/1/2358, 'The state versus Alby Desmond Hartman', 19 March 1975.

112 Philip Ariés put forward the influential thesis that the mid-nineteenth to mid-twentieth centuries were characterised by 'a regime of silence and denial' of death and dying. David Armstrong, influenced by Michel Foucault, challenges this. He argues that a *different* truth regime can be discerned from the 1950s and early 1960s in which patient and doctor participated in a 'conspiracy of silence' forming an unvoiced bond between them in a recognition of dying that can only be 'tentatively explored [in] marginal places'. D. Armstrong, 'Silence and Truth in Death and Dying', *Social Science and Medicine*, 24, 8 (1987), 653.

113 KAB, CSC, 1/1/1/2358, 'The state versus Alby Desmond Hartman', 19 March 1975.

114 KAB, CSC, 1/1/1/2358, KS 100/75',The state versus Alby Desmond Hartman', 19 March 1975; and KAB, CSC, 1/1/1/2358, KS 100/75', '[Captain] Willem A. Smit' examined by Mr Khan, 19 March 1975. Smit [written in the transcripts as Smith] was one of those present in Sister M.H.'s office in the evening of 11 September 1974. He was there in 'his capacity as a Lions visitor'. His sympathy for Dr Hartman is palpable in these transcripts. Lions International established a South African branch in 1957. These were service clubs, declaring commitment to philanthropic and humanitarian causes, including visiting hospital patients. At the time, women were excluded from membership, as, effectively, were all black South Africans.

115 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', Sister M.H. examined by Mr Khan, 19 March 1975.

116 *Ibid.*

117 *Ibid.*

118 *Ibid.*

119 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', A.D. Hartman cross-examined by Mr Khan, 19 March 1975.

120 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', Sister M.H. examined by Mr Khan, 19 March 1975.

121 *Ibid.*

122 *Ibid.*

123 *Ibid.*

124 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', Sister M.H. cross-examined by Mr van Schalkwyk, 19 March 1975.

125 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', Justice L. van Winsen, 21 March 1975.

126 *Ibid.*

127 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', Professor Guy A. Elliott, examined by Mr van Schalkwyk, 20 March 1975.

128 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', 'Mr Khan addresses the court on sentence', 20 March 1975.

129 See Ferber, *Bioethics in Historical Perspective*, esp. 55–56. The 'slippery slope' argument is usually associated with the formulations of physician Leo Alexander of the United States in the aftermath of World War II; but as we have seen, these arguments were essentially made as early as the 1930s.

130 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', 20 March 1975. The quotations for this section onwards are taken from the arguments made on that day in mitigation of sentence by Van Schalkwyk and in extension of sentence by Khan, as indicated.

131 'Hartman Verdict causes a stir', *Cape Times*, 22 March 1975.

132 'Expressions of Relief: Pats on Back for Freed Doctor', *Cape Times*, 22 March 1975.

133 'Hartman: Thank You for Prayers', *Cape Times*, 24 March 1975, 1.

134 KAB, CSC, 1/1/1/2358 KS 100/75, 'The state versus Alby Desmond Hartman', Rooth & Wessels Attorneys, Pretoria, to the Registrar of the Supreme Court, Cape Town, 3 February 1976.

135 Snyman's long career is worthy of critical study. A cultural nationalist, he was a staunch supporter of the Nationalist Party and its apartheid policies. He was professor of medicine at the University of Pretoria, vice-chancellor of the black students-only MEDUNSA (Turfloop), in 1974 was

awarded the rank of Major General in the South African Defence Force, and received the Southern Cross Medal (for meritorious service) soon after its inauguration.

136 'Plea by Euthanasia Doctor Rejected', *Rand Daily Mail*, 21 October 1976; D. Powell Douglas, 'Sons Helping Parents Die with Dignity – Davison's "Assisted Death" Trial Has Echoes of 70s Case', *Cape Times*, 22 November 2011.

137 'Plea by Euthanasia Doctor Rejected', *Rand Daily Mail*, 21 October 1976. Unfortunately, this petition and all relevant correspondence could not be traced.

138 *Ibid*. The Rapportryers were an Afrikaans business and service network akin to Rotary and the Lions Association. They have been viewed by critics as being a 'front' for the Broederbond. Later commentators such as Michael Simpson and Powell Douglas have generously interpreted this as 'cross racial' support for Hartman. In fact, the Management Committee was dominated by white officials.

139 *Ibid.*

140 'Obituary – Hendrik Willem Snyman', *South African Medical Journal*, 73 (1988), 381.

141 Simpson, 'SA Doctor Banned'. He refers to Snyman as 'icy'. In Simpson's analysis, Snyman had personally and 'most peculiarly' called the meeting of the full SAMDC in June 1976, which had been 'long and stormy'.

142 D. Powell Douglas, 'Sons Helping Parents Die with Dignity', *Cape Times*, 22 November 2011.

143 H.W. Snyman, 'Euthanasia', in C.G. Oosthuizen, H.A. Shapiro, and S.A. Strauss, eds, *Euthanasia* (Human Sciences Research Council Publication No. 65) (Oxford: Oxford University Press, 1978), 147–155. The symposium was convened by the Natal Council of Churches and the Human Sciences Research Council of South Africa, held at the University of Durban-Westville.

144 *Ibid.*, 148.

145 *Ibid.*, 154.

146 *Ibid.*

147 *Ibid.*, 155.

148 'The Medical, Dental and Supplementary Health Services Professions Act (56) 1974'., *South African Medical Journal,* 49 (1975), 1411. Elliott died somewhat unexpectedly in September 1975. Grant-Whyte remained an active supporter of SAVES until his own death in 1991.

149 The neglect and death of the injured Biko have been well documented. In its wake, the challenge to the SAMDC's indifference was led by determined and principled medical doctors and scientists, whose efforts were driven by fealty to their professional oath as much as, if not more, by political commitment. Thus, medical authority can be both progressive and punitive. See Baldwin-Ragaven, London, and de Gruchy, *An Ambulance of the Wrong Colour*, especially Chapter 8.

150 Strauss, 'Euthanasia: A South African View', 131.

151 Dr Hartman was reinstated on the medical register in 1977. See D. Powell Douglas, 'Sons Helping Parents Die with Dignity', *Cape Times*, 22 November 2011. For some time Dr Hartman

worked in hospital administration, then moved to Namibia, and eventually worked once more as a doctor. Michael Simpson, personal communication, 29 November 2016.

152 D. Powell Douglas, 'Sons Helping Parents Die with Dignity', *Cape Times*, 22 November 2011.

153 'Barnard Calls for Active Euthanasia', *Star*, 27 April 1979.

154 H. Grant-Whyte, *Between Life and Death* (Pietermaritzburg: Shuter and Shooter, 1976); 'The Living Will', *Natal Mercury*, 7 January 1983.

155 'NG Kerk gekant teen aktiewe genaadedood: maar hand mag soms teruggetrek word', *Die Kerkebode*, 27 October 1982.

156 'Assisted Suicide, Abortion and Capital Punishment', *Rapport*, 14 May 1989.

157 The phrase is from I. Dowbiggin, '"A Prey on Normal People": C. Killick Millard and the Euthanasia Movement in Great Britain, 1930–1955', *Journal of Contemporary History*, 36, 1 (2001), 62. As will be explored elsewhere, the same can be said of anti-euthanasia bodies in South Africa after 1991.

158 South African Law Commission, Discussion 71, Project 86, 'Euthanasia and the Artificial Preservation of Life', 1997, 1.

159 *Clarke* v. *Hurst NO and Others* 1992 (4) SA 630 (D). Dr Clarke had been a member of SAVES. This was taken into account in the judgement.

160 'SAHSSO Warns on Euthanasia', *The Leader*, 21 August 1992. The organisation recorded that euthanasia was practised by thousands of doctors.

161 'Quizzing the candidates', *Democracy in Action* (Institute for Democracy in South Africa), 8, 1 (1994).

162 It is often mistakenly reported that then President Nelson Mandela initiated the report.

163 'Question NW1280 to the Minister of Justice and Correctional Services', 11 May 2018, Ms. D. Carter, member of the Congress of the People (COPE), https://pmg.org.za/committee-question/8799/, accessed 9 September 2021.

164 For high profile instances: Terminally ill Robert Stransham-Ford applied for physician assistance in dying in April 2015. This was granted, but not before his death, which occurred hours before the judgement was passed. Judge Hans Fabricius' decision was not sustained in 2016. See *Stransham-Ford* v. *Minister of Justice and Correctional Services and Others* [2015] ZAGPPHC 230, 2015 (4) SA 50 (GP); *Minister of Justice and Correctional Services* v. *Estate Stransham-Ford* contemplated starving (531/2015) 2016 ZASCA 197 (6 December 2016). In 2017, author and historian Karel Schoeman considered starving himself to death rather than ask doctors to assist his suicide and thereby break the law. I. Makgetla, 'Karel Schoeman: A Literary Giant who Walked among Us', *Mail and Guardian*, 19 May 2017, https://mg.co.za/article/2017-05-19-00-karel-schoeman-a-literary-giant-who-walked-among-us/, accessed 21 September 2021; M. Thamm, 'Dying with Dignity: Karel Schoeman – a Private Life, a Public Death', *Daily Maverick*, 4 May 2017, https://www.dailymaverick.co.za/article/2017-05-04-dying-with-dignity-karel-schoeman-a-private-life-a-public-death/, accessed 21 September 2021. Cape Town professor of biotechnology Sean Davison not only assisted his mother in New Zealand to die but also a number of South African men, at their request. Davison also became a 'non-law'. See D. Forrest, 'South African Government Drags

its Feet on Legalising Assisted Suicide', *Daily Maverick*, 11 July 2021, https://www.dailymaverick.co.za/article/2021-07-11-south-african-government-drags-its-feet-on-legalising-assisted-suicide/, accessed 21 September 2021.

165 At the South Gauteng High Court, before Judge Rayleen Keightly. T. Broughton, 'Atheists Go to Court over Right to Die', *GroundUp*, 9 February 2021, https://www.groundup.org.za/article/atheists-go-court-over-right-die/, accessed 21 September 2021.