

**THE SOCIO-POLITICAL & MEDICO-
LEGAL PRACTICE OF MEDICINE IN
SOUTH AFRICA POST 1994**

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*MINI-
DISSERTATION*

**THE SOCIO-POLITICAL AND MEDICO-LEGAL PRACTICE OF
MEDICINE IN SOUTH AFRICA POST-1994**

By

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i. Declaration

I, Dr Thabani S Nkwanyana, ID number: *****, Student number 12299279, hereby declare that this mini-dissertation, submitted for the degree Master of Philosophy in Medical Law and Ethics at the University of Pretoria, is my original work in execution and style and that I have acknowledged all sources cited and that contributed to this work by means of references and/or footnotes.


.....

.....September 2016.....

Dr Thabani S Nkwanyana

Date

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I also wish to thank my wife, Makgotso, for the love, caring attitude and support throughout these years, for allowing me time away from home and for holding it together for our family, even when the schedule was tighter.

Lastly, I wish to dedicate this dissertation to my parents, my ill mother Rittah and to the memory of my late father, Mthengeni (Zikode), for their greatest genetic contribution and positive influence that shaped the person and the man that I am today.

iii. Abstract

South Africa's socio-political and medico-legal landscapes have dramatically changed since 1994 with the dawn of democracy and peaceful transition from apartheid South Africa to a Constitutional democracy, and the birth of the democratic South Africa. Considerable social progress has been made towards reversing the discriminatory practices that prevailed in most, if not all, aspects of life before 1994. The dawn of democracy brought with it changes in the healthcare policy and design and made it to almost become intuitive to think that human rights, equality and access to healthcare should be entitlements we should all enjoy, without exceptions, prejudice, fear or favour. But this has not been without challenges especially with regards to access to healthcare, health privilege, equality, distributive justice and medical ethics. Our healthcare system has evidently continued to be marked with the inequalities, poor service delivery and lack of resources, corruption, prejudice and reversal of fortunes. Majority of people, especially Blacks and Coloureds in South Africa are still underserved and disadvantaged compared with their White and Asian counterparts.

Arguably, there also have been increasing tensions in the medico-legal space, especially in the sphere of access to health care, health provision and management, quality of health care, medical malpractice and negligence, and medical research, experimentation and bio-ethics. At the same breath, and despite government commitment to equal medical care for all, regardless of financial or political considerations, the quality and accessibility of health services in South Africa are, in some instances, still dependent on the ability to afford, socio-political standing, political connectedness or status. It is not uncommon for some persons to get more attentive, responsive, and reputedly, competent health and medical care than it is available to general public and the majority. For celebrities, the rich or high-ranking officials, preferential treatment is still routinely provided and there still seem to be imposition of politics and ideology on the practice of medicine and ethics. This paper thus intends to explore the other ugly heads that have since surfaced with the dawn of democracy in the sphere of medical ethics and law.

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1. Chapter One: Opening Arguments

1.1. Brief History of the South Africa Healthcare System

1.1.1. Pre-1994

In the history of medical ethics in South Africa, the mention of the name such as that of Steve Biko¹ gets associated with the ghosts of medical ethics out of the horror that many people felt at the treatment he received as he was tortured and allowed to die, a lonely, torturous and painful death during apartheid South Africa, at the hands of the police and allegedly under the watch of medical professionals and professional medical bodies. According to Moodley & Kling (2015), the medical inquiry on Biko's death revealed that while '[e]xamining Biko in the presence of security police, Dr. Lang found him to be ataxic, with slurred speech, a swollen upper lip and various bruises'. But it was reported that '[n]evertheless, he issued a medical certificate stating, "I have found no evidence of any abnormality or pathology on the patient"' (Moodley & Kling 2015)'.

The world was shocked at the depths to which the apartheid regime was prepared to go in its war to advance racial discrimination, and to preserve white supremacy. This also can be seen as the abuse of power by a medical professional and a breach of medical code of ethics. These abuses also came at a time when the country had a highly fragmented and bureaucratic health care system that seemed to have pockets that played complicit with the apartheid regime. Medical professionals have a major role to play in protecting and promoting human rights as prescribed by ethics, and as much as some medical professionals, such as Dr Wendy Orr² opposed and resisted apartheid,

¹ Stephen Bantu Biko (18 December 1946 – 12 September 1977) was an anti-apartheid activist in South Africa in the 1960s and 1970s. A student leader, he later founded the Black Consciousness Movement which would empower and mobilize much of the urban black population. Since his death in police custody, he has been called a martyr of the anti-apartheid movement. While living, his writings and activism attempted to empower black people, and he was famous for his slogan "black is beautiful", which he described as meaning: "man, you are okay as you are, begin to look upon yourself as a human being" – From Wikipedia, the free encyclopedia

² Dr Wendy Orr was the first doctor to expose torture and abuse of detainees in (Apartheid) South Africa. Wendy Orr graduated as a medical doctor from the University of Cape Town in 1983, just as the organizations of the mass democratic movement were beginning to resurface after the banning and clampdowns of the 1970's. She saw first-hand the many political detainees that had been beaten up by the security police. In 1995 then President Nelson

most white medical professionals either collaborated with the apartheid system or did nothing to oppose it (Hassim et al. 2007). It can be argued thus from here that, even practice of medicine and healthcare provision was discriminatory and that it ignored the principles of health-for-all³ and universal access to healthcare. These all had a negative impact on medical ethics and fragmented further the healthcare system. The gap between the health care provided for white and black South Africans, widened further and further. The apartheid government passed special laws and policies to enforce racial inequality in access to health care services.

Prior to the 1994 democratic elections, South Africa had 14 separate departments to look after the health of the different racial groups: “white”, “coloured”, “Indian” and “black”. In addition, the 4 provinces⁴, the 4 homelands⁵ (called Bantustans) and 6 self-governing⁶ territories had their separate health departments. This arguably resulted in poorly coordinated healthcare services, further causing inequalities and disparities in health (Hassim et al. 2007). The four decades of apartheid legislation fragmented and infiltrated most aspects of life including the health sector, as even:

‘[h]ealth professional training was also conducted on racial grounds with only one medical school for the majority Black population up to 1977 and five for whites. Medical students training programmes at most universities ensured that white patients were not examined by black medical students in life or after death. Post-mortems on white patients were conducted in the presence of white students only. Students of colour were permitted to view the organs only after they were removed from the corpse’ (Moodley 2014).

Mandela appointed Dr Wendy Orr as a commissioner of the Truth and Reconciliation where she served until it ended in 1998’ – 702 Articles 2016

³ Health-for-All is a programming goal of the World Health Organization (WHO), which envisions securing the health and well-being of people around the world that has been popularized since 1970s. It is the basis for the WHO’s primary health care strategy to promote health, human dignity, and enhanced quality of life. – Wikipedia, the free encyclopedia

⁴ The provinces during apartheid were Transvaal, Free State, Cape Town, and Natal

⁵ The homelands (Bantustans) during apartheid were Transkei, Bophuthatswana, Venda and Ciskei.

⁶ The Self-Governing territories during apartheid were Gazankulu, Lebowa, Qwaqwa, KaNgwane, KwaNdebele and KwaZulu.

As Moodley (2014) suggests, apartheid system was ‘a process of dehumanization that reduced people to objects or physical entities’. Moodley (2014) contends that practice of medicine was also dehumanised to focus on the disease rather than the person, their families and community, and that it corrupted the moral fiber of the South African society, perhaps including medical society, in a manner that permeated and broke the core ethical covenants of the medical profession. Medical warfare became part of fighting for white supremacy as seen in the case of Dr Wouter Basson⁷, where medical practitioners played soldiers in the apartheid regime.

The racial discrimination that prevailed had many untoward effects to many black people. Hassim et al. (2007) remark ‘...racial discrimination against all black people affected people’s lives in many ways’. It resulted, amongst other things, in:

- ‘1) [s]ocial conditions that caused ill health,
- 2) [t]he segregation of health services,
- 3) [u]nequal spending on health services’ and
- 4) ‘[t]he failure of professional medical bodies and civil society to challenge apartheid health’ (Hassim et al. 2007).

Hassim et al (2007) further remark that ‘[i]n 1971, deaths from diarrhea were 100 times more common among black people than among white people’ and that ‘[i]n 1978, typhoid fever was 48 times more common among black people than among white people’. The observation here is that this had ethical implications towards the practice of medicine. Kon & Lackan (2008) also remark that ‘[a]ccording to the American Association for the Advancement of Science and the Physicians for Human Rights Organization, the South African health care system not only limited access to health

⁷Dr Wouter Basson (born 6 July 1950) is a South African cardiologist and former head of the country's secret chemical and biological warfare project, Project Coast, during the apartheid era. Nicknamed "Dr. Death" by the press for his alleged actions in apartheid South Africa, Basson was acquitted in 2002 of 67 charges, after having been suspended from his military post with full pay in 1999. Among other charges, Basson was alleged to have supplied a "lethal triple cocktail of powerful muscle relaxants which were used during Operation Duel (the systematic elimination of SWAPO prisoners of war and South African Defence Force (SADF) members who posed a threat to South African covert operations). The United Nations report identifies the triple cocktail as ketamine, succinylcholine, and tubocurarine. – From Wikipedia, the free encyclopedia

care for blacks and often ignored quality-of-care guidelines but also created an environment in which abuses such as the refusal of emergency care treatment, falsification of medical records, denial or limitation of blacks' access to ongoing medical care, and mistreatment of the mentally ill could occur'.

1.1.2. Post-1994

The dawn of democracy was the birth of hope for the South Africans. It was celebrated widely world over, and with the Constitution that is considered to be amongst the most progressive Constitutions in the world. The highly anticipated dawn of democracy brought with it changes in the healthcare policy and design and made it to almost become intuitive to think that human rights, equality and access to healthcare should be entitlements we should all enjoy, without exceptions, prejudice, fear or favour. The new government introduced new health policies that were seen to be progressive and inclusive and a lot of progress has since happened. Among these have been the:

- (1) Enactment of choice on termination of pregnancy (The Choice on Termination of Pregnancy Act 1996),
- (2) Anti-tobacco legislation (Tobacco Products Control Amendment Act 2000),
- (3) Realization of free primary health care for all, free care for children under the age of 6 and pregnant women (1996),
- (4) Improved malaria control,
- (5) Expanded program for immunization (EPI) (1995),
- (6) the legislation against discrimination against mental health-care users (Mental Health Care Act 2002),
- (7) The hailed policy shifts in the HIV and AIDS strategy (2003), and
- (8) A Green Paper (now White Paper 2015) on the proposal of the National Health Insurance (2011).

This has not been without challenges when it comes to implementation. The system still shows cracks with regards to a number of issues relating to access to healthcare, health privilege, equality, distributive justice and medical ethics. Over 2 decades after

democracy, our healthcare system has continued to be marked with the inequalities, poor service delivery, and lack of resources, corruption, privilege and prejudice. Majority of people are still underserved and disadvantaged (Kon & Lackan 2008). According to Mayosi & Benatar (2014) ‘...the health and well-being of most South Africans remain plagued by relentless burden of infectious and non-communicable diseases, persisting social disparities and inadequate human resources to provide care for a growing population with rising tide of refugees and economic migrants’. Arguably, there also have been increasing tensions in the medico-legal space, especially in the sphere of access to health care, health provision and management, quality of health care, medical malpractice and negligence, and medical research, experimentation and bio-ethics. This has reportedly seen a rise in litigations, medical malpractice claims and the so-called ambulance chasing attorneys, as ministers of health and government constantly seem to be insinuating. The burden of HIV/AIDS also seems to have affected the health budget and its allocation, with most resources channelled towards eradicating the pandemic, which badly impacted the health services after 1994.

1.2. Thesis Statement

Health provision and service delivery by healthcare professionals in South Africa is regulated by law and the legal system. There are also ethical guidelines set out by the Health Professions Council of South Africa (HPCSA)⁸. The matter of the clinical independence and ethics of medical practitioners have been under scrutiny when it comes to high profile cases, politically connected individuals, high ranking officials and celebrities. This paper wishes to answer the broader question of whether fear, favour, social class or political privilege should influence the practice of medicine and standard of care. It further looks deeper at the strides and progress made in healthcare legislation such choice of termination of pregnancy and the new developments in law, particularly in the sphere of medical law, and how these affect medico-legal practice of medicine in the current dispensation.

⁸ HPCSA is a statutory body established in terms of Health Professions Act 56 of 1974. It governs medical practice and sets standards for ethical and professional conduct of practitioners registered with it.

1.3. Objective

This mini dissertation seeks to interrogate and challenge the pervasive and widespread socio-political and socio-economic influences in the practice of medicine and healthcare and their medico-legal implications. It will examine the current regulatory framework and legislation governing access to healthcare, health rights, medical confidentiality and privilege, medical parole of prisoners, resource allocation, organ transplantation, medical futility, and euthanasia and assisted dying and potential gaps in the Constitution such as the highly contested 'right to die'. It will also examine the role of the HPCSA in the new dispensation and application of law to medical practice post-1994. It will then draw conclusions, analysing what the law and medical ethics prescribe, both domestically and worldwide, and the current legal framework and ethicalness, so to speak, of approaches towards discharging practice of medicine.

1.4. Literature Review

News articles, blogs, reports and public opinion on matters in the public interest were reviewed. We also reviewed the legislative and ethical framework applicable to these matters, locally and internationally. Where applicable and available, we discussed the relevant case law, its applications and limitations thereto. Position papers and public statements of media houses, independent organisations such as the Dignity South Africa (DSA), Doctors for Life, South African Medico-legal Society (SAMLs), South African Medical Association (SAMA), the HPCSA and government's position, were studied and explored. Various other open sources of information, such as the internet, different authors regarding medical privilege, preferential treatment, patient autonomy and clinical independence were reviewed, discussed and analysed, including views expressed in books, publications and medical journals, specifically concentrating on the views on South African medico-legal and socio-political landscape.

1.5. Methodology

An understanding of the relevant terms, guidelines and recommendations as well as relevant domestic law and its application, formed the theoretical and conceptual framework of this dissertation. South Africa's view and public opinion as deduced from

legislation, official news articles and publications were discussed. Whilst addressing the primary sources of the research, the study described relevant legislation, interpreted and analysed the legislation as it stands and where possible its application via case law. The South Africa's position regarding issues of contention, socio-political landscape and its influence on the medical profession was compared to the international position. Comparative analysis was drawn in order to address and understand the respective challenges in the different jurisdictions, which can be used to identify opportunities for improvement. Views expressed by authors and critics formed the basis of the secondary sources of this dissertation. Challenges around the practical implementation of the medicine were discussed and consideration given to criticism around the current legislative obligations, concluding with an ethical approach towards the application of the legislation and regulatory framework.

1.6. Limitations

This mini-dissertation mainly looks at the cases that were in the media and public domain and that were issues of contention that drew wide criticism, dissatisfaction or empathy about medical profession and practice. It looks specifically at the common aspects of medical ethics and law that are commonly affected by socio-political and socio-economic landscapes, such as privilege, access to healthcare and distributional justice. It does not address all aspects of the socio-political and medico-legal practice of medicine in South Africa, which is a much broader concept.

2. Chapter Two: The Remaining Healthcare Challenges in the Democratic South Africa

2.1. Continuing Poverty, Inequalities and Imbalances

Many authors have written about the relationship between poverty and poor health outcomes. Mayosi & Benatar (2014) reiterate that '[h]ealth should be considered within the broader context of direct and indirect links between wealth and health, although these relationships are complex'. The advanced argument is that 'when extreme poverty and unemployment affects a large proportion of the population, as in South Africa,

health is predominantly affected by lack of access to the basic requirements for life – clean water, adequate nutrition, effective sanitation, reasonable housing conditions, access to vaccinations, good schooling, and the childhood and adolescent nurturing that, with the availability of jobs, set the scene for improved health and longevity'(Mayosi & Benatar 2014).A comparison is drawn between societies less affected by poverty and those worse affected by poverty and Mayosi & Benatar (2014) point out that '[u]nlike in the societies affected by poverty, societies with less relative poverty, as indicated by a lower Gini coefficient⁹ of income inequality, tend to show reduced disparities in health and well-being'. Most African countries are still struggling with poverty and South Africa is no exception, arguably. Besides the challenges of health care access, South Africa is still faced with high levels of unemployment, lack of resources, poor standards of education, homelessness or poor home settlements, poor or aging infrastructure, poor service delivery, and government corruption.

According to the World Bank¹⁰ (2016), 'relative poverty in South Africa has become worse, with the Gini coefficient increasing from 0.6 in 1995 to almost 0.7 in 2009'. World Bank (2006) maintains that 'South Africa remains a dual economy with one of the highest inequality rates in the world, perpetuating inequality and exclusion and that growth is stuck in low gear, with real gross domestic product (GDP) growth estimated at 1.3% in 2015/16 and projected at 0.8% for 2016/17'. Social grants rolled out by government have reportedly reduced absolute poverty in South Africa (Mayosi & Benatar 2014), but other reports suggest that, at the same breath, a lot of people are still plunged in relative poverty and live below the so-called food poverty line. Mayosi & Benatar (2014) argue that '...although there are unique aspects to improving health in South Africa, the local challenges represent a microcosm of impediments to improving population health globally'. It can thus be argued that until absolute and relative poverty are eradicated, disparities in wealth, health and access to healthcare will continue to

⁹The Gini coefficient (sometimes expressed as a Gini ratio or a normalized Gini index) is a measure of statistical dispersion intended to represent the income distribution of a nation's residents, and is the most commonly used measure of inequality. – From Wikipedia, the free encyclopedia.

¹⁰[Online] World Bank, 2016. <http://www.worldbank.org/en/country/southafrica/overview>

widen and reducing these will take many decades. Mayosi & Benatar (2014) further remark that '[t]hese disparities, the widest in the world, are associated with diseases of poverty¹¹ ...', and that '[t]he persistence of such disparities is incompatible with improvements in population health'.

2.2. The Burden of HIV and AIDS

Harrison (2009) highlights that 'the accomplishments of the past decade [sic] are largely overshadowed by the burden of AIDS on mortality and health system'. Prior to 2003, antiretroviral drugs were not available for the public sector patients, in the country that had the highest number of people infected with HIV. Great strides have however, since been made in South Africa with regards to management and treatment of HIV and AIDS. The ambitious program of treating of HIV and AIDS was introduced by government in 2003 after the widely criticized 'AIDS denialism'¹² during the President Thabo Mbeki administration. Since then:

'[s]pending on HIV increased at an average annual rate of 48.2% between 1999 and 2005. The level of growth was consistently higher than that in other areas of national health expenditure and has continued at an annual rate of approximately 25%, with dedicated HIV funding estimated at \$400 million (in U.S. dollars) per annum, of which approximately 40% comes from international donors. Of 6 million HIV-positive South Africans, more than 2 million receive ART' (Mayosi & Benatar 2014).

Critics argue though that this policy shift and increased funding towards HIV has resulted in distributional issues and other health care services have been neglected. Mayosi & Benatar (2014) argue that '[t]he 2003, 2007, and 2011 national plans for HIV, with funding increasingly skewed toward HIV treatment, have implications for a deteriorating national public health system committed to equitably serving all South

¹¹ Diseases of poverty is a term sometimes used to collectively describe diseases, disabilities, and health conditions that are more prevalent among the poor than among wealthier people.- Wikipedia, the free encyclopedia.

¹² HIV/AIDS denialism is the belief, contradicted by conclusive medical and scientific evidence, that human immunodeficiency virus (HIV) does not cause acquired immunodeficiency syndrome (AIDS). – Wikipedia, the free encyclopedia.

Africans' (Mayosi & Benatar 2014). South Africa was widely criticized by the world and civil society for poor response in the past and the government of the day is arguably at crossroads and seem unable to strike this balance.

A report by World Health Organization (2010) indicated that '[a]ccess to HIV/AIDS treatment has expanded dramatically in the last past decade and, since the 1994 democratic elections, access to health services in general have improved for poorer South Africans'. Although this in an encouraging report, others argue that the standards of care has been deteriorating.

2.3. The Failure of the Government in Reducing Widening Disparities in Healthcare

According to the World Bank reports, South Africa overview (2016): the '[a]nnual per capita expenditure on health ranges from \$1,400 in the private sector to approximately \$140 in the public sector, and disparities in the provision of health care continue to widen. They report that '[t]he national public health sector, staffed by some 30% of the doctors in the country, remains the sole provider of health care for more than 40 million people who are uninsured and who constitute approximately 84% of the national population'. They report that '[a]pproximately 16% of South Africans (8 million people) have private health insurance that provides access to health care from the remaining 70% of doctors who work full-time in the private sector and that '[u]p to 25% of uninsured people pay out of pocket for private-sector care'. This is indeed regrettably a worrying picture and a reversal of fortune for a country that was once, arguably, taking the path towards substantial economic growth when the democracy was new.

According to Deloitte (2015) South Africa's health care system is a two-pronged system with a 'large, under-resourced and overused public sector and a small, well-funded and well-equipped private sector'. As much as it is hoped that perhaps the introduction of the National Health Insurance (NHI) will arguably reduce this gap, the fact remains that after more than two decades of democratic rule, the government, it can be argued, has failed to reduce these disparities in healthcare. Deloitte (2015) notes that '[w]hile the public sector provides health care for 80 percent of the population, it accounted for only

47.9 percent of total health care spending in 2012, according to the World Health Organization (WHO)'. Harrison (2009) remark that 'the challenge for policymakers is to demonstrate rapid improvements in the quality of care and service delivery indicators such as waiting time and patient satisfaction; while at the same time addressing the intractable health management issues that bedevil efficiency and drive up costs'.

2.4. Worrying Health Trends

According to the Mayosi & Benatar (2014), '[n]eonatal mortality, infant mortality, and mortality among children younger than 5 years of age have decreased despite adverse changes in the pre-2005 period exacerbated by the 'AIDS denialism' of the government led by President Thabo Mbeki'. Mayosi & Benatar (2014) recall that '[a]pproximately 330,000 lives or 2.2 million person-years were lost owing to the failure to implement a feasible and timely Anti-retroviral therapy (ART) program'. They remark that '[r]eported trends in maternal mortality vary widely but indicated that 'maternal deaths per 100,000 pregnancies increased from 150 in 1998 to 650 in 2007...'. They note however that 'other findings suggest that there has also been improvement toward the achievement of Millennium Development Goals (MDG) 6, which is to combat HIV/AIDS, Malaria and other diseases'. Most other reports also show the similar trends that many maternal deaths in South Africa are still related to HIV infection, despite the progresses made. 'The combination of HIV and tuberculosis (TB) is the leading cause of death among women of reproductive age' (World Bank 2016). Death rates have however reportedly declined since the launch of the ART program in 2003, according to World Bank (2016). The introduction of ART has reportedly had a positive effect in increasing the life expectancy at birth. World Bank (2016) reports show that general population life expectancy increased from 54 years in 2005 to 60 years in 2012. 'This improvement was reportedly due to sustained decreases in mortality among young adults and children, largely because of the rollout of the ART program and prevention of mother-to-child transmission (PMTCT) of HIV' (World Bank 2016). Most mortality curves show that people living with HIV and getting proper treatment, with good treatment response, now can expect to lead a normal life with near normal life expectancy. There are not many studies, however, on the future morbidity impact of HIV (World Bank 2016). According to

World Bank (2016) life expectancy in South Africa has recovered to 62 in 2014. This after it dramatically fell from 62 in 1992 to 53 in 2010. They attribute this recovery to the rapid expansion of the ARV treatment programs to fight HIV/AIDS. Child health, maternal health and HIV and AIDS should clearly form part of the urgent priority by government and measures need to be taken to make sure it is achieved, if South Africa is to avoid becoming a failed state when it comes to these issues.

2.5. The Changing Patterns of Disease

This picture described above that the life expectancy has improved dramatically in South Africa brings in another issue, that of the changing patterns of prevalence of diseases. As much as this is indeed good news, the question is whether this leaves us with other disease patterns? Mayosi & Benatar (2014) wrote about the changing patterns of disease in South Africa. They remark that the Global Burden of Disease Study has highlighted three major aspects of the changing burden of disease in South Africa during the past 20 years which are as follows:

- 1) 'First, there has been a marked change in causes of premature death, with HIV/AIDS rising to the top coupled with the increasing contribution of violence, injuries, diabetes, and other non-communicable diseases. The highest proportion of disability-adjusted life-years lost is attributable to alcohol use, a high body-mass index and obesity, and high blood pressure, if unsafe sex is not taken into account as a separate risk factor'.
- 2) 'Second, South Africa continues to stack up poorly against other middle-income countries with regard to age-adjusted death rate, years of life lost from premature death, years lived with disability, and life expectancy at birth'.
- 3) 'Finally, non-communicable diseases are emerging in both rural and urban areas, most prominently among poor people living in urban settings'.

Mayosi & Benatar (2014) argument is that '[t]his rising burden, together with demographic changes leading to an increase in the proportion of people older than 65

years of age, contributes to increasing pressure on short-term and long-term health care services' and that '[t]he burden of non-communicable diseases will probably increase further as ART further reduces mortality from HIV/AIDS'. The question perhaps then is: has government done enough to look at the other prevailing health issues? Has the focus towards HIV/AIDS treatment come at a cost of losing other battles? The government therefore, it can be argued, needs to develop policies that prioritize all health challenges affecting citizens. The management of HIV and AIDS is important, but it should not obscure the other chronic disease epidemics on the health system.

2.6. Medical Staff and Resources Shortages

The overburdened public health sector is also faced with staff shortages. The World Bank (2006) remark that state hospitals continue to lose senior medical staff, and that the introduction of the permission, known as 'Remuneration Work outside Public Sector agreement, has seen more medical professionals choosing to opt out of the public sector. Government also introduced Occupation Specific Dispensation (OSD) (Johnson 2015), for doctors and nurses intended at helping with the retention of scarce skills in rural areas, but this, argues Johnson (2015) only 'led to doubling of public sector expenditure on the existing health workforce without improving health outcomes'. This, OSD, it can be argued, brought it with it the entitlement mentality which was followed by a number of industrial actions demanding OSD in the late 2000's. This is surely not good for a country that has majority of its population reliant on the public sector. Making the matters worse, '[m]any of the state hospitals...', remark the World Bank (2006) '...are in a state of crisis, with much of the public health care infrastructure run down and dysfunctional as a result of underfunding, mismanagement, and neglect' (World Bank 2016).

Although the annual enrolling of medical students has seen an increased by 34% between 2000 and 2012, the number of graduating doctors by 18% between 2000 and 2012 (Mayosi & Benatar 2014), the public sector continues to be run at a much lower doctor-to-patient ratio compared to the counterpart private sector. According to Mayosi & Benatar (2014) 'the ratio of physicians per 1000 population, which was essentially

unchanged between 2004 (0.77) and 2011 (0.76), is failing to keep up with population growth'. A comparison is drawn by Mayosi & Benatar between South Africa and similar countries such as Brazil with the ratio of 1.76 in 2008, Russia with the ratio of 4.31 in 2006, China with the ratio of 1.46 in 2010 and India, which is rather doing worse than South Africa, at the ratio of 0.65 in 2009.

2.7. Immigration and Emigration of Health Professionals

According to Mayosi & Benatar (2014) 'South Africa and eight other sub-Saharan African countries have lost more than \$2 billion (in U.S. dollars) in investment from the emigration of domestically trained doctors to Australia, Canada, the United Kingdom, and the United States'. They further argue that the country '...incurs the highest costs for medical education and the greatest lost returns on investment for all doctors currently working in such destination countries'. They quote other previous studies that indicate that '...up to 30% of South African doctors have emigrated and that 58% were intending to emigrate to Western countries'. They table the statistics indicating that '[i]mmigration of doctors increased from 239 in 2003 to a peak of 427 in 2006, but this was followed by a rapid decline to only 10 registrations in 2013, owing to stringent registration requirements introduced by the Health Professions Council of South Africa'. This is a worrying trend, and government need to make it attractive for health professionals to stay in the country and perhaps for other health professionals to come to the country, if our health system is to improve and become efficient.

3. Chapter Three: Overview of the Healthcare Legislation

3.1. The Progress in the Health Legislative Space in South Africa

South African legislation has been an area of tremendous achievement since 1994 democracy. The range of health legislation passed since 1995 must be considered impressive, and substantial progress has clearly been made. In South Africa, the imperative to take reasonable legislative measures to ensure that everyone has access to health care services, for example, is constitutionally entrenched, making healthcare legislation to ensure equitable access, an explicit constitutional obligation. Our

Constitution is hailed as the best in the world and a very progressive and inclusive legislation. The democratic process involved in the establishment of the Acts and Regulations through the parliamentary process is vibrant and robust. The public participation and transparency, and accountability are promoted by the parliamentary process, making safeguarding democracy possible.

3.2. The Constitution and the Bill of Rights

The Constitution¹³ has played a significant role in providing the framework for a series of legal judgments that have entrenched the rights of South Africans to access health care. Achievements include the articulation of a rights based approach to health, including a commitment to greater equity, the patients' rights charter, Batho Pele¹⁴, and choice on termination of pregnancy. Carstens and Pearmain (2007) remark that '[t]he political and legal landscapes in South Africa have altered significantly and irreversibly since the advent of the final Constitution in 1997' and that '[t]his reality, of constitutional supremacy, obviously also had an indelible impact on the understanding, nature, scope and application of South African medical law, specifically in its common law context'. This is an impactful statement from Carstens and Pearmain (2007), as it indicates how much the medicine has had to adapt itself to fit in with the law and constitution in the new dispensation.

The South African constitution includes the Bill of Rights, Chapter 2, which is also been hailed as being one of the most progressive bill of rights in the world. It 'enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom' (Constitution of the Republic of South Africa 1996). The rights to human dignity, life, freedom from slavery, privacy, housing, education and access to information have all become important for good health. In addition to protecting people's rights to dignity and privacy, our Constitution specifically states that the government has

¹³The Constitution of the Republic of South Africa, Act 108 of 1996

¹⁴Batho Pele (SeSotho: "People First") is a South African political initiative. The initiative was first introduced by the Mandela Administration on October 1, 1997 to stand for the better delivery of goods and services to the public. The Batho Pele initiative aims to enhance the quality and accessibility of government services by improving efficiency and accountability to the recipients of public goods and services.- Wikipedia, the free encyclopedia

a legal duty to respect, protect, promote and fulfill people's rights (Constitution of the Republic of South Africa 1996). In South Africa, the Constitution's Bill of Rights is justiciable and legally enforceable if there is a dispute. The Constitution (1996) points out that '[t]he Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state'. This would inadvertently affect medicine and its practice (Hassim 2007).

3.3. The National Health Care Act

The National Health Act 61 of 2003 is also one of the progressive Acts enacted in the democratic South Africa. One of the explicit objectives of the National Health Act 61 of 2003, as cited, is that it is aimed at providing '...a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services, and to provide for matters connected therewith'. The Act also notes the socio-economic injustices and imbalances in health services of the past and hopes to correct these. In it, it's recognition, amongst other things, of 'the need to heal the division of the past and establish a society based on democratic values, social justice and fundamental human rights', and to 'improve the quality of life of all citizens and to free the potential of each person'. This is a direct recognition of Constitution as a supreme law of the land and respect of law and ethics. It also indirectly promotes the respect and fulfilment of rights enshrined in the Constitution and the Bill of Rights. These rights include the right to access to healthcare and information, privacy, and confidentiality, freedom of choice and participation in decision making (The National Health Care Act 2003).

3.4. The Choice on Termination of Pregnancy Act

One of the greatest developments in the sphere of reproductive ethics in South Africa has been the enacting of the Choice on Termination of Pregnancy Act of 1996. The Act provides for termination of pregnancy on request of the woman up to 12 weeks of pregnancy, and at the discretion of medical practitioner (for a variety of reasons) until 20 weeks of gestation. This remains a highly contested issue especially because it gives

power to women of any age to make this choice. It also invokes the issues of informed consent, treatment of minors, and the role of parents/guardians in the choices of the minors.

3.5. The Introduction of the National Health Insurance (NHI)

The proposed National Health Insurance (NHI), is identified as the solution, as it will apparently provide more equitable access to high-quality individual health services to the whole population on an equitable and sustainable basis. This program however, experts argue, will require a total re-engineering, transformation and the total overhaul of the existing system and the infrastructure (The Economist Intelligence Unit 2011). Health economists have suggested that it would be feasible to raise the additional required funding for the NHI. However, expectations that equity in healthcare delivery could be achieved at levels close to current private-sector levels appear to be unrealistic and farfetched. It is clear from the disparities in funding of the private and public sectors and the very large number of additional healthcare professionals required that this is unlikely and, if achievable, would take a very long time (Mayosi & Benatar 2014). They argue that ‘creating an efficient and effective National Health Service would be an even greater challenge’.

3.6. End of Life Decisions Act 1998: A Draft bill

The one legislation that has not received much attention from parliament is the draft bill of the End of Life Decisions Act 1998. In 1998 the then President Nelson Mandela commissioned the South African Law Commission (SALC) to write a report to be tabled in parliament on law reform in respect of range of end-of-life decisions. This report, Project 86, dated November 1998 – titled *Euthanasia and the artificial preservation of life*, Project 86 (“SALC Report”) was tabled in parliament in 2000, but regrettably, there has since been no progress (Landman 2012). The three legislative options in the 1998 draft bill were tabled by Landman (2012) as follows:

‘The SALC Report offered three legislative options in respect of assisted dying. Option 1 retains the *status quo*, with assisted dying remaining unlawful. Option 2 proposes legalising assisted dying, with the involvement of the patient, the

attending medical practitioners and the family in the decision-making. Option 3 also proposes legalising assisted dying, but the decision-making becomes the responsibility of an institutional ethics committee' (Landman 2012).

Landman (2012) argues however that the SALC report seems to favour Option 1 which Landman (2012) finds problematic. Landman (2012) argues that '...something akin to Option 2 should become law', and that '[t]his is where the public debate should commence, informed by interpretation of the developments in several sections and the spirit of the Constitution'.

4. Chapter Four: Brief Overview of Medical Law and Ethics

4.1. The Four Pillars of Medical Ethics

Many authors have written about medical ethics, but the most relevant framework is arguably the one Beauchamp and Childress (2001)¹⁵. Beauchamp and Childress (2001) describe the four principles that are cornerstone to ethics, which are beneficence, non-maleficence, autonomy, and justice. Perhaps it is worthwhile, before dwelling into these principles, to first describe the term *ethics*. Beauchamp and Childress (2001) describe *ethics* as a 'generic term covering several different ways of examining and understanding the moral life'. Slabbert (2010) further describe ethics as 'the systematic inquiry into human conduct with the purpose of discovering both the rules that govern or ought to govern human action, as well as the good that is worth seeking in human life'.

Slabbert (2010) argues that '[e]thicists attempt to answer the question: "What is right (or wrong), good (or bad)?"' although this view, argues Slabbert (2010), is not as straightforward as it may appear. 'It is more about what is the right decision (morally speaking), in particular circumstances, what is the lesser of two evils, what is the balance between doing good and causing harm' (Slabbert 2010). We can now then turn into Beauchamp and Childress guiding principles:

¹⁵ Beauchamp and Childress's four principles is one of the most widely used framework that offers a broad consideration of medical ethics issues generally, and not just for use in clinical setting –(UKCEN: www.ukcen.net)

4.1.1. The Principle of Beneficence

Moodley (2014) describes the concept of beneficence as referring to 'doing good and the active promotion of goodness, kindness and charity' whilst Slabbert (2010) add that this means that a doctor should act in the best interest of a patient or as the Hippocratic writings determine "at least do-no-harm". The further argument though here advanced by Slabbert (2010) is that '[b]y applying this principle, one may be confronted by the doctrine of double effect, meaning that a certain course of action with an overall benefit may be ethical even if it causes some harm'. A balancing game therefore has to be played between for example benefits of treatment against the risks and costs. The second principle, namely non-maleficence should therefore be considered simultaneously as beneficence cannot directly be applied to non-therapeutic interventions' (Slabbert 2010). According to Beauchamp and Childress (2001), therefore the '*principle of beneficence* refers to a statement of moral *obligation* to act for the benefit of others.

4.1.2. The Principle of Non-Maleficence

Moodley (2014) argues that 'medical practice is firmly rooted in the principle of *primum non nocere* – first do no harm'. An example of some controversy with this principle is best described by Slabbert (2010) in a context of the living organ donor and recipient where non-maleficence as a principle is to a measured extent breached since the surgery and the loss of an organ do carry some risks for the donor. Slabbert (2010) argues further to say however it would be narrow-minded to focus only on the donor, as the doctor has two patients to consider, both the donor and the recipient. Avoiding or minimizing harm is the cornerstone of this principle (Moodley 2014). Moodley (2014) reiterate the rules of non-maleficence from Beauchamp and Childress (2001) as follows:

- Do not kill
- Do not cause pain or suffering to others
- Do not incapacitate other
- Do not cause offense to others
- Do not deprive other of the goods of life

4.1.3. The Principle of Autonomy

McQuiod-Mason and Dhali (2001) recite Beauchamp and Childress in that they relate respect for autonomy to individual autonomous choice and decision making by the individual. Slabbert (2010) write that “[t]he word "autonomy" was first used in correlation with states that were self-governed and that [p]hilosophers adapted this term to be applicable to the rights and interests of individuals’. According to Slabbert (2010) ‘Kant¹⁶ taught that a person has free will and can therefore decide what should be done in specific circumstances, and by implication, he is also responsible for his own actions’. Slabbert (2010) argue, that ‘[f]or Kant, autonomy requires acting in accordance with one's true self – that is, one's rational will’ and that ‘...being autonomous means doing as one ought to, as a rational being’. Moodley (2014) recite quote of Isaiah Berlin (1969) from a *Companion to bioethics*, Kuhse and Singer (1998:441), to attempt to put autonomy into context, as follows:

“I wish my life and decisions depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not of other men's, acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes, which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not nobody: a doer – deciding, not being decided for, self-directed and not acted upon by external nature or by other men as if I were a thing, or an animal or a slave ... I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing responsibility for my choices and able to explain them by references to my own ideas and purposes”.

Rules that are justified by the principle of respect for autonomy as listed by Moodley (2014) from Beauchamp and Childress (2001) as follows:

1. Tell the truth
2. Respect the privacy of others

¹⁶Immanuel Kant; (22 April 1724 – 12 February 1804) was a German philosopher who is considered the central figure of modern philosophy. – Wikipedia, the free encyclopedia

3. Protect confidential information
4. Obtain consent for interventions with patients
5. When asked, help others make important decisions

Moodley (2014) emphasizes that '[m]edical confidentiality is another way of respecting the patient's autonomy.

4.1.4. The Principle of (Distributional) Justice

According to Beauchamp and Childress (2001) the principles of justice refers mainly to what is fair (fairness), to what is deserved (desert) and to what the individuals are entitled to (entitlement). Beauchamp and Childress (2001) summarize this principle as representing what is fair, equitable, and what is appropriate treatment in light of what is due or owed to individuals. It is concerned with "fairness and equality" and assists to determine whether the benefits and burdens are distributed fairly in society (Beauchamp and Childress 2001).

5. Chapter Five: A Case Review of Medico-legal and Ethical Issues in the Democratic South Africa

5.1. Issues Relating to Medical Confidentiality

5.1.1. The High Profile Patient

The media attention and public opinions are not uncommon in high profile cases. These happen especially where a person holds a public office, is a celebrity or public figures of interests. In this section the Medical Protection Society (MPS) (Casebook 2014) reviews 'the contrasting experiences of two South African health ministers when it came to the confidentiality of their medical conditions'. According to the Medical Protection Society (MPS) casebook (2014), in 2007, the late health minister Dr Manto Tshabalala-Msimang¹⁷ was admitted to the Johannesburg Hospital, reportedly suffering from anaemia and pleural effusion. Dr Tshabalala-Msimang, however, MPS (2014) reports,

¹⁷Dr. Mantombazana 'Manto' Edmie Tshabalala-Msimang (9 October 1940 – 16 December 2009) was a South African politician. She was Deputy Minister of Justice from 1996 to 1999 and controversially served as Minister of Health from 1999 to 2008 under President Thabo Mbeki. – Wikipedia, the free encyclopedia

later underwent a liver transplant. Reportedly, the stated cause was autoimmune hepatitis with portal hypertension, but the papers reported that the transplant was surrounded by accusations of heavy drinking. MPS (2014) remark that '[t]he fact that these details made it into the public domain meant Dr Tshabalala-Msimang's right to confidentiality had been breached'. In 2013, MPS (2014) reports, the 'current health minister Dr Aaron Motsoaledi¹⁸ was also reportedly admitted to Steve Biko Academic Hospital in Pretoria, for an undisclosed procedure'. His spokesperson reportedly confirmed to the media that Dr Motsoaledi had been admitted, but declined to give the reason – citing doctor-patient confidentiality'.

It is clear from the HPCSA guidelines and the national health act that the individual medical confidentiality is absolute, except when the patient gives consent, there is a court order or third parties or public health are at risk (Section 14 of the National Health Act 2003). But it is mute when it comes to public figures. The question is thus, whether being a public figure waives your right to medical confidentiality or privacy. In *Tshabalala-Msimang and Another v Makhanya and Others* (2007) the Judge Jajbhaj commented in the judgment that '[t]he difficulty is compounded when two competing constitutional rights come into conflict, one right must suffer. Thus, the first applicant must suffer the limitation of her right to privacy. However within all the euphoria and outcry against the conduct of the first applicant, she does enjoy support. Just because we possess rights, does not mean that we must exercise them to the hilt at every opportunity. Though we enjoy the freedom of expression, we would be ill advised to celebrate them by vilifying each other on the slightest pretext'. This, arguably, leaves us in the dark as there is a concept of public interest.

5.1.2. What Does The Law Say?

Section 1 of the Constitution informs us that the Republic of South Africa is one sovereign, democratic state founded on the following values: (a) human dignity, the achievement of equality and the advancement of human rights and freedoms. This means that there are in existence dominant values as well as an ethos that binds us as

¹⁸Dr Aaron Motswaledi is the Minister of Health of South Africa. – From Wikipedia

communities to ensure social cohesion. In South Africa we have a value system based on the culture of Ubuntu¹⁹. Ubuntu must become a notion with particular resonance in the building of our constitutional democracy. “The value of human dignity in our constitution is not only concerned with an individual’s sense of self-worth, but constitutes an affirmation of the worth of human beings in our society. It includes the intrinsic worth of human beings shared by all people as well as the individual reputation of each person built upon his or her own individual achievements. The value of human dignity in our constitution therefore values both the personal sense of self-worth as well as the public’s estimation of the worth or value of an individual. It should also be noted that there is a close link between human dignity and privacy in our constitutional order (*Tshabalala-Msimang and Another v Makhanya and Others* 2007).

The right to privacy, entrenched in Section 14 of the Constitution, recognises that human beings have a right to have a sphere of intimacy and autonomy that should be protected from invasion. This right serves to foster human dignity. The National Health Act 2003 makes it an offence to disclose patients’ information without their consent, except in certain circumstances. Sections 14, 15 and 16 of the Act are pertinent with regards to confidentiality. In particular, sections 15 and 16 describe how patient information may be disclosed by a healthcare worker “for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user”. It is not just in law that confidentiality is delineated; the HPCSA views it as central to the doctor-patient relationship and a core aspect of the trust that holds the relationship together (*Tshabalala-Msimang and Another v Makhanya and Others* 2007).

¹⁹ Ubuntu refers to the capacity to express compassion, justice, reciprocity, dignity, harmony and humanity in the interests of building, maintaining and strengthening the community. Ubuntu speaks to our inter-connectedness, our common humanity and the responsibility to each that flows from our connection. Ubuntu is a culture which places some emphasis on the commonality and on the interdependence of the members of the community. It recognizes a person’s status as a human being, entitled to unconditional respect, dignity, value and acceptance from the members of the community that such a person may be part of. – From *Khumalo and others v Holomisa*, [2002] ZACC 12; 2002 (5) SA 401 (CC) 418 at para [27]

The HPCSA's official guidance, Confidentiality: Protecting and Providing Information (2008), lists the key principles:

1. 'Patients have a right to expect that information about them will be held in confidence by health care practitioners. Confidentiality is central to trust between practitioners and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide good care.
2. Where health care practitioners are asked to provide information about patients, they should:
 - Seek the consent of patients to disclosure of information wherever possible, whether or not the patients can be identified from the disclosure; Comprehensive information must be made available to patients with regard to the potential for a breach of confidentiality with ICD10 coding.
 - Anonymise data where unidentifiable data will serve the purpose;
 - Keep disclosures to the minimum necessary.
3. Health care practitioners must always be prepared to justify their decisions in accordance with these guidelines'.²⁰

5.2. Distributional Justice Issues

5.2.1. Power, Politics and Preferential Treatment:

5.2.1.1. Regarding Access to Health Care

The South African Constitution, Section 27, dictates that all citizens have entitlement to access adequate healthcare and to be healthy. According to Slabbert (2010) '[i]n *Soobramoney v Minister of Health (KwaZulu-Natal)*(1998) however, the Constitutional

²⁰HPCSA, Confidentiality: Protecting and Providing Information (2008), para 4

Court had to interpret the scope and content of the right to access to health care under Section 27. The appellant was a 41 year old Indian male diabetic suffering from a heart disease, vascular disease and irreversible renal failure whose life could be prolonged by means of regular dialysis. He was not admitted to the dialysis programme at the Addington Hospital in Durban because the hospital did not have sufficient resources to provide dialysis to all patients suffering from renal failure. The primary requirement of the hospital for admission of a patient on dialysis was his eligibility for a kidney transplant. Because of his other illnesses, he was not a candidate for a transplant and therefore also not allowed on the dialysis programme. He applied to the local division of the High Court to direct the hospital to provide him with dialysis but the application was dismissed. He then appealed to the Constitutional Court' (Slabbert 2010).

The Court held, According to Slabbert (2010) that 'the obligation imposed on the State under Section 27 was dependent upon the resources available. Owing to budgetary constraints, there were not enough dialysis machines available at the hospital to treat all patients. Were all the people in South Africa who suffer from chronic renal failure to be provided with dialysis treatment, the cost of doing so would substantially affect the allocated health budget. It was thus submitted that in view of the above, the State should allow a patient an alternative by permitting him to buy a kidney from a living donor (seller) and thereby be removed from the dialysis programme and no longer be a financial burden to the State (Slabbert 2010)²¹.

A case perhaps that raised a lot of ethical questions about the equality, healthcare access and distributional justice, and even medical futility concerns, is that of Nelson Mandela²², the first black and democratically elected South African president. Wilkinson (2013) writes that '[a]t the age of almost 95, and physically frail, Nelson Mandela was admitted to an intensive care unit (ICU) with pneumonia. He remained there for

²¹*Ethics, justice and the sale of kidneys for transplantation purposes. Slabbert, M.* 2, s.l. : PELJ/PER, 2010, Vol. 13.

²²Nelson Rolihlahla Mandela (18 July 1918 – 5 December 2013) was a South African anti-apartheid revolutionary, politician, and philanthropist, who served as President of South Africa from 1994 to 1999. He was the country's first black head of state and the first elected in a fully representative democratic election. – Wikipedia, the free encyclopedia

three months before being transferred for on-going intensive care in a converted room in his own home'. Wilkinson (2013) argues that Mandela '...received, in his last six months of life, a very large amount of highly expensive and invasive medical treatment'. It was reported that he was receiving ventilation and renal dialysis, a level of treatment, Wilkinson (2013) argues '...that would be unthinkable for the vast majority of South Africans, and, indeed, the overwhelming majority of the people with similar illnesses even in developed countries'. 'Frail elderly patients with pneumonia are not usually admitted to ICUs', Wilkinson (2013) adds. 'They do not have the option of prolonged support with breathing machines and dialysis at home' (Wilkinson 2013).

Young (2013) argued in the Mail and Guardian Thought Leader that '[i]t would be wrong to speculate too much on the details of Mandela's care because they have not been released to the public. Nor should they be. This is private information on a private individual's health and it is protected by law. We have no right to know. So no one other than family and medical team knows what might have set the latter on an unusual, at least on *prima facie*, path of treatment'. The ethical questions raised however, are whether the medical decisions and the standard of care Nelson Mandela received, was deviation from standard medical practice, or whether was influenced by political pressure, or the status of Mr Mandela being an exceptional and loved person? And if so, is this position ethical? Young (2013) argues however that perhaps '[t]here might have been exceptional circumstances' but further debates that '[i]f Mandela got preferential treatment because of who he was, does this not break every ethical medical convention and principle of equality under the law and under our Constitution?' The other question raised is: what about the younger people, less frail, and with higher chances of survival, and more years of potential life ahead of them, being allowed, or even forced, to die because of economic considerations and financial constraints (Young 2013). It can be added here also that perhaps the other 95 year olds would also expect same kind of treatment, in a country with such limited resources. Young (2013) further pose an important which is whether Mandela, being the kind of a person he is, the freedom fighter, and a human rights champion, whether he would approve of such preferential treatment, if any (Young 2013)? It is impossible to take a position here, the

media spotlight on the doctors was staggering, and one can almost assume that no single doctor would have wanted to be blamed for Nelson Mandela's death. Others go further to argue that Mandela's death had to be timed for certain political benefit by the ANC, or to allow family disputes to be resolved, and that perhaps he had long been dead. If these conspiracies were true, would doctors have been part of this conspiracy, one can only wonder.

5.2.1.2. Regarding Organ Transplantation

A lot of newspapers wrote about the issues surrounding the liver transplant of the late health minister Dr Manto Tshabalala-Msimang. The issues raised include fairness, distributional justice and medical ethics. In a country that is stretched for resources with the availability of organs being one of the major problems, one would expect process that allows for fairness and justice. There are also medical standards that set prerequisites for organ transplantation. McGreal (2007) writes that '[a]s South Africa's health minister, Dr Manto Tshabalala-Msimang²³ was vilified as an accomplice to genocide for failing to provide treatment for the millions of people with HIV'. With the stance she took on HIV/AIDS approach, she, McGreal argues, 'became the subject of international ridicule for promoting garlic, beetroot and vitamins as an alternative to AIDS drugs, which earned her the synonyms such as Dr Beetroot and Dr Death'. This position, you would assume, was based on the lack of resources. In 2007 the minister was ill and needed a liver transplant according to the reports. With haste, and in an unusually short time, the minister received an organ, in what caused uproar within society in a country with a long waiting list for organs such as liver. She was accused, McGreal further writes, '...of abusing her position to hide chronic alcoholism and obtain a liver transplant'. 'The opposition parties called on the then president, Thabo Mbeki²⁴, to sack his health minister, calling her a "moral and legal liability" after Johannesburg's

²³Dr. Mantombazana 'Manto' Edmie Tshabalala-Msimang (9 October 1940 – 16 December 2009) was a South African politician. She was Deputy Minister of Justice from 1996 to 1999 and controversially served as Minister of Health from 1999 to 2008 under President Thabo Mbeki. – Wikipedia, the free encyclopedia

²⁴Thabo Mvuyelwa Mbeki, (born 18 June 1942) is a South African politician who served nine years as the second post-apartheid President of South Africa from 14 June 1999 to 24 September 2008. – Wikipedia, the free encyclopedia

Sunday Times reported that Dr Tshabalala-Msimang and her doctors hid her drinking problem so she could receive a donor liver from a teenage suicide victim, even though she had not given up alcohol - normally a prerequisite for the operation' (McGreal 2007).

Zuckerman & Loveland (2012) write about general listing criteria, indications, prioritization, for liver transplant, and seem to exclude alcohol related causes of liver damage. The age of the patient also seem to be the determining factor, with younger people prioritized especially in a resource limited setting. The papers argue that the minister was given preferential treatment in that she wouldn't qualify for transplant due to her age, alcohol abuse, and the fact that she was never place on the waiting list, like everyone else, they argue. 'The papers reported that the minister needed the transplant because alcohol had destroyed her liver and that usually a woman of her age - 66 - who had failed to give up drinking before the operation would not have qualified for an organ. The article claims that doctors and staff knew Dr Tshabalala-Msimang was drinking immediately before the transplant' (McGreal 2007)²⁵. If the doctors were aware of these, were medical ethics not bent? Was it also not medical futility, considering the outcomes thereafter? Did doctors apply their clinical independence, or was there coercion? These are perhaps ethical and medico-legal questions that remain unanswered.

5.2.1.3. Regarding Prisoner's Medical Parole

According to the newspaper reports, (Mail and Guardian and others), President Jacob Zuma's²⁶ former financial advisor, Shabir Shaik²⁷, was convicted of fraud in 2005 and sentenced to 15 years in prison on each of two counts of corruption and another three years for fraud. He only served two years and four months of that jail sentence, the

²⁵[Online] The Mail and Guardian, 2007. <https://www.theguardian.com/world/2007/aug/20/southafrica>

²⁶Jacob Gedleyihlekisa Zuma, (born 12 April 1942) is the President of South Africa, elected by parliament following his party's victory in the 2009 general election. He was re-elected in the 2014 election. – Wikipedia, the free encyclopedia

²⁷Shabir Shaik is a South African businessman from the Berea, Durban, who rose to prominence due to his close association with South African President Jacob Zuma during Zuma's time as Deputy President. On 2 June 2005, he was found guilty of corruption and fraud, which also led to Zuma's dismissal by then President Thabo Mbeki. – From Wikipedia, the free encyclopedia

majority of it in a hospital environment. He was subsequently granted medical parole in 2009 as a terminally ill prisoner and released out of prison. Shaik was released on medical parole on 3 March 2009 after serving two years and four months, ostensibly suffering from life-threatening severe hypertension. His brother Yunis said Schabir's body was responding less and less to hypertensive medication and that his eyes, kidneys and areas of the brain were affected, adding that their parents both died at a young age from the condition. The head of cardiology at Inkosi Albert Luthuli Hospital in Durban, Professor D P Naidoo, discharged him in December 2008 because he was considered well enough to leave but Shaik remained in the ward until his parole²⁸. From the very outset, the authenticity of Schaik's medical parole was questioned. When asked if he was terminally ill, Shaik told the Mercury newspaper in 2013 that he was suffering from "severe uncontrollable hypertension", the same genetic illness that both his parents apparently experienced. When he was released on medical parole in 2009 and taken home in an ambulance, there was an abundance of scepticism from an already cynical public about whether he was truly eligible or if he was just receiving preferential treatment. His proximity to President Jacob Zuma had surely earned him a free trip home, most surmised. His behaviour while on medical parole cemented that doubt. He allegedly throttled and slapped a journalist while playing golf. Then he was accused of punching and slapping a man at a mosque during an argument about parking. He swanned about Durban in his luxury vehicles and was frequently spotted on the golf course. It was hardly the behaviour becoming of a terminally ill patient waiting to die.

Weiner (2015) argues that the counter argument, according to reports, is that we cannot expect Shaik to justify his medical parole by dying. No one would reasonably wish death upon him in order to prove that the system is not corrupt. The same argument applied to former police commissioner Jackie Selebi²⁹. When he died in 2014, some responded

²⁸[Online] SAMJ, 2012. <http://www.samj.org.za/index.php/samj/article/view/5804/3980>

²⁹Jacob (The Polo) Sello Selebi (7 March 1950 – 23 January 2015) was the former national commissioner of the South African Police Service and the President of African National Congress Youth League 1987-1991, and a former president of Interpol. In January 2008, Selebi was put on extended leave as national police commissioner, and

by suggesting that in death he proved that he was indeed ill and worthy of medical parole. It was because of Shaik and the disingenuousness surrounding his medical parole that so many doubted the veracity of Selebi's claims of ill health. The erstwhile commissioner would not have had to endure the jokes and disparaging remarks about suffering from 'the Shaiks' or faking his diabetes had Shaik not poked holes in the integrity of the system. Jackie Selebi was serving 15 years after being convicted in July 2010 of accepting money from shadowy millionaire businessman, Glenn Agliotti, himself acquitted of murdering mining magnate Brett Kebble. Selebi was treated at the Steve Biko Academic Hospital for diabetes-related kidney problems and underwent laser surgery to his eyes before being discharged to the Pretoria Central Prison hospital unit. Clive Derby-Lewis³⁰ was suffering from cancer that metastasised and serving 25 years for the murder of South African Communist Party secretary-general Chris Hani³¹ in 1993. He had arranged a firearm for hit-man Janusz Walus, who is also serving the same prison term. He was repeatedly denied parole since he began applying in 2010, most recently in January 2015, after objections from the Hani family. After multiple times being declined parole, his appeal was taken to court where the judge granted him medical parole on 29 May 2015. He was released from prison in June 2015 after serving 22 years, due to his terminal lung cancer. Derby-Lewis was twice recommended for ordinary parole by the Correctional Supervision and Parole Board, but was turned down by the relevant minister in 2007, 2011 and again in 2013.

resigned as president of Interpol, after he was charged with corruption in his native South Africa. Selebi was found guilty of corruption on 2 July 2010 and sentenced to 15 years' imprisonment on 3 August 2010. His appeal against his sentence was rejected by the Supreme Court of Appeal on 2 December 2011, after the court unanimously ruled against him. However, he was released on medical parole in July 2012. - From Wikipedia, the free encyclopedia

³⁰Clive John Derby-Lewis (born 22 January 1936) is a South African ex-politician, who was involved first in the National Party and then, while serving as a member of parliament, in the Conservative Party. He served a life sentence for his role in the assassination of South African Communist Party leader Chris Hani. – From Wikipedia, the free encyclopedia

³¹Chris Hani, born Martin Thembisile Hani (28 June 1942 – 10 April 1993)[1] was the leader of the South African Communist Party and chief of staff of Umkhonto we Sizwe, the armed wing of the African National Congress (ANC). He was a fierce opponent of the apartheid government. He was assassinated on 10 April 1993.- From Wikipedia, the free encyclopedia

The widespread criticism around Shaik medical parole prompted the Correctional Services to appoint a Medical Parole Review Board, comprised of a dozen or more medical officers and experts. From 1 March 2012, all applications for medical parole (now allowed on grounds of incapacitating disease and not just terminal illness) went through the new single central Medical Parole Review Board. Prior to this, the power to recommend medical parole resided on a single medical officer attached to the particular prison. Set up in terms of the Correctional Matters Amendment Bill³², the new body is independent of government and may call in as many expert opinions as it pleases. While the 52 general parole boards could in the past call in expert medical opinion, the system was open to abuse and selective bias, as was the influence of each prison district's medical officer. In the past the doctor at each facility decided to board the patient and took it to the (case management) committee at the local level, who made the decision. Multiple prisons' inspections by government and South African Medical Association (SAMA) officials, also shown that very few prisons have sufficient or appropriate medical facilities for serious conditions. The probes uncovered a chorus of 'cry foul' complaints by prisoners who said politically connected individuals were receiving preferential treatment while large numbers of medical parole applications by seriously ill inmates were being overlooked.

5.3. End-of-Life Issues

5.3.1. Physician Assisted Suicide (PAS) and Assisted Dying (AD): An Overview

5.3.1.1. Current Legal status

"The time will come when our nation will honour the memory of all the sons, the daughters, the mothers, the fathers, the youth and the children who, by their thoughts and deeds, gave us the right to assert with pride that we are South Africans, that we are Africans and that we are citizens of the world" - Nelson Mandela May 1994.

³²The new Act says that any offender with a condition that constitutes a terminal disease or an offender who is rendered physically incapacitated as a result of injury, disease or illness 'so as to severely limit daily activity or inmate self-care', should qualify for medical parole.

Perhaps in what can be called a watershed judgement in South Africa on Assisted Dying is the Stransham-Ford case. In *Stransham-Ford v Minister of Justice and Correctional Services and Others* (2015), Judge Fabricius ruled in the application of Advocate Robert James Stansham-Ford who was diagnosed with terminal stage 4 prostate cancer and who had requested a medical practitioner, registered as such in terms of the Health Professions Act, 1974 (Act No 56 of 1974) to end his life or to enable him to end his life by the administration or provision of some or other lethal agent. Presiding Judge HJ Fabricius said that in his pronouncement that the Applicant was entitled to request a medical practitioner, who would be willing to assist him to end his own life, to do so (Herbst 2015) The Judge insisted however that a development of law is still required with regards to Assisted Dying (AD), since current legal position is that assisted suicide or active euthanasia is unlawful (De Rebus 2015). In his application, Advocate Stransham-Ford, advanced the argument about Human dignity, bodily and psychological integrity, and not to be treated in a cruel, inhumane or degrading way, amongst other things. He also put a request for the court to declare that the medical practitioner who assists him be immune from prosecution (De Rebus 2015). The latter point is important if one is to consider the current position of the HPCSA and the medical association, which are strongly opposed to assisted suicide, and even threaten prosecution or deregistration of medical practitioners that might consider doing so. In his application Advocate Stransham-Ford also referred to the project by South African Law Commission (1998) which has since been stagnant, and I what may be assumed to be a call on government to advance the legislation on assisted dying. Judge Fabricius pointed out that the Commission said that the department of health had in principle agreed with its proposed legislation legalizing euthanasia. This is an interesting observation from the judge as he continued to say that '[i]n the absence of legislation, which is government's prerogative, any other court will scrupulously scrutinize the facts before it, and will determine on a case by case basis...' (De Rebus 2015).

Grant (2015) argues that, on these bases that the Physician Assisted Suicide (PAS), AD, or Euthanasia is arguably, now, both legal and illegal in South Africa, which makes our law to be in a state of conflict. Grant (2015) notes the several old Appellate Division

(AD), now known as the Supreme Court of Appeal (SCA), decisions that euthanasia is unlawful (Robinson 1968; Grotjohn 1970) and the other case that Grant (2015) thinks was progressive for its time – of Clarke v Hurst (1992 D) and now, that of Stransham-Ford³³ in the Gauteng North High Court (of 29 April 2015), holding that euthanasia is lawful, the decision that was opposed by the Christian lobby group Doctors for Life, the HPCSA and Correctional services department. Grant (2015) also brings to our attention the recommendations made by SA Law Commission in 1999 that passive euthanasia/assisted suicide be legalized.

Newspapers reports reported that Stransham-Ford passed away shortly afterwards peacefully, but unassisted while under the care of medical professionals and in the presence of his family. He never got to hear of or benefit from the Court's ruling. Up until Judge Fabricius handed down the order, it was clear that assisting a patient to take his or her own life was illegal in terms of South African law and could potentially open doctors up to civil claims, criminal prosecution and disciplinary action from within the medical profession (Sowetan Live 2015).

5.3.1.2. Patient Autonomy

According to news reports, Stransham-Ford, a former advocate himself, had approached the Pretoria High Court urgently, assisted by Dignity SA³⁴. This right, Dignity SA argues is grounded in the constitutional rights to life, dignity, bodily and psychological integrity and to be free from cruel, inhuman and degrading treatment. Parliament's failure to pass a law to protect these rights is in Dignity SA's view a violation of its obligation to respect and protect the rights in the Bill of Rights and therefore in conflict with the Constitution. The case appeared to centre on Stransham-Ford's right to have his inherent human dignity respected and protected³⁵. In the

³³Stransham-Ford was a 65-year-old man who was dying of prostate cancer. He had asked the court to determine whether a doctor could legally assist him to end his life.

³⁴ Dignity SA is an organisation which campaigns for "the right of terminally ill, chronically suffering people to choose the time and place of their death"

³⁵[Online] The Mail and Guardian, April 2015. [Cited:] <http://mg.co.za/article/2015-04-30-court-grants-man-right-to-assisted-death>

application they note human dignity as a foundational value upon which the entire Constitution is built. The right to live with dignity, according to Dignity SA, includes the right to choose to die with dignity. Judge Fabricius's order gave an indication that it is a combination of some of these rights and other provisions of the Constitution detailing the state's obligations upon which his decision is based. He found that the crimes of "murder or culpable homicide in the context of assisted suicide by medical practitioners, insofar as they provide for an absolute prohibition, unjustifiably limit [Stransham-Ford's] constitutional rights" to dignity and bodily and psychological integrity. His judgment was therefore likely to acknowledge a right to choose to die with dignity and have professional medical assistance in doing so.

Although Judge Fabricius, according to news reports, appeared to be attempting to limit the scope of the influence of this decision, it was a decision which would have far-reaching implications. The judge was also reportedly careful to include in his order a proviso that although, doctors may have in terms of the order, been legally permitted to either administer a "lethal agent" to Stransham-Ford's or provide him with a lethal "to administer himself", no doctor is "obliged to accede to [Stransham-Ford's] request" (*Stransham-Ford v Minister of Justice and Correctional Services and others 2015*).

Other cases of that were also impactful although they did not advance, are those of Mario Oriani-Ambrosini³⁶, and Avron Moss³⁷. According to reports, in August 2014, Inkatha Freedom Party Member of Parliament, Mario Oriani-Ambrosini, a friend of Stransham-Ford's, who was in the final stages of terminal lung cancer, took the decision to shoot himself in his room in Cape Town. Most recently (2015), Avron Moss whose final statement to Dignity SA before taking the drugs and ending his life was: "*That healthcare professionals cannot assist [terminally ill patients], and that these patients*

³⁶On 19 February 2014 Mario Oriani-Ambrosini stood up in the National Assembly and introduced a private members bill to decriminalise the medical use of cannabis. The Medical Innovation Bill, he quoted is "to make provision for innovation in medical treatment and to legalise the use of cannabinoids for medical purpose and beneficial commercial industrial uses.

³⁷Avron Moss was a 49 year old Capetonian paediatric neuropsychologist and patron of Dignity SA, who went to the extraordinary length of illegally importing lethal drugs from Mexico and then ensuring their effectiveness by having them tested using a testing kit sourced in Australia to ensure that he could take his own life.

are forced to buy questionable medication to end their lives from unscrupulous websites, or suffer the terror of having to shoot or hang themselves, ought to be abhorrent to any caring professional . The relevant law in South Africa actively perpetuates suffering, in conflict with our Constitution and with Human Rights, and is indefensibly unjust. All caring health care professionals ought to be actively involved in campaigning to change the law”³⁸.

5.3.1.3. Implication to the Practice of Medicine

The HPCSA has adopted the World Medical Association’s (WMA) view on euthanasia and assisted suicide. Professor Sam Mokgokong wrote a report (undated but after 2015 Stransham-Ford case judgement) indicating the position of the council. In it, the WMA statement, adopted in Spain 1992, is re-emphasised that “Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession”. Mokgokong states that ‘[c]ouncil finds active euthanasia, or the wilful act by health care professional to cause death of a patient unacceptable, notwithstanding whether or not such as act is performed at the request of the patient or his or her closest relatives or of any other person’. Mokgokong also refers this council position to the Hippocratic Oath with prohibits assisted suicide.

This is however an unfortunate position taken by the HPCSA, seeing the progress that the world has made towards assisted suicide and the stark contrast that this has on patient autonomy and human rights. The reference to the Hippocratic Oath is also problematic as the medical profession is already not sticking to the tee of this oath. What perhaps the council is also failing to understand is the distinction between law and ethics. The debate that is being pushed is for assisted suicide to be made law instead. The debate on ethics is a different one as it perhaps needs one to consider a lot of common ground. It is also strange that the Council finds abortion acceptable and euthanasia not. This technically means that a woman can chose to have her foetus killed and not herself.

³⁸[Online] Ground Up, 2015. http://www.groundup.org.za/article/dying-and-law-dignity-sa-case-explained_2899/

The Hospice Palliative Care Association of South Africa (HPCA), which presumably employs doctors and other health care professionals, is opposed to assisted suicide and euthanasia on the basis that it does not in fact support an individual's dignity nor express the value of that individual and euthanasia is an 'unnecessarily extreme measure given the palliative alternatives that neither prolong nor hasten death' (Gwyther et al. 2015). HPCA argue, on the same breath, that '[t]he duty of the doctor is to heal, where possible, to relieve suffering and to protect the best interests of their patients' and that ' [t]here shall be no exception to this principle even in the case of incurable disease. These statements are in stark contrast, in that they conclude that 'life' and 'living', no matter how unbearable it becomes, for the individual that they would presumably act in best interest of, are worth living, at all cost. The notion that the available choices, which are palliative care, and/or sedation, are adequate is also self-serving and arguably not in the interest of those patients that may require it.

Grant (2015) argues that the expectation from the doctors is going to be higher as they will be expected to know the law or options available, at least until the SCA or Constitutional court decides on the matter?

5.3.1.4. Court arguments and Public Debate on Physician Assisted Suicide and Assisted Dying

Dignity SA (2015) reiterate that '[u]nderstandably, there are serious disagreements in public debate that include: Balancing the right to dignity and the right to life, freedom of choice, legitimate limits of medical practitioners' professional duties, whether suicide should be a purely personal matter, possible abuses of vulnerable persons, access by the poor, effectiveness of safeguards, limits of palliative care, relevance of God's will and cultural beliefs in constitutional interpretation', and that '[t]he question is whether the Constitution and the Fabricius ruling, with its authoritative sources, form the basis for public debate?'. In *Stransham-Ford v Minister of Justice and Correctional Services and others (2015)*, the Health Minister Aaron Motsoaledi's argued that 'giving doctors the right to end a life is dangerous and could lead to a situation in which unscrupulous families arrange the premature deaths of their terminally ill loved ones to cash in on

insurance payments'. He argues that '[t]his judgment has the potential to give rise to fraud and unethical behaviour among doctors'(Motsoaledi2015). "Very soon we will start hearing stories of families colluding with doctors to end the life of their loved ones because they wanted to cash in on insurance policies. Some people may even start planning their deaths because they know that their policies are maturing. We can't have that situation in South Africa because it would be difficult to police and deal with. To prevent it, we must stop it before it goes any further," he said. Motsoaledi said 'doctors should not be given the right to end a person's life because they were not God'. This is a rather weird stance from the minister of health, seeing that abortion, as an example, is already legal in South Africa, but doctors are still able to choose whether to partake or not. It can be argued further here that the minister is insinuating that the doctors are so eager to kill that given any chance, they would run for it.

The South African Medical Association (2015) warned that 'even if the law were to permit medical practitioners to help patients end their lives, the ethical rules of the HPCSA would not allow this'³⁹. This is strange, considering that HPCSA is not above the law or the Constitution of this country. The Department of Justice and Correctional Services stated that '... (a)ny medical doctor providing the assistance sought would be criminally liable, and that the applicant's right to dignity was not at question'. This is rather intriguing considering that the very basis of the application included the request to have doctors not subjected to prosecution.

The HPCSA also opposed the application on the basis that '...the question before the Court was not a matter of dignity and that the applicant could consider other options in the context of palliative care'. The National Prosecuting Authority (NPA), for its part in opposing the application, merely stated that 'assisted suicide was a criminal offence'. Doctors for Life and Cause for Justice were both admitted to the case as *amici*

³⁹Right to die judgement under siege. [Online] The Eye Witness News, May 2015. [Cited:2016]
<http://www.medicalbrief.co.za/archives/right-to-die-judgment-under-siege/>

*curiae*⁴⁰ and argued that that ‘the applicant had merely expressed his subjective views in relation to the right to dignity and his medical condition, whereas the Constitution had to be interpreted in an objective manner’⁴¹. Dignity SA however argued that ‘concern by the health minister is a misplaced concern, given dysfunctional public hospitals’. They argued that ‘there is no intrinsic moral difference between assisted dying and current standard-of-care practices such as not initiating treatment (withholding), terminating treatment (withdrawal), pain management that shortens life (doctrine of double effect) and palliative care is non-negotiable, yet limited by free choice’. They argue that ‘it is not for the state to say we should choose other options, such as palliative care, since we have a constitutional right to dignity, and dignity encompasses one’s own conception of how to cease to live (Judge Fabricius; *Carter v Canada*)’⁴² (*Stransham-Ford v Minister of Justice and Correctional Services and others 2015*).

The Court rejected the Department’s argument that the right to dignity was not at the heart of the application. Instead, the Court stated, that it would have been preferable for the Minister of Justice and Correctional Services, in this instance, to state his intentions about the proposals contained in the South African Law Commission’s (The Commission) 1998 report entitled “*Euthanasia and the Artificial Preservation of Life*”. In that regard, the Court remarked that the Commission’s report, according to the Court, struck a proper balance between the State’s duty to protect life and the individual’s right to end his life. The Court further rejected the Department’s contention that the development of the common law would leave a void which would lead to abuse, stating that in the absence of legislation, which was the legislature’s responsibility, any court

⁴⁰An amicus curiae (literally, friend of the court; plural, amici curiae) is someone who although not a party to a case and unsolicited by any of the parties in the case, to assist the court in the case offers information that bears on the case. – From Wikipedia, the free encyclopedia

⁴¹*Case discussion, Assisted suicide. What the court said.* [Online] The Centre for Constitutional Rights. <http://www.cfc.org.za/index.php/latest/430-case-discussion-assisted-suicide-what-the-court-said>

⁴²*Carter v Canada* (Attorney General) is a landmark Supreme Court of Canada decision where the prohibition of assisted suicide was challenged as contrary to the Canadian Charter of Rights and Freedoms by several parties, including the family of Kay Carter, a woman suffering from degenerative spinal stenosis, and Gloria Taylor, a woman suffering from amyotrophic lateral sclerosis (ALS). In a unanimous decision on February 6, 2015, the Court struck down the provision in the Criminal Code, giving Canadian adults who are mentally competent and suffering intolerably and enduringly the right to a doctor’s help in dying. From Wikipedia, the free encyclopedia

would still need to determine on a case-by-case basis whether any safeguards against abuse are sufficient. The Department had also contended that the right to life is paramount and that life is sacrosanct as provided for in section 11 of the Constitution. The Court agreed with this contention, but clarified that this provision is meant to safeguard an individual's right in relation to the State and society, rather than one's own life. The Court also rejected the arguments advanced by Doctors for Life and Cause for Justice stating that out of practical necessity, a court was obliged to look at the subjective views of a person whose complaint was that their constitutional rights have been affected. Another consideration for the Court in rejecting the argument advanced by the *amici curiae* was the consideration that the Applicant's view of his condition within the context of human dignity was entirely justifiable. As such, the arguments raised by the *amici* in this regard lacked merit, the judge concluded.

Landman (2012) reiterate that '[t]he exact legal status of the following practices – each involving an underlying moral right – requires greater statutory legal clarity to enable the best possible healthcare for the dying: (i) Terminal pain management– the right to be free from unnecessary suffering; (ii) Withholding and withdrawal of potentially life-sustaining treatment (sometimes referred to as “passive euthanasia”) – the right to a natural death; (iii) Advance directives – the right to future control over one's body and (iv) Assisted dying (the umbrella term used here for assisted suicide and voluntary active euthanasia) – the right to assisted dying'⁴³. The Ethics Institute of South Africa found in 2011 in an admittedly small pilot survey that a majority of doctors were opposed to euthanasia (51%) and Patient Assisted Suicide (PAS) (52%), although an overwhelming majority (73%) was sympathetic to the legalization of patients' advance directives clarifying the degree to which doctors were asked to preserve lives. Forty-three per cent were sympathetic to legalization of provision of lethal drugs to patients seeking PAS (39% opposed, 18% neutral); while 44% were sympathetic to voluntary euthanasia (47% against, 9% neutral). These somewhat confused and confusing results

⁴³*End-of-Life decisions, ethics and law. A case for statutory legal clarity and reform in South Africa. Landman, Willem A.* Geneva : Globethics.net, 2012

suggest that even if euthanasia /PAS were legalized, medical practitioners would be divided as to the morality of the law⁴⁴.

6. Chapter Six: Closing Arguments and Conclusion

6.1. The Right to Die: A Gap in the Constitution?

The South African Constitution, in the Bill of Rights, confers a number of Rights and Freedoms to all citizens. Amongst these rights it's the Right to Life (Section 11), the Right to Human Dignity, both of which have been described as the most important of all human rights, and the Right to Privacy, which at its minimum ensures that certain aspects of an individual's life should remain free from interference by state and by others. The Constitution also puts great emphasis on the individual's Right to Self-determination, Freedom of Choice, and the Right to Autonomy, especially where decisions are about one's life, health and welfare are to be taken. But what about the Right to Die, where life is perceived to be no longer worth living or is devoid of quality of life? (Lukhaimane 1997). Surely, looking at the shift in philosophy in the country's Constitution since the dawn of democracy, the question of the whether individuals have the right to die, begs the answer. Is the right to life absolute, and at all costs? Is this not in contrast with the right to dignity, especially where, for example, terminal illness or aging have stripped the entire individual's right to privacy or dignity?

In a constitutional democracy, diversity amongst citizens is acknowledged, and as such all persons have right to freedom of expression, religion, opinion and choice. Is the right to choose to die of bounds? The Constitution also recognises that some citizens may have moral objections to say for instance abortion, or polygamy, but those citizens have an obligation to respect others' freedom to have different beliefs and the legal right to such practices. Likewise, then it could be argued that law should also recognize the freedom to assisted dying or the right to die. 'In a liberal democracy, the law/Constitution should recognize freedoms of adults that some may consider unethical

⁴⁴ [Online] The Ethics Institute of South Africa, March 2011.
<http://www.tei.org.za/index.php/resources/articles/business-ethics/2198-the-ethics-of-end-of-life-medical-care>

(examples), including the legal right to A[ssisted] D[ying]’ (Landman 2012). In *S v Makwanyane and Another* the Constitutional Court observed that: ‘respect for the dignity of all human beings is particularly important in South Africa. For apartheid was a denial of common humanity. Black people were refused respect and dignity and thereby the dignity of all South Africans was diminished. The new Constitution rejects this past and affirms the equal worth of all South Africans. Thus recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution’.

6.2. The Duty to Live: Is life/living an obligation?

In *Stransham-Ford v Minister of Justice and Correctional Services and others (2015)* the judge quoted the statement from the SA Law Commission Project 86, dated November 1998 – titled *Euthanasia and the artificial preservation of life*, Project 86 (“SALC Report”) that stated that ‘a dying person was still a living person’, and Stransham-Ford was entitled to the rights of a living person. Judge Fabricius remarked that:

‘[t]he irony is, they say, that we are told from childhood to take responsibility for our lives, but when faced with death we are told we may not be responsible for our own passing’. That ‘...[o]ne can choose one’s education, one’s career, one can decide to get married, one can live according to a lifestyle of one’s choice, one can consent to medical treatment or one can refuse it, one can have children and one can abort children, one can practice birth control, and one can die on the battlefield of one’s country. But one cannot decide how to die’. ‘The choice of a patient such as the present is consistent with an open and democratic society and its values and norms as expressed in the Bills of Rights’. And that ‘...the State sanctions death when it is bad for a person, but denies it when it is good’.

He thus concluded that there is ‘...no duty to live, and a person can waive his right to life’. It can be argued that this is a most progressive statement that is arguably in line with Constitution. In *Clarke v Hurst and Others*, the same view is shared in that the maintenance of life cannot be equated with living.

6.3. The Slippery Slope

Critics of euthanasia often claim that legalizing euthanasia will lead to slippery slope effect. Lewis (2007) discusses the slippery slope argument for euthanasia and points out that slippery slope argument has been present in euthanasia debate since at least 1930's'. Lewis (2007) points out that, as applied to euthanasia debate, the slippery slope argument claims that endorsing some premise, doing some action or adopting some policy will lead to some definite outcome that is generally judged to be wrong or bad. Lewis (2007) further describe that the "slope" is slippery because there are claimed to be no plausible halting points between the initial commitment to a premise, action, or policy and the resultant bad outcome'.

To argue therefore, based on this principle, that the acceptance of certain practices, such as physician-assisted suicide or voluntary euthanasia, will invariably lead to the acceptance or practice of concepts which are currently deemed unacceptable, such as non-voluntary⁴⁵ or involuntary euthanasia⁴⁶ is not only absurd, in that there it's a bad principle, but also because there is no evidence suggesting that in societies where such practices are permitted, bad outcomes are happening.

6.4. What about Medical Futility?

The case of Nelson Mandela has been discussed with regards to preferential treatment, but the other issue is perhaps whether the treatment he received did him any good? Was it to his benefit to receive such high-tech and state of the art medical treatment at his age? Landman (2012) argue that '[d]ying is a natural and inevitable part of life' and that '[u]nless we die an unnatural death, we will go through a natural dying process'. 'For some, it will be peaceful and dignified; for others it will be filled with pain, anxiety

⁴⁵**Non-voluntary euthanasia** is euthanasia conducted when the explicit consent of the individual concerned is unavailable, such as when the person is in a persistent vegetative state, or in the case of young children. It contrasts with *involuntary* euthanasia, when euthanasia is performed *against* the will of the patient. – Wikipedia, the free encyclopedia.

⁴⁶**Involuntary euthanasia** occurs when euthanasia is performed on a person who would be able to provide informed consent, but does not, either because they do not want to die, or because they were not asked – Wikipedia, the free encyclopedia.

and suffering (Landman 2012)⁴⁷. Archbishop Desmond Tutu was also very vocal about the matter and when calling for a “mind-shift” in the issue of assisted dying, Archbishop Tutu⁴⁸ stated: “I revere the sanctity of life — but not at any cost⁴⁹,” and recalled the “disgraceful” treatment of his friend and ally Nelson Mandela who was kept alive artificially in the last stages of his life, and even propped up for a photo shoot with politicians just before he died at 95. Perhaps Nelson Mandela did not require euthanasia, Gwyther (2015) argues, and that perhaps he ‘required that his medical team, family and proxy decision-makers agree to allow natural death without extraordinary measures that did not add to his quality of life and personal dignity, and not to have his life/dying prolonged by artificial means’ (Gwyther 2015).

According to CNN (27 June 2013) and News 24 (4 July 2013), the 95-year-old Nelson Mandela was in a persistent vegetative state and on life support to help him breathe. Already in June medical staff advised his family that the machines should be switched off. Mandela eventually died on 5 December 2013. It seems that the delay could have been caused, at least in part, by a family dispute. In Good Morning, Mr Mandela - Zelda la Grange's, the late statesman's personal assistant lifted the lid on behind-the-scenes family drama as Mandela lay on his death bed, as well as the power struggles that marred the period immediately after his death⁵⁰. It can be argued that is not appropriate to initiate or continue futile treatment that does not improve quality of life and may in fact negatively affect quality of life or prolong the dying process. When a sick, elderly person is put onto a ventilator it is very, very difficult to wean that person off the machine and

⁴⁷*End-of-Life decisions, ethics and law. A case for statutory legal clarity and reform in South Africa.* Landman, Willem A. Geneva : Globethics.net, 2012

⁴⁸Desmond Mpilo Tutu, (born 7 October 1931) is a South African social rights activist and retired Anglican bishop who rose to worldwide fame during the 1980s as an opponent of apartheid. He was the first black Archbishop of Cape Town and bishop of the Church of the Province of Southern Africa (now the Anglican Church of Southern Africa). – From Wikipedia, the free encyclopedia

⁴⁹*Desmond Tutu in favour of assisted dying.* [Online] Christian today, 2014.

<http://www.christiantoday.com/article/desmond.tutu.in.favour.of.assisted.dying.i.revere.the.sanctity.of.life.but.not.at.any.cost/38824.htm>

⁵⁰*Ugly truth behind Mandela's final days.* [Online] Times Live, June 2014.

<http://www.timeslive.co.za/local/2014/06/15/ugly-truth-behind-mandela-s-final-days1>

have him/her breathing normally again. Medical consensus is that medical interventions like that are often best never started.

Wilkinson (2013) argues 'whether the treatments provided to Madiba over this period did more harm than good', which brings in the debate of the principle of non-maleficence. Wilkinson (2013) argues whether these treatments were in Mandela's best interest, which should always be the doctor's priority in terms of ethics. Intensive medical treatments may prolong life, argues Wilkinson (2013), but sometimes only at the cost of 'significant pain, discomfort, confusion an agitation, indignity and distress' (Wilkinson 2013). Can this not be classified as medically futile treatment? McQuoid-Mason (2013) discusses the issue of medical futility and its meaning, and remark that although the concept of medical futility is controversial, it generally means 'treatment that is useless, ineffective, or does not offer a reasonable chance of survival'.

Wilkinson (2013) also raises a number of ethical questions about the treatment Mandela received such as whether it is 'ethical for Mandela to receive treatment that would be unavailable to others?' and raises with this the question of equality and fairness given the limited resources. Another interesting argument Wilkinson (2013) brings is that perhaps '...providing Mandela with exceptional treatment might be out of recognition or recompense for his contribution to South Africa'. And argues that, 'Mandela was imprisoned for 27 years for his part in the political movement against apartheid and that '[h]e is widely recognized for playing a key role in the peaceful transition of South Africa to democracy'. 'Either or both of these might be thought to justify a country choosing to provide a significant additional health care benefit to Mandela Wilkinson (2013) argues but adds that 'if that were the case there might be others who suffered in the apartheid era who would also be deserving of additional health care, or others who have contributed to the country' and that '[t]here would need to be some transparent means of assessing the claims of others'. This, Wilkinson (2013) argues brings in another questions about 'who decides on exceptional status and how much additional treatment they can access'?

6.5. The Doctrine of Double Effect

The question can perhaps also be asked: Is it right to condemn the elderly to less and poor standards of care because of their age? Is it socially right that majority of old people would not have access to extended health care to their homes, where they can be in the care of their loved ones and die in dignity, if we are to re-humanize the practice of medicine? Is it not better to have the doctors and health care professionals visit patients at their homes?

6.6. Conclusion

In final analysis, one seems always to come back to the same point when considering the South African Health care system: The system has provided an extremely large, diverse and previously deprived people with (at least) adequate, universally accessible healthcare. It has turned, through its progressive health policies, a country ravished by AIDS and AIDS denialism, and communicable diseases and ill health into one that is a leader in AIDS treatment, a champion of Human Rights advocating, and a country full of hope and optimism. Problems of equitable distribution remain, but the current government appear committed to minimize these. Its building blocks are in place to provide a comprehensive health system that is underpinned by quality, a skilled workforce and appropriate infrastructure. There is an impressive constitutional, legal and policy framework that guarantees the right to access health care to all persons in South Africa. Some difficulties lie in its implementation and problems with corruption. The need to strengthen cooperative governance across the national, provincial and local government spheres as well as between the private and public sectors is recognised and will assist the agenda for further reform and transformation.

Much of the hope for narrowing disparities in the new South Africa was embedded in the reversal of legislated racial discrimination generally and in aspirations for more equitable provision of health care specifically. But this places too much emphasis on legislation and biomedicine as the dominant routes to improved health, without consideration of the socio-political and medico-legal determinants of health and the complexity associated with the effective practical application of new laws and health services.

The long-term challenges in South Africa are to narrow disparities in wealth, health, and education and to generate opportunities for many more people to survive childhood, reach their full human potential, and lead healthy, productive lives. In the medium term, improving access to equitable, sustainable and effective health care services should be a high priority. Short-term measures should include strengthening public health care services, improving resource-allocation policies, and training an appropriate balance of health care professionals. Nurses and community health workers will probably play an increasingly important role in rural areas. Efforts to achieve sustainable improvements in health with limited resources and much reduced prospects for economic growth call for improved health care management and governance, and widespread shifts in attitude to “doing better with less”. At a time characterized by local and global crises that engender much despondency, and when it seems that we are probably collectively unable to recognize the dire nature of our mutual predicament, it is appropriate to recollect how President Nelson Mandela's attitude of magnanimity and reconciliation (despite 27 years in prison) spearheaded peaceful progress toward a new South Africa. His example continues to be an inspiration to many in South Africa and beyond, as reflected in the affection, admiration, and awe in which he is so widely held. This should perhaps be an attitude that healthcare practitioners adopt.

The interplay between human rights and medical ethics is crucial for the proper provision of healthcare in democratic and caring societies. Not only do practitioners have to ensure that their own conduct does not contravene professional ethics and human rights standards, but they also need to advocate for their patients. They have an obligation to protest when the behaviour of others seem to violate these standards. Although the primary responsibility for ensuring that human rights are respected lies with governments, medical practitioners also have a moral and an ethical duty to uphold and promote the human rights and justice. Medical professionals, medical school and their teaching staff, and medical students can become important instruments for this much needed change. Medicine need to be re-humanised, and this is a change that is not merely desirable, but essential. The narrow outlook of the past can neither be tolerated nor justified. Human rights are entitlements people can claim relating to their

basic needs because they are human. It is thus vital that the medical profession is seen to have the desirable humility, altruism, impartiality and respect for human dignity as required by law and medical ethics, rather than the one that is seen to be influenced by politics, less caring and bias.

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