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DECRIMINALISING VOLUNTARY ACTIVE EUTHANASIA THROUGH THE RECOGNITION OF FUNDAMENTAL HUMAN RIGHTS: A COMPARISON OF SOUTH AFRICA AND FOREIGN JURISDICTIONS

by

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ABSTRACT

'If death is in a patient's best interest, then death constitutes a moral good'.[1]

Euthanasia, a concept initially thought of merely as a medical procedure that serves as the literal 'kill switch' in determining the extinguishment of life. It may not be perceived by many as exercising one's freedom of choice and, furthermore, the right to life. However, the concept of euthanasia integrates numerous fundamental rights simultaneously on an intricate level within South Africa's legal system. Therefore, seeking clarification on whether or not voluntary active euthanasia should be implemented as a legal form of euthanasia is of paramount importance in giving effect to numerous fundamental human rights of which everyone is afforded.[2]

Delving deeper into understanding the complexity of rights to be affected in such a medical procedure, it is essential to distinguish between the various forms of euthanasia. In addition to this, the focus is to be drawn as to why the decriminalising of voluntary active euthanasia is to be advocated for in South Africa.

The action and ability to provide informed consent serve as the founding premise in separating the two main categories of euthanasia, namely voluntary and involuntary euthanasia. The importance of informed consent will further be discussed at length, emphasising the reasoning as to why involuntary euthanasia will never be an acceptable practice under South Africa's current constitutional dispensation. This, in turn, draws focus to voluntary euthanasia in the form of active and passive application.

Currently, the only form of euthanasia recognised and afforded limited protection and application under South Africa's legal regime is voluntary passive euthanasia. Although, this seems to function as the exception rather than the rule.

A causal link exists between euthanasia and the right to life,[3] as outlined in the Constitution. This link, which the Courts deem steadfast in upholding, is functioning in a sense that ironically prevents the full accessibility and enjoyment of the right.

1 Doyal L. 'Why active euthanasia and physician-assisted suicide should be legalised' BMJ Vol:323 (2001) par 8.
2 The Constitution of the Republic of South Africa, 1996.
3 The Constitution *supra* 2, section 11.

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Since the right to life has not been expanded upon in the Bill of Rights, incorporating other rights, such as the right to freedom and security of the person, is needed to understand the various aspects of a person and their body to which protection is afforded.[4] This creates a problematic area of application in so far as the right to life and freedom and security of the person.

For this reason, the central premise of this academic piece will focus on the right to life. Furthermore, it will be argued that under strict and regulated conditions, the termination of this right should function as an exception to the absolute nature of the right. In essence, decriminalising voluntary active euthanasia in South Africa's legal system.

KEYWORDS

Voluntary active euthanasia; voluntary passive euthanasia; fundamental human rights; patient autonomy; informed consent; quality of life; right to life; assisted dying; medical practitioner; legal framework; Constitutional dispensation; Bill of Rights; National Health Act.

LIST OF ABBREVIATIONS

HPCSA	Health Profession Council of South Africa
MAID	Medical Assistance in Dying
PAS	Physician-assisted suicide
SALRC	South African Law Reform Commission (The Commission)

[4] The Constitution *supra* 2, section 12.

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PREFACE

i. Purpose of the study

This study sets out to analyse the decriminalisation of voluntary active euthanasia in South Africa through the application of fundamental human rights. The purpose of this study relies heavily on the comparison of South Africa's legal framework and current position to that of various alternative legal jurisdictions, including the Netherlands, Canada, and Austria.

In doing so, it will be determined whether exceptions to the current legal standpoint in South Africa surrounding voluntary active euthanasia (including its nature and implementation) do exist and whether such exceptions rest on the premise of recognising fundamental human rights. Several research questions have been posed for this study to ascertain clarification on the abovementioned topical works.

These research questions are as follows:

i) What are the various forms of euthanasia, and why is voluntary passive euthanasia currently the only legalised form of euthanasia in South Africa?

ii) Which rights are fundamental to the application of euthanasia, and to what extent do their nature and scope serve as a limiting factor regarding euthanasia?

iii) Is there a need to expand upon current legalised forms of euthanasia in South Africa? (Namely, to make provision for voluntary active euthanasia in the current legal system).

iv) How does South Africa's current position on euthanasia compare to that of alternative foreign jurisdictions?

The purpose and underlying thread to this study can be summarised by affirming the statement life is dependent on the will of others, whereas death should be on ours.

This study aims to provide a means for participation and take a stance, resulting in raising and sustaining the consciousness of South African citizens by engaging in topical debates surrounding euthanasia.

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ii. Outline of study

This study will begin with identifying and discussing numerous vital concepts relating to euthanasia to better understand the discourse as a whole. This section of the work will comprise mainly of definitions. These definitions will be further analysed and discussed through the use of various academic articles.

Concepts, such as (but not limited to); bodily integrity, patient autonomy, privacy and informed consent, will be discussed due to euthanasia not being an isolated concept but rather one that incorporates many rights and ideologies. A distinction will be drawn between the various forms of euthanasia. In addition, the current legal standpoint of euthanasia in South Africa will be identified and further expanded.

In order to analyse the current legal position of euthanasia in South African law, relevant legislation, journal articles, and case law will be used, with a specific focus on fundamental human rights.

The Constitution will play a paramount role to determine whether or not there is the possibility of decriminalising voluntary active euthanasia practices within the current legislative framework. Specific emphasis will be drawn to the right to life, freedom and security of the person, bodily integrity, and patient autonomy.[5]

In conjunction with relevant legislation, the Constitution will be further utilised to outline which exceptions to euthanasia exist and under what circumstances they can be enforced. Herewith, it will be adduced whether a paradigm shift in applying the Bill of Rights is necessitated as the cornerstone of democracy.

Moreover, the historical formulation of euthanasia will be addressed to determine what brought about the required legislative protection. In addition to this, a discussion will take place regarding the various obstacles that the judiciary faced throughout integrating euthanasia into the South African legal system.

Following this, the current legal stance of euthanasia in South Africa will be compared to foreign law jurisdictions. Consideration will be given as to how each of these opposing legal

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5 The Constitution *supra* 2.

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systems differs. Furthered discussions will analyse the thresholds and safeguards implemented by these countries, ensuring that legal liability is maintained.

To determine whether limited application of the Constitution has hindered and restricted the implementation of fundamental rights contained therein (such as the right to life), articles published in view of euthanasia will be analysed to compare the goals of the Constitution to the reality thereof. In addition to this, various oversights preventing the implementation of voluntary active euthanasia will be identified and further discussed.

Furthermore, an entire chapter has been dedicated to the interpretation of case law in South Africa. The chapter will consist of case law pertaining to passive euthanasia, active euthanasia, and physician-assisted suicide. Quintessential judgements under each category of euthanasia have been identified and discussed insofar as their role in developing the common law if any.

Finally, this writing piece will be consolidated into several recommendations and conclusions to present the findings. The objective will be to conclude the initial problem statement, namely, whether the need exists for the decriminalisation of voluntary active euthanasia in South Africa as an exception to the absolute nature of the right to life.

iii. Methodology

This study will be structured in a layered approach whereby each chapter will embark on identifying and discussing a unique contributing factor to the law and application of euthanasia as a whole.

The primary purpose of this writing style will be to identify whether a need exists to develop the law and legislation concerning voluntary active euthanasia, with a specific focus on fundamental human rights. Therefore, the very Constitutional framework will be challenged by identifying how the Constitution may be restricting the application of certain fundamental human rights.[6]

The methodology style will remain largely uniform throughout this study as the initial problem statement serves as the cornerstone to research and write each chapter.

[6] The Constitution *supra* 2.

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An in-depth comparison will be taken in Chapter 3 to draw a parallel among various international legal systems and critique their current standpoint surrounding euthanasia as a whole.

The reasoning for selecting a mixed methodology approach is to seek out the proper function of the law surrounding euthanasia in the medical field. The result will ensure a contribution to the legal standpoint on euthanasia for any prospects of development in the law.

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CHAPTER 1: DECONSTRUCTING EUTHANASIA AND OTHER CONCEPTS

1.1. Introduction

This chapter serves to introduce the discourse of this study. The subject matter encompasses a brief discussion of the law and principles pivotal to euthanasia in South Africa. Central notions will be identified, elucidated, and elaborated upon further to associate their relevance to the ongoing topic, that is, decriminalising voluntary active euthanasia. The various notions discussed herein pertaining to euthanasia will provide a basis for knowledge and understanding for the remainder of this discourse.

It is to be noted that a systematic approach will be taken for this chapter. As previously mentioned, the definitions and legal standpoints of the various concepts to be discussed within this chapter will be drawn solely from a South African standpoint. Thus, no topics will be dealt with comparatively. Differentiation to that of relevant foreign jurisdictions, in relation to any of the concepts to be discussed hereunder, will commence in Chapter 3 to address any divergent perspectives that may present themselves.

1.2. Concept of euthanasia

The medical practice of euthanasia remains a controversial topic, not only here in South Africa but also on a global scale.[7] An insurmountable amount of public pressure continues to build in an attempt to remove the shroud that is draped over euthanasia.[8] Carstens and Pearmain affirm this notion by emphasising the ambivalence of legal and often emotional public debates surrounding the possible legalisation of euthanasia since the advent of the sacrosanct Constitution.[9]

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7 Jacobs R.K. and Hendriks M. 'Medical students' perspectives on euthanasia and physician-assisted suicide and their views on legalising these practices in South Africa' SAMJ (2018) par 1.

8 Singer P.A. 'Should doctors kill patients?' CMAJ (1988) pp 1000-1001.

9 Carstens P.A. and Pearmain D. 'Foundational principles of South African medical law' (2007) pg 200.

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Euthanasia cannot be interpreted as an isolated concept but rather one that is kaleidoscopic. One could say transparency surrounding euthanasia is necessitated since it governs the precarious balance between life and death.

Euthanasia is a distinct means by which the end to a patient's life can be brought about, different to that of physician-assisted suicide.[10] The word 'euthanasia' derives from the Greek language, wherein '*eu*' means 'good' and '*thanatos*' meaning 'death'.[11] In its literal sense, then, euthanasia amounts to a 'good death. This word, namely 'euthanasia', has been construed into numerous interpretations and may mean different things to different people. Generally speaking, it is taken for granted that the idea of a good death means 'dying painlessly and free of stress'.[12] Most manners in attempting to define euthanasia result in a chaotic and irrational understanding as they are formulated with the premise of emotion rather than legality.[13]

In order to gauge greater clarity as to how euthanasia is to be applied in a legal sense, for purposes of this study, the definition will be deconstructed into three fundamental concepts as provided by Leenen.[14] Leenen notably influenced the understanding of euthanasia by isolating and simplifying various concepts within the definition as follows:[15]

i) An act, which has resulted in death. Legally no difference exists between acting and omitting to act if acting is a duty. Causing the death of the patient by action is the same as not helping him, with death as a result when treatment is available. The act must have hastened death, which would not have occurred without that act.
ii) The act has to be performed by someone other than the person who has died.
iii) The act must have been performed at the request of the person who has died. This request constitutes the borderline between euthanasia on one hand and murder and manslaughter on the other—medical acts not requested by the patient but causing death to legally fall under the second category.

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10 A brief discussion as to the distinction in concepts follows later in this chapter (Subchapter 1.3).

11 The issue at hand has no relation to the withholding or withdrawing of life-sustaining treatment, nor 'mercy killings; performed by a patient's family or friends, nor the administration of analgesia to a patient in response to pain, but rather that of a direct injection of a lethal substance by a medical practitioner with the intention of causing the death of the patient.

12 Koenane M.L.J. 'Euthanasia in South Africa: Philosophical and theological considerations' (2017).

13 Podgers J. 'Matters of life and Death: Debate Grows over Euthanasia' ABAJ (1992) wherein euthanasia has been defined as, "mercy killing of the hopelessly ill, injured or incapacitated" or by Ralls L. 'The Doctor's Dilemma: Relieve Suffering or prolong life?' (1997) SALJ pp 1-40 as, "the ending as painlessly as possible of the life of the person who is fatally ill and suffering pains".

14 Leenen H.J.J. 'The Definition of Euthanasia' (1984) pg 333.

15 *Ibid.*

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Drawing from the fundamental concepts above, Leenen formulated the following definition, which will serve as the primary reference for 'euthanasia'.[16] Leenan articulates the process of euthanasia as follows, "Euthanasia is a deliberate life-shortening act, including an omission to act, by a person other than the person concerned, at the request of the latter".[17]

Albeit defined by numerous authors, misconceptions surrounding the practice of euthanasia continue to exist on a multitude of levels. The ambivalence in this regard is prevalent throughout society, including ethics, morality, religious beliefs, and legality.[18]

It is for this reason that the above-mentioned definition of euthanasia been borne in mind when considering the following: Euthanasia is not a procedure to be initiated by a medical practitioner with the aim of causing death of a patient: the onus of decision making to initiate the procedure rests solely with the dying patient; nor is it about the ability of a person committing suicide: no criminal sanctions exist in this respect, suicide is considered to be a legal act in South Africa with no means of becoming a criminalised act under any proposed or pre-existing legislation; nor is it about persons suffering from depression to use this procedure as a means of engaging in physician-assisted suicide: such persons will be referred, diagnosed and treated; nor is it about the question of whether a spouse or other family members are entitled to make an informed decision to initiate euthanasia: a living will and testament serves as a pre-requisite for any form of euthanasia, such that the decision to initiate the process stems solely from the person requesting aid in dying.[19]

Euthanasia aims to recognise the fundamental rights available to all persons. Should the procedure of voluntary active euthanasia be decriminalised, only a tiny portion of people would satisfy all the requirements set out within the regulatory controls, and an even smaller portion after this would request it.

Euthanasia is not a controversial topic, nor is it to be debated. It is merely a matter of choice, in the form of action, preceded by a decision for a person to terminate their own life.

[16] It is noted that for practical reasons, assistance in suicide is omitted from this definition and will be discussed as a separate topic later in this chapter (Subchapter 1.3).

[17] Leenen H.J.J. *supra* 14.

[18] Keown J. 'Euthanasia, Ethics and Public Policy: An Argument Against Legalisation' (2002) pg 37.

[19] Carstens P.A. and Pearmain D. *supra* 9, pp 206-207.

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1.3. Various forms of euthanasia and their position in South African law

In recent decades, the intention to integrate death and dying into medical ethics has increasingly gained momentum. This has, in turn, given rise to the classification of euthanasia as a medical procedure into various distinguished forms. These forms include active euthanasia, passive euthanasia, and physician-assisted suicide, which occur either voluntary,[20] involuntary,[21] or non-voluntary.[22]

Throughout each form of euthanasia, the central tenet is whether an intentional killing materialises through ethical and legal means.[23] The advent of the Constitution has transfigured the contextualisation of the various forms of euthanasia into a rationalisation based on the justiciable Bill of Rights and not sectional moral or ethical convictions.[24] The question of whether any such forms of euthanasia are ethically or morally justifiable practices is separate from the question of whether they should be legalised. This dissimilarity should be dealt with independently since they are mutually exclusive events.

In order to approach this nodus, each identified form of euthanasia will be defined and briefly contextualised within the ambit of South Africa's legal framework.

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20 Euthanasia performed in accordance with the wishes of a competent individual, whether those wishes have been made personally or by a valid, written advanced directive.

21 Involuntary euthanasia is considered to be the most controversial way of hastened death. It refers to euthanasia that is performed against the wishes expressed by a competent person or through a valid advance directive. Involuntary euthanasia is congruent with the non-compliance of informed consent and legal capacity. See further 'Euthanasia in South Africa: Philosophical and theological considerations' *supra* 12, wherein Koenane contextualises involuntary euthanasia as follows: 'where a patient may not necessarily request the intervention of the doctor to end his or her life, but a decision is made on behalf of the patient without his or her knowledge by a doctor, a friend, or any member of the family (this is generally done in secret). Again, this is unethical; a decision to end one's life (mercy killing) is generally supported when the request is made by the patient. This is supported by each person's self-autonomy to decide; further, the very same problem that led to individuals having a final say in the decision to end their lives suggests respect for individual autonomy'.

22 Non-voluntary euthanasia takes place wherein the informed consent of a user is unavailable, such as when the user is in a persistent vegetative state, or in the case of young children. Non-voluntary euthanasia comprises of similar underlying principles to that of involuntary euthanasia, in relation to informed consent, with the only differentiating factor being that of the former is performed without any knowledge of the wishes expressed by a competent person or through a valid advance directive.

23 Carstens P.A. and Pearmain D. *supra* 9 pg 200.

24 The Constitution *supra* 2.

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1.3.1. Voluntary passive euthanasia

Voluntary passive euthanasia, or what is generally known as withholding or withdrawing treatment, refers to the hastening of the death of a person by withdrawing some form of life-sustaining support and letting nature take its course.[25]

Regarding the legality of voluntary passive euthanasia in a South African context, the theoretical and practical implementation are often viewed as two sides of the same coin.[26] Subsequential rights that emanate when considering life-ending measures require the judiciary to intercede, as seen in the case of *Clarke v Hurst*.[27]

Dr Clarke, a lifelong member of the South African Voluntary Euthanasia Society, announced his favoured stance of passive euthanasia publicly. Shortly after being admitted for the treatment of a pre-existing injury, Dr Clarke suffered cardiac arrest resultant from a sudden drop in blood pressure. Dr Clarke's heart ceased to beat for a substantial period of time before being restored through the means of resuscitation. By the time Dr Clarke's heartbeat and breathing had been restored, irreversible brain damage had already occurred.[28] Despite losing

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[25] Various examples of withdrawing life sustaining support include a) the removal of life support equipment (e.g., turning off a respirator) or b) stopping of any medical procedures, prescribed medication, and treatment or, c) terminate provisions of food and water, allowing the patient to starve to death or dehydrate or, d) not delivering CPR (cardio-pulmonary resuscitation) when required, allowing the patient whose heart has stopped to die.

[26] *Clarke v Hurst NO & Others* 1992 (4) SA 630 (D).

[27] *Ibid.*

[28] The medical condition of Dr Clarke after suffering extensive brain damage, taken as an excerpt from the court in *Clarke v Hurst supra* 26, is as follows:
(a) He has suffered serious and irreversible brain damage of a diffuse and generalised nature which has left him in an irreversible persistent vegetative state. As a result of the brain damage: (i) there has been a serious loss of brain tissue; (ii) gross atrophy of the cortex; (iii) large areas of the brain have become fluid filled as the ventricles expand to occupy the space left by the retreating brain tissue; (iv) the patient has no control over and no use of his limbs and is not capable of any movement; (v) the patient has no cognitive, sapient and intellectual life and no volitional functioning; (vi) the patient has no self-awareness or awareness of his external environment at any level; (vii) the patient cannot speak and is not capable of deliberate vocal noise; (viii) the patient has no auditory capacity; (ix) the patient cannot communicate and cannot receive any communications; he has no capacity for conscious thinking or purposive action; (x) the patient does not have any sense or sensory perception or sentient life.
(b) The patient's swallowing mechanism is non-functional owing to damage to the cortex and brainstem. The patient therefore cannot swallow voluntarily or involuntarily and cannot take food or fluids in the natural way.
(c) Because the autonomic nervous system which controls the biological life of the body is largely unimpaired (although there is evidence of some brain-stem damage), the patient's respiratory system, digestive system, circulatory system, kidneys, heart, and lungs are functioning satisfactorily.
(d) The patient does not experience pain or discomfort because he has lost the capacity to experience these sensations. There is, however, no doubt that legally the patient is still alive; nor is death imminent. His life expectancy is uncertain.

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function of the neocortical brain, Dr Clarke still maintained some brainstem function and was therefore diagnosed to be in a persistent vegetative state as opposed to being brain dead.[29]

Resultant from the fact that Dr Clarke's brain was neo-cortically dead, he was to be fed via a nasogastric tube which kept him alive for four years, whereafter his wife made an application to the court to be *curatrix personae*. She sought authority to legally decide upon matters of her husband's medical treatment. These matters included decisions authorising the discontinuance of any current or future proposed treatment.

In addition to this, Dr Clarke's wife was in possession of a so-called 'valid' living will concluded by Dr Clarke himself, while he was of sound mind and had the capacity to do so. There is currently no direct authority at common law which considers the legal validity of a living will. Notwithstanding the application thereof, section 8(1) of the National Health Act provides no room for doubt that a healthcare user has the right to participate in any decision regarding their health and treatment.[30] The content of this section was applied in the matter of *Clarke v Hurst* whereby Thirion J stated the following:[31]

> It is indeed difficult to appreciate a situation, save where a patient is suffering unbearable pain or is in a vegetative state, where it would be in the best interests not to exist at all. The patient in the present case has, however, passed beyond the point where he could be said to have an interest in the matter. But just as a living person has an interest in the disposal of his body, so I think the patient's wishes as expressed when he was in good health should be given effect.

In his judgment, Thirion J expressed that removing the nasogastric tube was considered the factual cause of Mr Clarke's death. However, the element of legal causation was not complied with by the intended actions of Mrs Clarke. In this instance, the *conditio sine qua non*[32] was far too removed in order for it to have given rise to any criminal liability. Therefore, the Court

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29 *Clarke v Hurst supra* 26, Thirion J. provided the following explanation as to what constitutes a permanent vegetative state 'a neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body is functioning entirely in terms of its internal controls. It maintains digestive activity, the reflex activity of muscles and nerves for low level and primitive conditioned responses to stimuli, blood circulation, respiration and certain other biological functions but there is no behavioural evidence of either self-awareness or awareness of the surroundings in a learned manner'.

30 National Health Act 61 of 2003. Section 8(1) clearly provides that: 'A health care user has the right to participate in any decision affecting his or her personal health and treatment'.

31 *Clarke v Hurst supra* 26.

32 A condition without which.

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held that the living will allowed for the passive treatment of Dr Clarke to be lawfully discontinued.[33]

The decision of the Courts in *Clarke v Hurst* gave recognition to the act of voluntary passive euthanasia. Nonetheless, it is yet to be determined whether this judgement functions as a reasonable recognition of the right to life or whether it is a feeble attempt to reduce pressure on the courts when dealing with euthanasia in its entirety.[34] In support of Constitutional justification, the ongoing consideration of euthanasia is inconsequential to the Constitution's consistency and fairness. Landman furthers this argument by emphasising that:[35]

> It would be inconsistent, as well as cruel if the state were also to deny the 'condemned' man's request for physician-assisted suicide or voluntary euthanasia so that he could die sooner and perhaps with less suffering.

Juxtaposed to Constitutional perspectives, the common law is perspicuous on the legal status of a person's decisional capacity to refuse life-sustaining medical treatment. The court confirmed in *Castell v Greeff* that a person's decisional capacity stems from their fundamental right to self-determination, inclusive of the right to bodily integrity.[36]

The judgement, as handed down, recognised the autonomy of a patient insofar as it allows the person to make decisions on whether they wish to receive or refuse medical treatment. This notion is further confirmed by Strauss wherein he invokes the right of refusal:[37]

> In principle, every person is legally entitled to refuse medical attention, even if it has the effect of expediting his death. In this sense, the individual has a right to die. All that is required is that the declarant at the time in making his refusal known is *compos mentis*.[38] The declaration remains valid even though the declarant may at a later stage become *non-compos mentis* as a result of physical or mental illness or for any other reason.[39]

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33 Strauss S.A. 'The "right to die" or "passive euthanasia": Two Important Decisions, One American and the Other South African' (1993) SACJ 196 pg 208.Whereby it is noted that the case of *Clarke v Hurst* does not provide for recognition of the legal validity of a living will in South Africa. See further the South African Law Commission Report which initiated a research project on euthanasia in 1992 to address this *lacuna* within the law in this regard.

34 The Constitution *supra* 2, section 36.

35 Landman W.A. 'A proposal for legalising assisted suicide and euthanasia in South Africa' (2001), in Kopelman L. and De Ville K.A. (eds.) 'Physician-assisted suicide: What are the issues?' (2001) pg 215.

36 *Castell v De Greeff* (1994) 4 SA 408 (C).

37 Strauss S.A. 'Doctor, Patient and the Law: A Selection of Practical Issues' 2ed (1984) pg 387.

38 Of sound mind and understanding.

39 Of unsound mind and lack of understanding.

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Perplexed by ethical considerations, morality facilitates the shrouded uncertainty pertaining to the right of refusal, as well as passive euthanasia in its entirety. Withholding treatment creates an ethical conundrum for health practitioners, whereby moral obligations vest to provide essential treatment for patients who need it.

Although silent on the general duties and obligations of a practitioner, the Hippocratic Oath is imperative to the euthanasia debate.[40] Kuhse simplifies the Hippocratic Oath and its application in the matter of passive euthanasia by submitting the following moral questions:[41]

a) Does it make a moral difference whether death is actively (or positively) brought about rather than occurring because life-sustaining treatment is withheld or withdrawn?
b) Must all available life-sustaining means always be used, or are there certain extraordinary or disproportionate means that need not be employed?
c) Does it make a moral difference whether the patient's death was intended or whether it comes about as a merely foreseen consequence of the agent's action or omission?

This adaptation by Kuhse is imperative to confirm that general duties and obligations placed on doctors are not expressly contained within the Hippocratic Oath, but rather that the Oath operates as a checks and balances system within the medical profession. This does not absolve medical practitioners from the onus placed on them, encumbering moral and legal responsibility.

Unlike the Hippocratic Oath, the Declaration of Geneva sets forth a benchmark concerning general duties imposed upon medical practitioners, especially in instances where human life is threatened. Medical practitioners are required to pledge, amongst other things, "I shall treat human life with the greatest respect; even when I am deceived, I shall not exercise my knowledge of medicine in conflict with the laws of humanity". [42]

Although the Declaration of Geneva is not directly applicable under South African law, as previously mentioned, it functions as a benchmark. All practitioners should strive to uphold its values, advocating for compliance with the laws of humanity within the ambit of current legal

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[40] Carstens P.A. and Kok A. 'An Assessment of the use of disclaimers by South African hospitals in view of constitutional demand, foreign law and medico-legal considerations' (2003) pg 18. The Hippocratic oath is often acknowledged by both medical practitioners and lay persons, to be foundational insofar as medical ethics is concerned.

[41] Kuhse H. 'Euthanasia', in Singer P. 'A companion to ethics' (1993) pg 296.

[42] The WMA Declaration of Geneva (1968). See further Appendices A-D which include the Hippocratic Oath and other Codes of Medical Ethics. See also the comprehensive work of Carstens and Pearmain 60ff, *supra* 9.

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frameworks. Therefore, an evidentiary causal link between obligations placed on medical physicians and a patients' right to refuse treatment insofar as passive euthanasia is concerned. These concepts, although independent, further indicate the polarised reality of euthanasia and its application under South African law.

1.3.2. Voluntary active euthanasia

The distinction between active and passive euthanasia is crucial, not only from a medical-ethics perspective but also due to their different standpoints regarding the legality insofar as their application in the medical field.[43]

This subchapter brings to life the complexity of the principle that is voluntary active euthanasia.[44] Accordingly, Koenane defines the act of voluntary active euthanasia as the following:[45]

> Voluntary active euthanasia occurs when the patient, in his or her full senses and with full understanding, requests a medical practitioner to end his or her life. This deliberate killing is always for the benefit of the patient and at his or her request. In other cases, it is at the request of family members.

The recent decision in *Stransham-Ford* to allow voluntary active euthanasia has polarised many people regarding their stance on euthanasia,[46] regardless of the stringent obligations to be complied with.[47]

The decision taken by the court does not function as an overarching ruling in which euthanasia has now been legalised in South Africa. The implication, on the contrary, advocates

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43 Often it is said that what distinguishes active euthanasia from passive euthanasia is the distinction between acts of *commission (Conditio sine qua non)* and acts of *omission (Conditio cum qua non)*. Voluntary active euthanasia and physician-assisted suicide are currently criminalised under South African law due to the death being caused by a direct act of commission. See further James R. 'Active and Passive euthanasia' NEJM 292 (1975) pp 78-80.

44 Unlawfully and intentionally causing the death of a person through a direct action, in the response to a request from that person.

45 Koenane M.L.J. *supra* 12 pp 4.

46 Koenane M.L.J. *supra* 12 pp 2.

47 *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP). Fabricius J. sets out requirements to be met prior to voluntary passive euthanasia being considered: a) Patient has to be terminally ill and subjected to extreme pain but mentally competent, b) a second independent medical practitioner would have to confirm the diagnosis and the findings- these must be recorded in writing, c) the request must be based on informed and well-considered decisions, and d) the request must have been made repeatedly.

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for each case to be considered on its merit and contextualised within the ambit of South Africa's legal framework.[48]

The judgement set out in the case of *Stransham-Ford* manifests the precedent to which similar cases dealt with in the future are subject.[49] The decision taken by Fabricius J has been challenged by a multitude of persons and institutions alike on the basis that euthanasia is not yet lawful and remains a misnomer within South African law until the ratification of the decision takes place by the Constitutional Court.

Some argue that the burden of proof for deciding on euthanasia does not necessarily fall on the ailing person, as long as it is for their benefit. In reality, voluntary active euthanasia should ultimately be at the discretion of the competent individual. A person should be allowed to terminate their own life by merely choosing to do so.

In Singer, Kuhse articulates that not only should such a decision be for the benefit of the ailing person, but this act of benevolence should also be initiated by the user, if at all possible.[50] This line of thought by Kuhse is congruent with the principle of individual autonomy and the right to self-determination.[51] The authority in devising the moral decision to endure or end suffering vests in the suffering person themself.[52]

Rooted in its current application, voluntary active euthanasia undoubtedly amounts to an unlawful act, and the person aiding in this manner could be convicted of murder.[53] According

48 De Lange I. 'Euthanasia ruling "huge victory" for dignity SA' (2015) pg 3. Landman indicates Judge Fabricius's ruling was specific to this case, all other patients who find themselves in a similar situation would be required to approach the courts individually until parliament decides to adopt the draft legislation on euthanasia.

49 Health Professions Council of South Africa 'Ethical guidelines for good practice in the health care professions' (2002).

50 In terms of the National Health Act *supra* 30, 'user' refers to, "The person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is: (a) below the age contemplated in section 39(4) of the Child Care Act, 74 of 1983, 'user' includes the person's parent or guardian, or another person authorised by law to act on the first mentioned person's behalf; or (b) incapable of taking decisions, 'user' includes the person's spouse or partner or, in the absence of such spouse or partner, the person's parent, grandparent, adult child or brother or sister, or another person authorised by law to act on the first mentioned person's behalf". See further Kuhse H. *supra* 41, pp 294–302.

51 'Patient autonomy' further defined in subchapter 1.6.

52 Koenane M.L.J. *supra* 12 pp 3.

53 *S v Hartmann* (1975) 3 SA 532 (C), stating the punishable repercussions for the act of carrying out a patient's wish to die in the form of voluntary active euthanasia; see also Mahomed I. 'Euthanasia and the Artificial Preservation of Life' SALC (1998) pp 66-68.

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to Benatar, denying a patient the legal right to euthanasia amounts to more than just the violation of a persons' freedom to live:[54]

> To be forced to continue living a life that one deems intolerable when there are doctors who are willing either to end one's life or to assist one in ending one's own life is an unspeakable violation of an individual's freedom to live—and to die—as he or she sees fit. Those who would deny patients a legal right to euthanasia or assisted suicide typically appeal to two arguments: a 'slippery slope' argument and an argument about the dangers of abuse. Both are scare tactics, the rhetorical force of which exceeds their logical strength. Slippery slope arguments, which are regularly invoked in a variety of practical ethics contexts, make the claim that if some specific kind of action (such as euthanasia) is permitted, then society will be inexorably led down the 'slippery slope' to permitting other actions that are morally wrong.

Benatar seeks to question the legitimacy of criminalising voluntary active euthanasia in its entirety and does so through a pragmatic approach. In disproving the existence of a 'slippery slope' insofar as voluntary active euthanasia is concerned, Benatar argues that until now, the term has been used as a blanket tool to deny patients a legal right to euthanasia without any waiver.

The applicable enactment of the term 'slippery slope' is indicative throughout the lives of many people. Numerous persons face the prospect of continuing the remainder of their biological lives in a minimally conscious or unconscious state whereby their happenings may be described as a 'fate worse than death'.[55]

This, in turn, raises the question of who the responsible party for determining a person's 'quality of life' is. One would surmise that concepts such as 'quality of life' are widely understood and defined in today's day and age. The phrase 'quality of life'[56] takes on a multitude of variable definitions, all founded on the premise of enjoyment of life, general well-being, comfortableness, and degree of a person's healthiness.[57] So then, why is it that when

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54 Benatar D. 'A legal right to die: Responding to slippery slope and abuse arguments' (2011) par 1.

55 *Ibid.*

56 Singer P. 'Rethinking Life and Death' (1994) at paras 326-327 argues that in present-day, quality of life is an embodied feature of medical practice. As discussed in 'Rethinking Life and Death', Dworkin emphasises, however, that the context of a dependent life considered to not be worth living should not be applied in a broad sense but rather on a fact-by-fact basis. Reference is made to the consequential life of the ingenious scientist Stephen Hawking and numerous other ordinary people who lead lives worth living despite being handicapped. But, in his view, "total or near-total dependence with nothing positive to redeem it may seem not only to add nothing to the overall quality of a life but to take something important from it". This is specifically the case where there is no cognizance of care being given.

57 'Quality of life' as per Merriam-Webster Dictionary.

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this phrase is raised as a direct factor for considering one's end-of-life decision, does it automatically become ambiguous and clouded in judgement?

In South Africa, the argument for palliative care, as brought about by the Ministry of Health, is sought to erode the debate regarding the quality of life,[58] or the lack thereof.[59] This further problematises the concept of quality of life in its application to euthanasia.

Insofar as the quality of life is concerned, we as persons need to be ever conscious of our mortality and what it means to the way we live our lives. Life and quality of life are inseparable to the core since these are mutually inclusive events in every aspect.[60]

We find ourselves living in an age of pluralism, with the common denominator being watered-down to that of life and death. This reality emanated in the 14th century by the French philosopher Michel de Montaigne:[61]

> Death is a remedy against all evils: it is a most assured haven, never to be feared and often to be sought. It all comes to a period, whether man makes an end of himself or whether he ensures it. Whether he runs before his day or whether he expects it. Whencesoever it comes, it is ever his own; wherever the thread is broken, it is all there. It is in the end of the web. The voluntarist death is the fairest. Life depends on the will of others, death on ours.

As made known, death goes hand in hand with life. One, afforded protection by our sacrosanct Constitution, the other merely a means to an end. Balancing of rights is a standard principle of law that emerged with the advent of the Constitution.

At present, there is little to no guidance regarding a patient's wish to die and the fundamental rights afforded via the application of the Constitution. Through carefully balancing all rights relevant to the subject, voluntary active euthanasia will cease to be a mere contingency in its legal application under South African law.[62]

The notion of voluntary euthanasia regarding both life and death encompasses several widespread rights as contained in the Bill of Rights, including the right to dignity (section 10),

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58 Koenane M.L.J. *supra* 12, further discussed in subchapter 1.7.
59 Medical Brief 'The right to die judgement under siege' (2015).
60 Two events cannot occur independently and happen at the same time. Imposed by rule or natural law.
61 Screech M.A (1993) 'Michael de Montaigne- The Complete Essays'.
62 Jordaan D.W. 'Human dignity and the future of the voluntary active euthanasia debate in South Africa' SAMJ 107 (2017).

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the right to life (section 11), the right to freedom and security of the person (section 12), the right to privacy (section 14), and the right of access to emergency treatment and health care services (section 27).

The applicability of these rights is discussed further in Chapter 2 of this study.[63] In addition, the measures determining whether the state has met its constitutional obligation to ensure the fundamental human rights are being affected and balanced, according to lady justice.

1.3.3. Physician-assisted suicide

Legalising assistance with dying has taken on various forms in recent times, one of which includes physician-assisted suicide.[64] PAS denotes an instance wherein a physician supplies information and/or the means of committing suicide to a person to terminate their own life.[65] Kevorkian signifies that PAS is effectuated in the best interests of the patient.[66] Furthermore, PAS removes the prolonged pain and suffering in a situation lacking 'quality of life'.[67] Kevorkian states that:[68]

> In quixotically trying to conquer death, doctors all too frequently do no good for their patients' 'ease', but at the same time, they do harm instead by prolonging and even magnifying patients dis-ease.

As previously discussed, a paradigm case of voluntary active euthanasia is indicative of a qualified medical physician administering a lethal dose of medicine, often due to the patient not being able to do so themself. This differs from PAS suicide insofar as with the former; the physician administers the lethal dose rather than the patient, as in the case with the latter.

In both scenarios, the practitioner is consequential and is involved in an active and necessary causal role.[69][70] The commonality entrenched in PAS and euthanasia alike includes

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63 The Constitution *supra* 2.
64 Hereinafter referred to as 'PAS'.
65 *Minister of Justice and Correctional Services v Estate Stransham-Ford* 2016 ZASCA 197.
66 Kevorkian J. 'Prescription-medicide: the goodness of planned death' (1991). Dr Jack Kevorkian, a Michigan physician, who assisted a number of patients to commit suicide. Dr Kevorkian was eventually convicted by a jury for second degree murder in 1999.
67 Singer P. *supra* 56.
68 Kevorkian J.*supra* 66.
69 Brock D.W. and Colen, B.D. 'Voluntary Active Euthanasia' (1992).
70 Somerville M. 'Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide' (2014) pg 106.

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acknowledging fundamental human rights, in conjunction with patient autonomy, to which persons are afforded in determining their end-of-life decisions.

Under the current state of South African law, PAS is, in all circumstances, considered to be unlawful.[71] However, should a court today be faced with a case dealing with PAS, the facts would have to be considered independently.[72] The courts must be guided by the changed medical circumstances that have passed since the articulation of principals as provided for in *Grotjohn*, nearly fifty years ago. In addition, the court would be required to effect the requirements set out in section 39(2) of the Constitution.[73]

There seems to be a lack of international unanimity as to the effect of guaranteeing human rights in respect of PAS. This task is further complicated by the lack of commonality in the rights to be guaranteed.[74] Landman asserts that recourse rests in this inconsistency:[75] 'It would be inconsistent, as well as cruel if the state were also to deny the 'condemned' man's request for PAS or voluntary euthanasia so that he could die sooner and perhaps with less suffering'.

As indicated above, PAS becomes further problematised when the patient at hand is neither brain dead nor in a persistent vegetative state, but rather one that is 'grievously and irremediably' ill.[76] Contained in the Stransham-Ford judgement written by Judge Fabricius, a person's bodily integrity is intrinsic to their request for physician assistance in dying:[77]

> An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment but denies them to request their physicians' assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty.

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71 *S v Grotjohn* 1970 (2) SA 355 A.

72 *Stransham-Ford supra* 47.

73 The Constitution *supra* 2, section 39(2) sets out: In the development of the common law, the court must strive to give effect to the spirit, purport and objects of the Bill of Rights.

74 *Minister of Justice and Correctional Services v Estate Stransham-Ford supra* 65.

75 Landman W.A. *supra* 35 pg 215.

76 *Carter v Canada (Attorney General)* 2012 BCSC 886 states that 'grievously and irremediably ill' means patient has a serious medical condition that has been diagnosed as such by medical practitioner and which is without remedy, as determined by reference to treatment options acceptable to the patient; and causes the patient enduring physical, psychological or psychosocial suffering that is intolerable and cannot be alleviated by any medical treatment acceptable to the patient; a 'medical condition' means an illness, disease or disability, and includes a disability arising from traumatic injury. Section 39(1) of The Constitution should be effected in this regard.

77 *Stransham-Ford supra* 47.

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In light of the above depiction concerning physician assistance in dying, the *boni mores* continues to reverberate the 'slippery slope' in the context of wrongfulness and unlawfulness.

Furthermore, the total prohibition in this regard is overbroad.[78] To what extent should a life, devoid of all quality, continue to be considered a 'life worth living'?[79] Progression regarding the clinical medical principle of PAS continues to berate arguments concerning society's legal, moral, religious, and social convictions. In essence, these continued advancements attempt to pry open the proverbial can of worms relating to the cessation of human life.

This inconsistency will further prevail should the state, in certain circumstances, refute a request for PAS.[80] In conjunction with the views of Landman, PAS is considered morally justifiable when dealt with in thoughtfully circumscribed circumstances.[81]

Moreover, in a country founded on principles of democracy, legalising and regulating practices dealing with PAS may nevertheless be required as not all citizens share the same beliefs on such a topic.[82]Although the subject of PAS continues to be debated on a global scale, attempts to legislate PAS in South Africa should remain focused on substantive arguments rather than emotive responses.

1.4. Defining death

'Death draws the final curtain on all our lives'[83]

The notion of death is denoted as a great evil, as it should be. Consequently, the *raison d'être*[84] for the fraternity of medical sciences has always been to sustain life, or to rearticulate, to defer the onset of death.[85] Death used to be seen as an insurmountable natural event. This thought

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78 The Constitution *supra* 2; section 36(1)(e) refers to a Court, "when considering the limitations of rights contained in the Bill of Rights, must take into account, amongst others, less restrictive means to achieve the stated purpose". If adequate safeguards were in place for any given instance, the necessity of total prohibition of assistance would be rendered void.

79 Barnard C.N. 'Good Life, Good Death: A Doctor's case for Euthanasia and Suicide' (1980). Barnard articulates that, "It is therefore, not the diagnosis of death that concerns me as much as a possible means of determining when the state of 'being alive' ceases. Dying in this context, can be defined as the irreversible deterioration in the quality of life which precedes the death of that particular individual".

80 *Soobramoney v. Minister of Health (KwaZulu-Natal)* 1997 (12) BCLR 1696.

81 Hampton W.A. 'The ethics of physician-assisted suicide and euthanasia' SAMJ (1998) pp 241-242.

82 Landman W.A. 'Legalising assistance with dying in South Africa' SAMJ Vol 90 (2000).

83 Wallis J.A. '*Minister of Justice and Correctional Services v Estate Stransham-Ford' supra* 65 par 1.

84 The most important reason or purpose for someone or something's existence.

85 Jordaan L. 'The Legal validity of an advance refusal of medical treatment in South African law (part 1) (2011) pg 33.

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process is no longer considered wholly irrational and is contingent on how death is defined in each circumstance.

In both medicine and law, important implications flow independently from the moment of death.[86] Accordingly, decisions are required to be made on whether a person is regarded as 'legally dead'[87] and, if not, whether the persons' life, although tainted, should nevertheless be prolonged through artificial means.[88]

Legal commentators have asserted that 'death' includes a recognised and accepted legal criterion: that brainstem death has occurred.[89] Whereas the National Health Act indicates this to be unnecessary and sufficient to accept that death occurs upon the irreversible cessation of spontaneous and circulatory functions.[90] Before enacting the National Health Act, a definition ceased to exist in both common law and South African law.

86 McQuoid-Mason D. and Sneiderman B. in 'Decision-making at the end of life: the termination of life-prolonging treatment, euthanasia (mercy killing), and assisted suicide in Canada and South Africa' (2000). Articulates that death occurring from natural causes is lawful, whereas unnatural death-inducing death by killing or helping some kill themselves- is not.

87 National Health Act *supra* 30, section1. Moment of death is defined as 'brain death'. 'Brain death' is further defined as, "an irreversible and irreparable cessation of all the brainstem functions inclusive of complete cessation of the heartbeat, respiration, blood circulation and digestive functions". See further Carstens and Pearmain *supra* 9 pg 204, "This definition of death is accepted in other jurisdictions as well but defining death remains problematic and controversial". See further Mahomed I. *supra* 53 for additional requirements pertaining to the definition of death: "a person is considered to be dead when two medical practitioners agree and confirm in writing that a person is clinically dead according to the following criteria for determining death, namely - (a) the irreversible absence of spontaneous respiratory and circulatory functions; or (b) the persistent clinical absence of brain-stem function". See also Herring J. 'Medical Law and Ethics' (2010) pp 464-469 for a discussion of alternative definitions of death.

88 Jordaan L. *supra* 85.

89 Van Oosten, F.F.W. 'Patients' rights: a status report on the Republic of South Africa' (to be published). At pg 1024 Van Oosten articulates: "The recognition and acceptance of brainstem death as a legal criterion for death would: (a) remove brainstem dead patients from the realm of euthanasia and thus, narrow the scope of the euthanasia problem in respect of terminal patients to instances of patients in a vegetative state or terminal patients in a conscious state who are connected to life support measures or who receive life-supporting medication and; (b) accord with medical practice in instances of (i) the transplanting of vital organs and; (ii) the replacing of brainstem dead patients with patients with a prospect of recovery on respirators or ventilators in intensive care units where the demand for respirators or ventilators is greater than the supply". See further 'Report of the Select Committee on medical ethics of the British House of Lords' (1994) wherein it is held that irrespective of whether other criteria is applicable or not, death sets in when the brainstem ceases to function.

90 National Health Act *supra* 30, section 1.

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Due to this, when considering death, two cardinal points must be borne in mind. Not only does medical treatment to preserve life cease, but the moment of death must be identified in order to deduce at what moment such medical treatment may be discontinued.[91]

Hence, it is essential to determine at what point a person is considered 'legally dead'. The moment of death determines which actions amount to being the cause of death of a person, moreover upon whom legal liability for such actions will rest. Thus, the so-called 'moment of death' is consequential in contextualising the various forms of euthanasia. Furthermore, it serves as a reference in establishing a determinant of when euthanasia can be considered.

In *S v Williams,*[92] the Appellate Division held that disconnecting medical treatment to preserve life (in the form of a respirator) could not be seen as the act that caused the death, but that "it was merely the termination of a fruitless attempt to save the person's life". In the findings issued by the court, it was held that the removal of the respirator did not kill the deceased; instead, it was the action of the accused.[93] Disconnection of the respirator, in this case, does not amount to an action that can be described as mercy killing or euthanasia.[94] The Commission confirms this decision by further stating that:[95]

> According to the present legal rules, the medical practitioner would be entitled to disconnect the life-sustaining system of a person if it could be proved that the person was clinically dead… but was being kept 'alive' by a heart-lung machine or ventilator. There is no rule in our law that requires any person to artificially bestow certain signs of life on a person who is already dead. The respiration and heartbeat that seemingly exist are artificial and do not represent life. To disconnect the life-sustaining system would therefore not be to cause death.

When considering legality surrounding euthanasia, specifically when dealing with the so-called moment of death, it is essential to integrate both considerations pertaining to medical and legal fields alike. From a legal perspective, the moment of death is irregular in its interpretation proceeding from existing statutory and common-law sources.[96]

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91 In terms of the National Health Act *supra* 30, 'The death of a person concerned shall be established by at least two medical practitioners, one of whom shall have been practising as a medical practitioner for at least five years after the date on which she or he was registered as a medical practitioner'.
92 *S v Williams* (1986) 4 SA 1188 (A).
93 As per the National Health Act *supra* 30, 'deceased' means, "somatic death where there is cessation of circulation and respiration, including loss of corneal reflexes, the eyeballs become flaccid, and the pupils are fixed and dilated".
94 Mahomed I. *supra* 53.
95 Ibid.
96 Van Oosten F.F.W. *supra* 89, pg 1022.

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The intricate technicalities surrounding the exact moment a person is considered dead do not differ when contrasting the application of voluntary active euthanasia to that of voluntary passive euthanasia. Both forms of euthanasia are synonymous when dealing with the concept of death after the fact. The distinguishing factor regarding voluntary active euthanasia and voluntary passive euthanasia insofar as death is the cause of death rather than the moment of death (death does not occur from natural causes when considering the former).[97]

The principles surrounding and in defining death, are foundational to the sphere of medical law. As such, when considering various decisions and actions leading up to the moment of death, and consequentially, the legal liability that is rooted in death itself. It is thus empirical to bear in mind that death is all-important within the context of euthanasia contemporaneously.

1.5. Informed consent and privacy

Informed consent, whether oral or written, functions as a precondition for implementing a defence based on the infringement of privacy of a particular person.[98] The viewpoint that consent may render an act not unlawful constitutes the defence of *volenti non-fit injuria.*[99] The rule by which no injury is committed against a user who consents is an age-old tale.[100] It renders any related fault void and does not amount to a ground of justification.[101]

When dealing with a doctor-patient relationship, informed consent functions as the foundation or core element, emanating from the law of obligations and accentuated by ethical

97 McQuoid-Mason D. and Sneiderman B. *supra* 86. In view of voluntary active euthanasia, the cause of death is the act of killing, in the form of a direct commission. Whereas in the case of voluntary passive euthanasia, death ensues as a result of an act of omission.

98 National Health Act *supra* 30. For the purposes of this section 'informed consent' refers to consent being obtained for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6 of this Act. See further Grisso T. and Appelbaum P.S. 'Assessing Competence to Consent to Treatment' 27 (1998), where 'capacity' is explicated in a layered approach to assess the term wholly. The capacity of a person encompasses not only the competence of said person's functional ability of the decision at hand but also their cognisance to identify, assess and understand any potential consequences that may present themselves as a result of such decision.

99 *Waring and Gillow Ltd v Sherborne* (1904) TS 340 at 344 Innes C.J. set forth the essential elements to be proven: "It must be clearly shown that the risk (of injury) was known that it was realized, and that it was voluntarily undertaken. Knowledge, appreciation, consent – these are the essential element, but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent".

100 *Santam Insurance Co Ltd v Vorster* (1973) (4) SA 764 (A).

101 Neethling J. 'Law of Delict 7th Edition' (2014) pg 177.

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considerations.[102] Ordinarily arising through the signing of a contract between the two parties, in this instance, consent is derived *ex lege*.

By the same token, consent may be given expressly or implied by the patient. The manner in which consent is given depends mainly on the type of medical procedure required, whether ordinary or emergency in nature, such that a person cannot give informed consent.[103]

Numerous medical practitioners argue that it is unfeasible to normatively obtain informed consent on the basis that many patients are 'illiterate and ignorant'.[104] This is used as a scapegoat by many, resulting in consent not being obtained, albeit the practitioners continue to act in the patient's best interest.

Indicative of medical paternalism, this approach to informed consent or lack thereof erodes the very cornerstone upon which the constitutional framework is built.[105] Be that as it may, the practical implementation of informed consent is often compromised in areas of public health due to lacking infrastructure and resources.[106]

As set out by the National Health Act, several foundational requirements seek mandatory compliance for the consent of a user to be considered valid.[107] These requirements are associated with knowledge, appreciation, and acquiescence on the user's part. Including, amongst other things, consent given voluntarily and without constraint and ensuring that the user is capable of consenting.[108]

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102 *Stoffberg v Elliot* 1923 CPD 148 pp 148-150.

103 HPCSA *supra* 49.

104 Carstens P.A and Pearmain D. *supra* 9 pg 878.

105 The Constitution *supra* 2, section 12(2)(c).

106 Van Oosten F.F.W. 'Financial Resources and the Patient's Right to Health Care: Myth and Reality' (1999) *De Jure* 1-18; see also *Soobramoney v Minister of Health, KwaZulu-Natal supra* 80.

107 Strauss S.A. *supra* 33 pg 4.

108 National Health Act *supra* 30 sets out exceptions wherein a health service may be performed without the requirements of informed consent being complied with. The exhaustive list of these unique situations is set out as follows:

(1) Subject to section 8, a health service may not be provided to a user without the user's informed consent. Unless:

- (a) the user is unable to give informed consent and such consent is given by a person-
  - i. mandated by the user in writing to grant consent on his or her behalf; or
  - ii. authorised to give such consent in terms of any law or court order;
- (b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;
- (c) the provision of a health service without informed consent is authorised in terms of any law or court order.

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In South African law, informed consent has been a requirement for medical treatment for well over a century.[109] However, this age-old notion has been subjected to a revolutionary disposition. The focus of which transposed from a narrowed approach, in reference to a medical practitioners' obligation of disclosing information to a patient, to a more subjected understanding of consent by the patient.[110]

The doctrine of informed consent in South Africa has been codified via the National Health Act, prescribing the nature of the information disclosed to the patient. This includes the patient's health status, the range of diagnostic procedures and treatment options available to the patient, any benefits, risks, costs, consequences, and the patient's right to refuse the health procedure as mentioned above.[111]

Therefore, a medical practitioner has an inherent duty to disclose all information and material risks relating to the procedure to which a reasonable person in such a position, if informed of these risks, would be likely to attach significance and decide whether or not to continue with the procedure. In addition to this, any patient should be furnished with all relevant information regarding post-operative treatment. In such a situation where a patient decides not to undergo the said procedure after being informed of the relevant procedure, it will amount to informed refusal.[112]

Informed refusal once again serves as a practical application of patient autonomy in the South African medical sphere. As with informed consent, when dealing with informed refusal,

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(d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or

(e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage io his or her health and the user has not expressly, impliedly or by conduct refused that service.

(2) A health care provider must take all reasonable steps to obtain the user's informed consent.

109 *Stoffberg v Elliot supra* 102.

110 Veatch R.M. 'Medical Ethics' (1989) pg 175; Beauchamp T.L. and Childress J.F. 'Principles of Biomedical Ethics' (1994) pg 120; Faden R.R. and Beauchamp T.L. 'A History and Theory of Informed Consent' (1986) pg 41 ff; cf Parker M. and Dickenson D. 'The Cambridge Medical Ethics Workbook' (2005) pg 125 ff.

111 National Health Act *supra* 30 prescribes the legislative requirements as stated in section 6 of the Act (to be read in context with sections 7, 8, and 9 of the said Act). The requirements set forth by this section are as follows: "Every health care provider must inform a user of – (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associate with each option; and (d) the user's right to refuse health services".

112 HPCSA *supra* 49.

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the practitioner bears a duty to furnish all relevant information regarding the potential negative consequences related to the refusal of such a procedure or treatment.[113]

It is insufficient for a patient to have knowledge of the procedure or treatment merely. The patient must be capable of appreciating and understanding such knowledge to decide on the procedure.[114]

Failure by a medical practitioner to obtain informed consent or refusal from the patient may result in an allegation of negligence or assault unless it is proven to be in the patient's best interests. According to Rule 27A sub-rule (g), a practitioner is required to "except in an emergency, obtain informed consent from a patient or, if the patient is unable to provide consent for treatment himself or herself, from his or her next of kin".[115]

In cases of a medical emergency, and in light of section 27(3), it can be seen that the right to privacy of a patient can be limited by circumventing the requirement of informed consent.[116] The restriction on the right to privacy is due to the fact that it enforces the continuance of the right to life and that of bodily integrity.[117]

It is evident that informed consent functions as a preliminary requirement regarding the implementation of euthanasia in any of its prescribed forms. The ability to procure and provide consent cannot be restricted; however, the effects may be rendered purposeless. Thus, consent does not function as the limiting factor in such a case, but rather the restriction to fundamental rights as set out in various aforementioned constitutional provisions.

1.6. Patient autonomy

As a principle in medical law, patient autonomy serves to be the most influential and favoured argument in support of euthanasia to date.[118] That being said, regarding the privacy of individuals in South African law, patient autonomy is anything but an emerging concept.[119]

113 *Ibid.*
114 *Ibid.*
115 *Ibid* pp 20.
116 The Constitution *supra* 2, section 27(3).
117 The Constitution supra 2, section 36.
118 Mdhluli S. T. 'Your life, your decision? The Constitution and euthanasia' (2017).
119 *Stoffberg v Elliott supra* 102. In the judgement given by Watermeyer J., it was noted that the principle of patient autonomy founded its application in South African medical law. Thereby, patient autonomy has been judicially recognised in South Africa since 1923.

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Due to the extent of its application in the sphere of medical law, the legal principle of patient autonomy has been codified within numerous legislated instruments.[120]

The relationship of autonomy to that of informed consent is inseparable, and therefore these topics cannot be dealt with in isolation.[121] However, the functioning ability of human beings to form opinions and act on them in a quantifiable manner of being morally autonomous requires the enactment of further constitutional rights.[122] Thus, it is to be said that patient autonomy extends beyond that of informed consent as the recognised role of freedom of expression.[123]

Patient autonomy entails exercising the right of a patient to make their own decisions, uninfluenced by a medical practitioner, regarding their medical care.[124] The predominant requirement for autonomy is thus narrowed down to the mere independence of decision making. Alasdair Mclean confirmed this requirement by stating, "all that is necessary is the absence of external constraint and the capacity to make (and act on) a decision".[125]

In light of the above, a positive duty rests on all healthcare practitioners to respect the decisions of a patient and ensure that a patient has acquired all information deemed necessary to make the abovementioned informed decision regarding the appropriate treatment or medical procedure. In the instance whereby a medical practitioner concludes, in their learned opinion, that treatment is futile and death inevitable, the patient must vest the deciding capacity to make an informed choice as to what the course of action should entail. This is an accurate measure of patient autonomy.

The ongoing incorporation of a patient's participation in their treatment or care, whether in understanding or making informed decisions pertaining to their necessary treatment/medical procedure, indicates the healthcare system regressing from a former paternalistic approach. Engelbrecht validates this changed notion by encapsulating the patients' standpoint concerning

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120 Engelbrecht S. F. 'Can autonomy be limited- an ethical and legal perspective in a South African context' 2014. The principle to respect patient autonomy is codified within the International Bill of Rights, the African Charter, The South African Constitution, and the Patients' Right Charter.

121 Rowe K. & Moodley K. 'Patients as consumers of health care in South Africa: the ethical and legal implications' BMC Medical Ethics (2013) pp 1-9.

122 The Constitution *supra* 2, close links exist to a multitude of fundamental rights including human dignity, privacy, and freedom and security of the person.

123 Rowe K. and Moodley K. *supra* 121.

124 HPCSA *supra* 49 'The right of patients to make decisions about their medical care without their health care provider trying to influence the decision'. This definition gives effect to the right to human dignity (section 10) and bodily integrity (section 12(2)) as contained in The Constitution.

125 Maclean A. 'Autonomy, informed consent and medical law' (2009) pg 12.

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patient autonomy as follows, "The patient is the ultimate person to cast a decision about their health and wellbeing".[126]

The current era in which we are situated places emphasis on the importance of human rights considerations, both internationally and in a South African context.[127] A transition has taken place, as a result, from that of a former traditional paternalistic model to one wherein patient autonomy serves to be the premise of privacy for patients in healthcare.[128]

Patient autonomy requires the careful balancing of the individual's interests with those of society. Decisions about a patient's healthcare, although personal, may at times be required to be made by a medical professional on behalf of said patient in order to protect the interests of society as a whole.[129] Although the Constitution provides for the justifiable limitation of rights,[130] it can be argued to some extent that this mindset dealing with patient autonomy is congruent with the principle of utilitarianism.[131]

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126 Engelbrecht S. F. *supra* 120.

127 The Constitution *supra* 2, section 12 (2).

128 Faunce T.A. 'Pilgrims in Medicine: Conscience, Legalism and Human Rights' (2005).

129 In Koenane M.L.J. *supra* 12, the author poses a number of open-ended questions to ascertain the extent to which autonomy functions prior to any limitation being imposed by section 36 of The Constitution. These questions include: "How free are mature, competent individual(s) to decide their own fate, especially in making a choice between living and dying? Does autonomy mean that a person is free to dispose of his or her life as he or she pleases?" Although instances such as these would need to be dealt with on a case-by-case basis, they serve as preconditional thoughts as to how patient autonomy may be unreasonable restricted under current voluntary active euthanasia debates.

130 The Constitution *supra* 2, section 36.

131 Robertson M. & Walter G. 'A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics' (2007). Utilitarianism is a normative ethical theory, founded by Jeremy Bentham and John Stuart Mill, according to which, actions deriving the greatest benefit for society are favoured to those aimed at satisfying individual needs. It is a form of consequentialism, whereby the moral worth of each action is determined solely by the consequence thereof. Mills expanded this principle even further by emphasising the need to derive the highest level of happiness for the most amount of people. The main objective of utilitarianism is the avoidance of pain, in any given situation. Thus, we look to the outcome or consequences of an action to determine the rightness or wrongfulness. The notion of utilitarianism is one which is ordinarily instilled in society. The principle has been translated into a phrase often referred to as, 'for the greater good'. To what extent should this be applied in the field of medicine? Can the potential benefit to society trump the rights of one individual? This controversial topic has become highly debated on an international scale. An example of such is the infamous 'Pernkopf Atlas', compiled by Eduard Pernkopf during the Nazi era. Although the courts have done much to recognise the value of the common good as well as individual rights, striking the right balance between protecting the public interest and maintaining personal rights can prove to be difficult. The Bill of Rights, better known as 'the tool for social justice', regulates this unequal relationship between the state and the individual. A principle is instilled whereby no person is above the law, and everyone is subject to the Constitution, as a result. South African law therefore makes provision to incorporate philosophies, such as utilitarianism, within the legal framework, should they be in accordance with the Constitution as per section 172(1)(a).

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Prior to the existence of the Constitution, in the case of *Stoffberg v Elliott*, Watermeyer J draws attention to certain common law rights, in view of autonomy of a person, which are protected absolutely as follows:[132]

> In the eyes of the law, every person has certain absolute rights which the law protects. They are not dependent on statute or contract, but they are rights to be respected, and one of the rights is absolute security to the person . . . Any bodily interference or restraint of man's person which is not justified in law or excused in law or consented to is a wrong, and for that wrong, the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.

The importance of this statement presupposes the assertion that patient autonomy is unable to function independently from the Constitution without limitation.[133] The application of the Constitution restricts the freedom of choice insofar as exercising decisions relating to a person's right to life and will to live. As a result, patient autonomy is rendered futile in light of voluntary active euthanasia.

Taking the contextualisation of patient autonomy into account, it can be deduced that patient autonomy functions as an integral component in the governance of euthanasia. However, patient autonomy remains to be an afterthought in its application alongside voluntary active euthanasia.

Fundamental human rights remain to be the focal point of departure for purposes of this dissertation. That being said, this ought not to be done in isolation. All justifiable legal principles and doctrines, such as patient autonomy, are factored in, affecting the purpose and application of the abovementioned rights.

1.7. Palliative care

Palliative care is a term that has been defined in a multitude of ways. As set out in each definition, the main focal point is that of relieving pain and suffering, in conjunction with improving the quality of life of the patient concerned.

As proposed by the Commission, Palliative care ought to be defined as: "The treatment and care of a terminally ill patient with the object of relieving physical, emotional and psycho-

132 *Stoffberg v Elliott supra* 102 pg 148.
133 The Constitution *supra* 2, section 2.

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social suffering and of maintaining personal hygiene".[134] An alternative definition for palliative care as provided for in the HPCSA ethics guidelines is set out as follows:[135]

> Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial, and spiritual.

Palliation requires the sedation of a patient, placing them in a state of minimal or no consciousness to guarantee a pain-free existence.

However, this suggestion fails to recognise that it is not always the presence of pain that renders a life not worth living.[136] A minimally conscious state coupled with zero prospects of recovering amounts to a person's life lacking quality and being described as nothing more than 'sombre in nature'.[137] Serendipity, in a moment such as this, serves to be a patient's strongest ally.

Palliation is often suggested as a substitute for euthanasia for those patients who find their lives intolerable. Palliative care should not function so that it is considered an alternative to euthanasia but rather as a precondition to the decision for a person to terminate his or her own life.

As a result, contrasting arguments manifest in consideration of palliation and the quality of life, or lack thereof. The basis of palliation advocates for an improved quality of life through the recession of pain. However, this defined quality of life is one of the many reasons euthanasia is considered preferential in these instances. This remains to be an ever-present ramification in the palliation versus euthanasia debate.

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134 Mahomed I., *supra* 53. See further Browde S. 'There would be little need for euthanasia if doctors understood how to deliver a 'good death'' (2008) wherein palliative case is described as, "Medical intervention not intended to cure but to alleviate the suffering, including the emotional suffering, of the patient. It is concerned with the quality of life when, in the course of an illness, death becomes inevitable".

135 HPCSA, *supra* 49.

136 Benatar D. *supra* 54.

137 *Ibid*. Patients being kept physically comfortable until their moment of death does not provide that such situation to be emotionally or psychologically acceptable.

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Although it has been contended that palliation fosters respect for a patient's life, Benatar states that this interference amounts to "no less a violation of human freedom in forcing the continuation of life when people believe that their continued life is worse than death".[138]

Precautionary measures are thus required to be taken by medical practitioners in light of palliative care. Inclusive is for a patient to indicate their wishes regarding treatment options in the form of an advance directive.[139] Although unrelated to the restraint placed on a patient's freedom, these abovementioned measures serve as a means to make known the wishes of a patient.[140] Consequently, to these measures, the protection of patients subjected to diminished autonomy is ensured.[141]

The Department of Health has recognised palliative care as a fundamental and essential component of health service delivery. The integration of palliative care is further necessitated due to South African medical facilities' significant ongoing disease burden as a correlative factor to HIV.[142]

Palliative care has been synonymous with the medical profession since its existence. Such that it is recognised within the ambit of the World Health Organisation and often applied in instances of the following diseases:[143]

> Cardiovascular disease; cancer, chronic respiratory diseases; AIDS; diabetes; kidney failure; chronic liver disease; multiple sclerosis; Parkinson's; rheumatoid arthritis; neurological disease; dementia; congenital anomalies; and drug-resistance tuberculosis.[144]

The above indicates the prevalence of diseases amongst society that demand the provision of palliative care to relieve pain and suffering and improve the quality of life of the patient.

Therefore, it has been made known that palliative care does serve a vital purpose within the medical fraternity insofar as dampening the discomfort and pain resulting from several diseases. However, caution should be taken to avoid using palliation as a scapegoat for

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138 Mahomed I. *supra* 53 pg 54.

139 A written nomination must be stipulated in the said advance directive to mandate a person to make decisions on behalf of the patient concerned if they become incapacitated and unable to do so.

140 HPCSA *supra* 49 (Booklet 3). An onus is placed on the patient to advise their health practitioner as per their wishes regarding death.

141 HPCSA *supra* 49 (Booklet 17).

142 *Ibid.*

143 World Health Organization 'Global Atlas of Palliative Care at the End of Life' (2014).

144 This list is not exhaustive.

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euthanasia, as they do not always advocate for the same rationale. Both palliation and euthanasia should be applied where necessitated and in the best interests of a patient's wishes and rights.

1.8. Living wills

Living wills are not recognised as 'wills' under the ambit of the Wills Act, as they record a person's will regarding a particular medical context rather than testamentary dispositions over a person's assets.[145] Pace & Van der Westhuizen describe living wills as follows:[146]

> A 'living will' is a declaration or an advanced directive in which a patient expresses their directives by refusing consent to any medical treatment and attention, which will keep him alive by artificial means when they are no longer competent to express their instructions.

At present, there is no direct authority at common law regarding the legal validity or enforceability of 'living wills' in South Africa.[147] The only decision in which a so-called 'living will' featured was that of *Clarke v Hurst*.[148]

However, living wills and advanced directives are recognised and may be afforded application, specifically regarding medical treatment.[149] Carstens correctly states that the recommendation of The Commission should be followed, in that a 'living will' should be legally recognised with emphasis on human dignity and patient autonomy as set out in the Constitution.[150]

For a living will to be regarded as such, the validity requirements must be met in full. These requirements include that a person must be of the required age to provide medical consensus and be '*compos mentis*' when concluding the relevant living will. The declaration remains valid even if the declarant at a later stage becomes '*non-compos mentis*'.[151]

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145 The Wills Act 7 of 1953.
146 Pace R.P. and Van der Westhuizen W.M. 'Wills and Trusts Service' Issue 20, (2016).
147 South African Medical Association 'Living Wills and Advance Directives' (2012).
148 *Clarke v Hurst supra* 26.
149 Judgment of Thirion J. in *Clarke v Hurst supra* 26 shows that it may be lawful to withhold or discontinue medical treatment of a patient who is in a persistent and irreversible vegetative state, in conformity with the patient's wishes expressed in a 'living will' while still in good health.
150 Carstens P.A. and Pearmain D. *supra* 9 pg 209.
151 Living Wills and Advance Directives *supra* 147.

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As previously mentioned, living wills and durable powers of attorney confer limited weight in the South African legal framework since they are not recognised by law. However, if this position changes and advance directives become legalised, following examples set out in the United States of America,[152] there would be no ground to exclude voluntary active euthanasia from advanced directives. Doing so would amount to an inconsistency in the law.[153]

Living wills give effect to many fundamental rights as set out in the Constitution.[154] However, the choice for a person to refuse medical treatment, even if such treatment will result in irreversible harm or death, is only afforded insofar as the treatment is sanctioned by law.

As it stands, concerning voluntary active euthanasia, the state safeguards the notion of the sanctity of life. By doing so, the state affirms that in allowing medical practitioners to actively participate in actively terminating the lives of their patients, at their patient's request, the lives of other 'vulnerable' members of society may potentially be devalued.[155]

The context of this argument remains to be, at best, too broad when dealing with a mere refusal of medical treatment. Not only would it seem unreasonable, but also unorthodox, to require a person to forfeit their right of refusing medical treatment in the general interest of society, in respecting the sanctity of life.[156]

Medical practitioners should thus respect any living will where clear evidence exists that the living will was compiled when the patient was mentally competent and reflect the current wishes of the patient insofar as the treatment is sanctioned by law.[157] This viewpoint is accepted by other experts within the medical law sphere at large.[158] A third party may be nominated to

152 Right to a Natural Death Act (1989). North Carolina General Statutes, sections. 90320 to 90322. See also Health Care Power of Attorney Act (1991). North Carolina General Statutes, sections. 32A-15 to 32A-26.

153 Landman W.A *supra* 35.

154 The Constitution *supra* 2, Chapter 2 Bill of Rights.

155 Perry S.J. 'Legal Implications for Failure to comply with Advance Directives: An Examination of the Incompetent Individual's Right to refuse Life-Sustaining Medical Treatment' 2002.

156 Porter D. 'Advance Directives and the Persistent Vegetative State in Victoria: A Human Rights Perspective' (2005) JLAM pg 256. Porter indicates (at pp 261-262) that the right to life is concerned with the prevention of arbitrary taking of life which is a threat to the existence of society and that it is not violated where a person is allowed to die following the withdrawing or withholding of treatment in accordance with a person's previously expressed wishes.

157 Strauss SA 'Doctor, patient and the law: A delicate Triangle' (3ed 1991) pg 344.

158 Carstens P.A. and Pearmain D.*supra* 9 pg 209; Burchell J. Principles of Criminal law (2006) pg 328; McQuoid-Mason (2005) SACJ pp 27-28.

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give such consent of wishes on the patient's behalf in certain situations.[159] This level of respect stemming from a practitioner regarding any refusal of treatment extends to any situation whereby an advanced statement is not available; however, the patient's wishes are known.[160]

Medical practitioners are thus tasked with the paramount role of imparting the required knowledge surrounding living wills onto their patients regarding their treatment, but more particularly to the refusal of such treatment.[161]

In light of the enforceability of living wills, legal intervention is required to eradicate uncertainty in the application thereof, via development of the common law or through legislation.[162] As it stands, the lack thereof only creates confusion in decisions handed down by the courts. Furthermore, it gives rise to the ongoing lack of development insofar as active euthanasia is concerned.

The Commission intends to address this discrepancy through the request to legally recognise a so-called 'Living Will' insofar as it requests a passive form of cessation of life.[163] However, the lapse in time since the request was handed down until current developments have shown to be nothing but fruitless.

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159 HPCSA *supra* 49 Booklet 4 (Seeking patients' informed consent: The ethical considerations) states that: "The National Health Act allows patients – while still mentally competent - to mandate another person in writing to give consent on their behalf. If health care practitioners are treating a patient who has lost the capacity to consent to or refuse treatment, for example through the onset or progress of a mental disorder or other disability, they should try to find out whether: The patient has previously mandated someone else in writing to make decisions on their behalf; or have indicated preferences in an advance statement (e.g., an 'advance directive' or 'living will'). Health care practitioners must respect any refusal of treatment given when the patient was competent, provided the decision in the advance statement is clearly applicable to the present circumstances, and there is no reason to believe that the patient has changed his or her mind".

160 HPCSA *supra* 49 Booklet 4 (Seeking patients' informed consent: The ethical considerations) further states: "Where an advance statement of this kind is not available, the patient's known wishes should be taken into account".

161 Living Wills and Advance Directives, *supra* 147.

162 The Constitution *supra* 2, section 39(2) of provides that a court, when developing the common law, must promote the spirit, purport and objects of the Bill of Rights. Since the inception of the Constitution the Constitutional Court and the Supreme Court of Appeal have ruled in a number of cases that the common law should be developed in terms of these values, norms, and objects. See *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC); *Van Eeden v Minister of Safety and Security* 2003 (1) SA 389 (SCA); *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA); *Minister of Safety and Security v Hamilton* 2004 (2) SA 216 (SCA).

163 Mahomed I. *supra* 53.

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1.9. Concluding remarks

The purpose of this chapter sought to provide clarity regarding the initial problem question as set forth: "What are the various forms of euthanasia, and why is voluntary passive euthanasia the only legalised form of euthanasia in South Africa currently?".

In order to provide clarification, the concept of euthanasia as a whole was explained. After that, the various forms of euthanasia were further defined, deconstructed, and discussed using a layered approach. This, in turn, made known the application and legal implications concerning each form of euthanasia within the context of South Africa's legislative framework.

Further clarification was provided by identifying the inter-relationships that vest between euthanasia and the concepts mentioned above relating to it. These intricate components emphasized that euthanasia is incapable of being viewed as a topic in isolation, but instead that it requires incorporating a multitude of principles, doctrines, and ideologies.

As seen in this chapter, the multifaceted aspects and complex nature of euthanasia indicate possible reasons surrounding the stagnant development of euthanasia in South Africa's legal system. The basis of this notion will continue to be applied and assessed further in the forthcoming chapters in an attempt to answer the second part of the initial problem question as identified.

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CHAPTER 2: THE CONSTITUTIONAL DISPENSATION

2.1. Introduction

This chapter is said to be the crux of this study, whereby the foundation of the Constitution will be challenged concerning voluntary active euthanasia. By interpreting several fundamental human rights, as afforded by the Bill of Rights, it will be determined whether the ambit of such rights extends to include the choice to end one's life by way of voluntary active euthanasia. A positivist law approach will expand upon the interpretation of the identified fundamental human rights.

In doing so, this chapter seeks to identify any exceptions to the current rule of law. As it stands, the current approach as set out by legislation is restrictive. Any proposition to impose legislation that decriminalises the termination of life in terms of voluntary active euthanasia would be deemed inconsistent with the Constitution.[164]

It will be argued that the resolution to the obstacle, that is, voluntary active euthanasia, does not lie in the implementation of further legislation but rather in recognising the already prescribed human rights as contained in the Constitution.[165]

For this reason, the decriminalisation of euthanasia within South Africa's current dispensation remains to be conceivable, should such a practice be regarded as a justifiable limitation to the right to life.[166] With the correct exertion of the limitation clause, in conjunction with an appreciation of the supreme nature of the right to dignity, little doubt remains as to why euthanasia is incapable of operating under South Africa's Constitution as a procedure to end one's life in specified circumstances.

A paradigm shift within the current constitutional dispensation is necessitated regarding each human right, which finds application with the practice of voluntary active euthanasia.

164 The Constitution *supra* 2, section 2.
165 The Constitution *supra* 2, Chapter 2 Bill of Rights.
166 The Constitution *supra* 2, section 26.

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2.2. The constitutional dispensation

South Africa is equipped with arguably one of the most intricate and diverse Constitutions in the world. Heralded by a new legal order, the Constitution was established to seek constitutional supremacy, along with a justiciable Bill of Rights.[167] This necessitated change was brought about through the ceasing of apartheid, an era of *Patrimoine*. A new democratic regime commenced, encompassed by equality, human dignity, freedom, and equity.[168]

South Africa's legal system is one that is uncodified. Such that, there is no single source from which the law originates and can be found.[169] However, the Constitution is supreme, embodying countless obligations which are to be fulfilled within the confines of the legal framework of South Africa.[170]

South African jurisprudence continues to be developed by way of ancillary sources of law. The Bill of Rights acknowledges all rights and freedoms conferred in this regard to the extent that they conform with the constitutional directives as provided.[171] A landmark judgement was delivered by the Constitutional Court in *S v Makwanyane*, whereafter *ubuntu* was introduced to South African jurisprudence. The court affirmed that recognition should be given to "African law and legal thinking as a source of legal ideas, values and practice". In line with democratic ideologies, Sachs J led the court by asserting that:[172]

> The court is to take account of the traditions, beliefs, and values of all sectors of South African society when developing South Africa's jurisprudence—owing to the fact that in broad terms, the function given to this court by the Constitution is to articulate the fundamental sense of jurisprudence and rights shared by the whole nation as expressed in the text of the Constitution.

Although customary law is recognised and forms part of South Africa's legal framework, its application insofar as it relates to euthanasia is vastly limited.

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167 Nwabueze B. 'Constitutional democracy in Africa' (2003) pp 36-45. In which Nwabueze presupposes the relevance and duties of incorporating Constitutions into a countries' legal framework by stating that, "Constitutions create state institutions, allocate to them powers and, importantly, define the limits of their powers".

168 Moseneke D. 'A journey from the heart of apartheid darkness towards a just society: Salient features of the budding constitutionalism and jurisprudence of South Africa' (2012) 101 GLJ 749.

169 African Charter on Human and Peoples' Rights Chapter 2.

170 The Constitution *supra* 2, section 2.

171 The Constitution *supra* 2, section 39(2).

172 *S v Makwanyane and Another* 1995 ZACC 3 paras 361-362 per Sachs J.

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For purposes of this study, considerations of *ubuntu* have been integrated with the right to life, supported by section 11 of the Bill of Rights. Quality of life remains to be a fundamental precept in furthering the notion of decriminalising euthanasia. *Ubuntu* makes provision for the right to life, extending to the way in which attributes of quality preserve life.[173]

The Constitutional Court's new democratic approach to jurisprudence suggests a more inclusive approach when interpreting law topics unbeknownst or opposed by persons of differentiated backgrounds. The overarching power of the Constitution remains to restrain unorthodox applications of the law, incongruent with constitutional principles.

The Constitution functions as a 'checks and balance' system to which all added sources of law are supplementary in their application. As set out by the Constitution, this notion also makes provision for an essential democratic principle, namely, the separation of powers.[174] The entrenchment of fundamental human rights within the Bill of Rights guaranteed protection against abuse by the State.[175]

Ancillary to the protection against abuse of State power is a general limitation clause as set out by section 36 of the Constitution.[176] As the name suggests, the limitation clause renders the oppressive tiers of state power redundant through inviolable levels of scrutiny.[177]

During drafting the Constitution, many debates were had as to whether the Bill of Rights should apply vertically and horizontally. The issue in dispute was raised before the Constitutional Court, which concluded that the Bill of Rights was not of direct horizontal application.[178] Subsequently, the Constitutional Court led a different viewpoint, certifying that

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173 Broodryk J. 'Ubuntu management philosophy: Exporting Ancient African Wisdom into the Global World' (2005) pg 14. Khanyile J. defines *ubuntu* as "The common spiritual ideal by which all Africans south of the Sahara give meaning to life and reality". On account of this study reflecting a positivist approach considering decriminalising euthanasia, there will be no furthered arguments pertaining to *ubuntu* and the principles related thereto.

174 The Constitution *supra* 2, section 173. Ancillary inherent powers are afforded to the Constitutional Court, Supreme Court of Appeal and High Court, enabling the 'protection and regulation of their own processes, and to develop the common law, considering the interests of justice'.

175 In addition to these aforementioned rights, although not expressly stated, the Constitution incorporates foundational principles, throughout the wording, as stipulated in The Preamble. An example of which is that of patient autonomy, a medico-legal principle which is consequential to the decriminalising of euthanasia.

176 The Constitution *supra* 2, section 36.

177 Woolman S. 'Out of Order? Out of Balance? The Limitation Clause of the Final Constitution' (1997) SAJHR 13:1, pp 102-134.

178 *Du Plessis and Others v De Klerk and Another* 1996 (3) SA 850.

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section 8(2) of Chapter 3 "unequivocally provides for the horizontal application of the Bill of Rights".[179]

Accordingly, the Constitution purports to establish a society based on democratic values, social justice, and fundamental human rights and ensures equal protection of the citizens of South Africa through a democratic and open society.[180]

2.3. Fundamental human rights pertinent to euthanasia

Contained within Chapter 2 of the Constitution is a justiciable Bill of Rights. One that encompasses a multitude of human rights, available to all person's resident within South Africa. The onus rests on the State to respect, promote, and fulfil the rights outlined in the Bill of Rights, ensuring protection and fairness to all applicable persons.[181]

With respect to the medical profession within South Africa, numerous enforceable rights find their application daily. These rights seek to protect the patient and the medical practitioner, and society as a whole. Courts have been unnecessarily inundated with cases pertaining to the medical field, often in an attempt to seek clarity as to whether certain fundamental rights find their application or not.[182] Developments in medical knowledge are ongoing and have prompted legislators to revisit current medical health laws, with specific reference to euthanasia.

However, legal protectionism of the industry's professionals functions in such a way as to limit actions surrounding a breach in medical confidentiality from being brought before the judiciary. The current enactment of the constitutional dispensation insofar as its application within the topic of euthanasia is evident in an unequal relationship between medical professionals and patients.

Therefore, it is imperative for this subchapter to determine whether a basis exists for all fundamental rights pertaining to voluntary active euthanasia to be redefined and expanded.[183]

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179 *Du Plessis and Others v De Klerk and Another,* In Re: Certification of the Constitution of the Republic of South Africa, 1996 (10) BCLR 1253 (CC).
180 The Constitution *supra* 2, The Preamble.
181 The Constitution *supra* 2, section 39(2).
182 *Suzanne Walter and Others v Minister of Health and Others* (2017).
183 The Constitution *supra* 2, section 74 (2).

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The content of these rights and interpretation thereof will determine whether their application stands in need of further clarity.

Specific rights to be discussed herein include the right to life, freedom and security of the person; right to bodily integrity; right to privacy, and access to emergency treatment and healthcare services. This subchapter will identify and further expand upon these rights, their enforceability, and limits, with specific reference to the medical sphere insofar as voluntary euthanasia.

2.3.1. Right to Life

The inalienable right to life is considered by many jurists, along with the South African courts, as being the predominant human right, antecedent to all other fundamental rights as contained within the Bill of Rights.[184] Nevertheless, in recognising its pertinence, the right to life is interlaced among the right to dignity, with the intent to maintain a life of sustenance.

Section 11 of the Bill of Rights provides that "Everyone has the right to life".[185] This definition should not be interpreted in the narrow sense whereby it is referred to as a non-derogable right (to be respected and protected in all circumstances),[186] but rather explicated to include the right to live, as being embodied in humanities societal constructs.[187]

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184 Currie I. and de Waal J. 'The Bill of Rights Handbook' (2005) pg 280. See also Pearmain D.L. 'A critical analysis of the law on health service delivery in South Africa (2004) pg 118. Wherein the right to life is characterized as being elementary from which all human rights are applicable. See also *S v Makwanyane supra* 172, wherein varied judges of the court described the right to life as the most crucial of all fundamental human rights. Kriegler J stated at para 213, "in the hierarchy of values and fundamental rights guaranteed under the Bill of Rights I see the right to equality, dignity and freedom as ranked below the right to life". Congruent with this belief, Langa L. went on to describe how the right to life is 'the most fundamental of all rights' in that it is 'the supreme human right' See further O' Regan remarks *in lieu* of the right to life, "The right to life is, in one sense, antecedent to all other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to share in the experience of humanity. This concept of human life is at the centre of our constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. So, the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity".

185 The Constitution *supra* 2, section 11.

186 Van Wyk D.H., Dugard J., De Villiers B., and Davis D. 'Rights and constitutionalism: The New South African Legal Order' (1996) pg 660. See further the Constitution *supra* 2, section 37 as tabulated.

187 Pearmain D.L 'A critical analysis of the law on health service delivery in South Africa' (2004). pg 118. The right to life safeguards the physical biological existence of human beings.

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The right to life was included in the Constitution to advocate for the assurance of a certain quality of living. The principles of what a 'quality life' consists of remains a dynamic notion attributed to emotional well-being, physical well-being, self-determination, and interpersonal relationships at the very least.[188] Underscored by the right to live a dignified life, sanctity of life appears straightforward when described without qualifications.

Corroboration of this ideology is elevated in the self-contained Preamble of the Constitution with the aim to "Improve the quality of life of all citizens and free the potential of each person".[189] One must consider the societal construct contained within the phrase 'all citizens' and 'each person' as described in this section. The implicit wording in this sense refers to the greater society of South Africa in its entirety.

South Africa is often referred to as a 'rainbow nation', a metaphor first coined by Archbishop Desmond Tutu. It has been adopted and utilised throughout the country as a motif when referring to society, who form South Africa's people. South Africa is considered to have one of the most segregated pluralistic societies.

Therefore, one must question whether the drafters of the Constitution are in the position and have the acquired knowledge to decide what the legal convictions of such a multi-facet society should include when considering the definition of what 'quality-driven life' should entail. In the case of *Clarke v Hurst*, Thirion J states that "morality plays a role in shaping society's legal convictions", yet in fact, the test is to be based on societies legal convictions and not the moral counterpart.[190]

This question becomes increasingly difficult when referring to such a diversified society in terms of a single notion or concept. Freeman highlights the impracticality of this mindset about the entire population that constitutes South Africa:[191]

> What is 'society'? Which 'society' is he [Thirion J] talking about? Are we talking of the 'reasonable man' test? Is the Clapham omnibus a township bus or a corporation one? Does the person on the Umlazi bus have the same legal convictions as the one on the Bluff bus or the Chatsworth bus? Does the judge really believe there is a consensus?

188 Serfontein E.M. 'The nexus between the rights to life and to a basic education in South Africa' (2015) pg 2268.
189 The Constitution *supra* 2, The Preamble.
190 *Clarke v Hurst supra* 26.
191 Dworkin R. 'Lord Devlin and the Enforcement of Morals' Yale Law Journal Vol 76 (1966).

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It has been made progressively more apparent that the concept of 'society' and legal convictions thereof are used as a convenient cloak for the protection against public policy infringements, especially evident in the ruling sanctioned in *Clarke v Hurst*.

Therefore, a broad societal interest is imposed by the state in the preservation of life, accompanied by the principle that all human life retains equitable value.[192] In order to gain greater insight into the intrinsic quality of a person's life, one needs to consider the right to life in the circumstances of euthanasia.

The eminence of the right to life, underscored by the right to self-determination, was substantially dealt with in the Constitutional Court case of *S v Makwanyane*, whereby Mahomed regarding the interpretation of section 9 of the Interim Constitution J remarked as follows:[193]

> Does the right to life preclude the practitioner of scientific medicine from withdrawing the modern mechanisms which mechanically and artificially enable physical breathing in a terminal patient to continue, long beyond the point when the 'brain is dead' and beyond the point when a human being ceases to be 'human' although some unfocused claim to qualify as a 'being' is still retained? If not, can such a practitioner go beyond the point of passive withdrawal into the area of active intervention? When? Under what circumstances?

Integrated with a layered and inordinately complex precept, the judgement of Mahomed J serves as compelling jurisprudence for recognising voluntary active euthanasia in a regulated and dignified system. This is particularly appropriate in specific instances where life has become devoid of all quality due to a terminal illness.

The duty to live is considered in the Constitutional Court case of *Soobramoney v Minister of Health*. It was held that no positive obligation is imposed upon the state to provide life-sustaining treatment to critically ill patients.[194] Hence, the right to life contains no unqualified obligation owing to the continued living of an individual, proven by the Court in this matter.

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192 Barnard C.N. *supra* 79 pg17. Barnard draws emphasis to the quality of life maintained whilst being alive as follows, "It is therefore, not the diagnosis of death that concerns me as much as a possible means of determining when the state of 'being alive' ceases. Dying in this context, can be defined as the irreversible deterioration in the quality of life which precedes the death of that particular individual…I have learned from my life in medicine that death is not always an enemy. Often it is good medical treatment. Often it achieves what medicine cannot achieve – it stops suffering".

193 *S v Makwanyane supra* 172 par 268.

194 *Soobramoney supra* 80.

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Such that, the right to life is, in fact, eligible to be waived, depending on the present circumstances. A legal order that warrants such a person to morally request help in finding a natural means to end their life indicates consistency with the principles of an open and democratic society.

Furthermore, it could be said that the right to life is inextricably linked to the prevention of arbitrarily taking of life. This remains to be countervailing to the public interest, as purported by the Bill of Rights.[195]

However, this right does not violate where the withdrawing or withholding of treatment is done so under a valid advanced directive.[196] Professor Geoffrey Falkson articulates that when concerned with the arbitrary taking of life, “the accent should be on the sacredness of the quality of life, rather than the sacredness of life per se”.[197] The complexities ascribed to the right to life are required to be evaluated separately because the right to life necessitates objective consideration, free from limitation.[198]

The right to life is encapsulated by the freedom of choice, right to bodily integrity, and self-determination. This provision, however, does not extend to a legal right to die. Legislating such a provision under the current constitutional paradigm will only be possible in the event that the practice of active euthanasia is seen as a reasonable and justifiable limitation to the right to life. By doing so, a certain measure of legal certainty would be made available to medical practitioners instead of the fear of acting outside the bounds of the law. As it stands, the Constitution makes provision for the right to life without imposing a duty to live.[199]

2.3.2. Right to Dignity

Human dignity is indeterminate, yet with an unbounded application that is potentially so inclusive at the same time. Courts have devoted much ink in an attempt to earnestly seek and understand the true meaning within the rights broad scope of application.

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195 The Constitution *supra* 2, section 39(2).
196 Porter D. *supra* 156 pp 251-252.
197 Mahomed I. *supra* 53.
198 Cheadle H., Haysom N., and Davis D. ‘South African Constitutional Law: The Bill of Rights’ (2002) pg 143.
199 *Soobramoney supra* 80.

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Accordingly, the Constitutional Court has referred to dignity as "a notoriously difficult concept … which needs precision and elaboration".[200] Despite these difficulties, the courts have taken on this mammoth task with enthusiasm and persistence.

Dignity represents the essence of what it means to be human; as a core element of human functioning, it individuates us from majoritarian norms.[201] Albeit ambiguous, it remains to be a noteworthy attribute of humanity.[202] In reality, dignity displays divergent functions, owing to its multiple meanings from diverse sources of the idea. Beyleveld and Brownsword deconstruct how dignity can be construed as a right, a principle, or a legal value as follows:[203]

> Dignity appears in various guises, sometimes as the source of human rights, at other times as itself a species of human right (particularly concerned with the conditions of self-respect); sometimes defining the subjects of human rights, at other times defining the objects to be protected; and sometimes reinforcing, at other times limiting, rights of individual autonomy and self-determination.

Dignity thus represents a 'wide moral view',[204] invoked throughout the world and subsequently forms part of various constitutional texts, among other things, as the basis of fundamental human rights.[205] Inside South Africa's legal system framework, dignity has been incorporated both expressly and impliedly within the new Constitution.[206]

Section 10 of the Bill of Rights specifies that everyone has inherent dignity and the right to have their dignity respected and protected.[207] Recognising and protecting the intrinsic worth of dignity as a fundamental human right within the Constitution is a quintessential feature of the new political order.[208] Confirmed by the founding provisions of the Constitution, the reinvented

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200 *Harksen v Lane* 1998 1 SA 300 (CC) para 50, quoting the Canadian Court in *Egan v Canada* 1995 29 CRR (2d) 79 106.

201 Barber B.K. et al 'Politics Drives Human Functioning, Dignity, and Quality of Life' (2014) pg 92.

202 Weisstub D.N. 'Honor, Dignity and the Framing of Multiculturalist Values' (2002) in Kretzmer D. and Klein E. (eds) 'The Concept of Human Dignity in Human Rights Discourse' (2002) pg 269.

203 Beyleveld D. and Brownsword R. 'Human Dignity, Human Rights, and Human Genetics' (1998) MLR pp 661-662.

204 Steinmann A.C. 'The core meaning of human dignity' (2016).

205 Clapham A. 'Human Rights in the Private Sphere' (1993) pp 148-149. See also Wood A. 'Human Dignity, Right and the Realm of Ends' (2008) *Acta Juridica* pg 47.

206 *S v Makwanyane supra* 172 at para 329.

207 The Constitution *supra* 2, section 10.

208 Schachter O. 'Human Dignity as a Normative Concept' (1983) AJIL pg 850. Wherein respect for intrinsic worth requires that 'the person is entitled to have his or her own beliefs, attitudes, ideas, and feelings'.

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republic "is one, sovereign, democratic state founded on . . . Human dignity, the achievement of equality and the advancement of human rights and freedoms".[209]

Therefore, the right to inherent human dignity is a foundational constitutional value that not only informs the interpretation of most constitutional rights but is also central in the limitations analysis of constitutional adjudication.[210] As a result, dignity establishes harmony among the different rights and values so entrenched within the Bill of Rights as observed by the court in Dawood:[211]

> The value of dignity in our constitutional framework cannot, therefore, be doubted. The Constitution asserts dignity to contradict our past in which human dignity for black South Africans was routinely and cruelly denied. It asserts to inform the future, to invest in our democracy respect for the intrinsic worth of all human beings. Human dignity, therefore, informs constitutional adjudication and interpretation at a range of levels. It is a value that informs the interpretation of many, possibly all, other rights. This Court has already acknowledged the importance of the constitutional value of dignity in interpreting rights such as the right to equality, the right not to be punished in a cruel, inhuman, or degrading way, and the right to life. Courts have relied on dignity to interpret human rights, to give them substance and meaning. Dignity is a lens through which courts determine the extent and scope of human rights and for the purpose of determining what interests the right should protect.

Dignity is constituted within the framework of South Africa's Constitution as the basis from which all other human rights are interpreted. Due to this, dignity in all its various forms and functions is regarded as supreme and to be respected as an end in itself.[212]

Nevertheless, incorporating dignity along with other human rights within a democratic society presents its own set of challenges. The underlying difficulties lie in recognising human dignity and equality alike with the appropriate seriousness that they warrant, whilst at the same time giving effect to the constitutional objectives as set out. Consequently, the right to dignity is subjected to open-ended impairment throughout society as a whole.

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209 The Constitution *supra* 2, section 1.

210 Cornell D. *et el* (eds) 'The dignity jurisprudence of the Constitutional Court of South Africa' (2013).

211 *Dawood and Another v Minister of Home Affairs and Others* 2000 ZACC 8.

212 Englard I. 'Human Dignity: From Antiquity to Modern Israel's Constitutional Framework' (1999) pp 1999-2000. See further Devenish G.E. 'A commentary on the South African Bill of Rights' (1999) where the courts have regarded the right to dignity above any other right, including the right to life.

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The impairment of dignity can occur in many different ways; the result often leads to the degradation of a person.[213] The impact is determined by whether the degradation causes harm or deprives the person of a dignified life.

On further inspection, the infringement of human dignity, as stated by Schachter relates to, "conduct and ideas that directly offend or denigrate the dignity and worth of individuals".[214] The extent of this notion of undignified suffering was conceptualised by Fabricius J in *Stransham-Ford* by saying that dignity of a person is not afforded when:[215]

i) having severe pain all over one's body
ii) being dulled with opioid medication;
iii) being unaware of your surroundings and loved ones;
iv) being confused and dissociative;
v) being unable to care for one's own hygiene;
vi) dying in a hospital or hospice away from the familiarity of one's own home;
vii) dying, at any moment, in a dissociative state, unaware of one's loved ones being there to say goodbye.

Following this conceptualisation, Fabricius J stipulates that the presence of eternal and unbearable suffering constitutes an infringement of the imperatives as set out by section 10 of the Bill of Rights. As a justiciable and enforceable right, human dignity is to be respected and protected at all times, obliging the recognition of autonomy by the State.[216]

The effect of personal autonomy concerning the rights to dignity and life were provided for in the case of *Stransham-Ford*. Fabricius J held that "a person's decision on when to end life is a manifestation of their own sense of dignity and personal integrity".[217] In many instances, making such a decision to end one's own life is essential to a person's sense of dignity and personal integrity.[218]

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213 Devenish G.*supra* 212 pg 83. Degradation of a person refers to treatment which, "grossly humiliates an individual or drives a person to act against his or her will or conscience . . . any act which diminishes a person in rank, position, reputation or character can be regarded as degrading treatment, if it reaches a certain level of severity".

214 Schachter O. *supra* 208 pg 851.

215 *Stransham-Ford supra* 47 para 15.

216 The Constitution supra 2, section 7(2) whereby a duty is imposed upon the state to respect, protect, promote, and fulfil the rights contained within the Bill of Rights. See further Paleker M. 'A grandchild's claim to maintenance from a deceased grandparents' estate' (2014) pp 41-77.

217 *Stransham-Ford supra* 47 para 18.

218 Schwikkard P.J. 'Can we discard the doctrine of legal guilt?' Acta Juridica. (2015) pp 360-373.

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The importance of human dignity, specifically concerning interpreting the constitutional right to life, has been highlighted by South African case law on numerous occasions.[219] Prominence has been placed on the right to die with dignity or not to die at all. With the latter being inescapable, the inability to control one's destiny, in the form of end-of-life decisions, essentially involves a loss of 'inherent' dignity.[220]

Dignity and the right to life serve to be the cornerstone upon which all other fundamental rights in South Africa are built. Superseding the right to life in certain aspects, yet simultaneously supportive thereof, every person must be accorded dignity of equal proportions.[221] Together, these rights are mutually inclusive of one another, as evident in the *dictum* of O'Regan J in *Makwanyane*, "Without dignity, human life is substantially diminished. Without life, there cannot be dignity".[222]

The courts should revisit the topic of decriminalising euthanasia in order to give effect to the fundamental inherent right to human dignity, as aligned with the values and principles entrenched within the Constitution. Such that persons living in intractable pain or undignified circumstances can elude both inhuman and degrading treatment.[223]

As previously identified, the legal framework of South Africa makes no current provision for legalised euthanasia practices, thereby sequentially failing to recognise a right to die with dignity. It is submitted that an absolute prohibition of euthanasia practices unjustifiably limits a person's right to human dignity and subsequently the right to bodily and psychological integrity.

When considering justifiable limitations of the right to dignity, great emphasis is placed upon the sanctity of autonomy and bodily integrity when balanced against any justifications

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219 *Dawood supra* 211; *Shalabi v Minister of Home Affairs* 2000 (3) SA 936; *Thomas v Minister of Home Affairs* 2000 (8) BCLR 837, para 35: *Dladla v City of Johannesburg* 2014 6 SA 516 (GJ), para 35.

220 Krause S. 'Going Gently into that Good Night: The Constitutionality of Consent in Cases of Euthanasia' (2012) *Obiter* pg 49.

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

222 *S v Makwanyane supra* 172.

223 *Stransham-Ford supra* 47.

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for infringement.[224] Such that, any limitation must be purposeful in a constitutional and democratic society.[225]

In reality, the choice for voluntary active euthanasia should only be extended to persons whose dignity has become impaired, resultant from a life that lacks quality coupled with insurmountable pain. As it stands, there is no escape in law for persons who find themselves in such a position. The only option made available at present is to remain alive, prolonging life in a futile manner to the point of denying all dignity in the dying process.

Summarily, the rights to life and human dignity are not synonymous, one is fleeting whilst the other is transcendent to the core of being human. Humanity is suffering not from the right to life but from a perverse and crooked understanding of what it means to live truly. Dignity, therefore, functions as the master key of humanity, that when properly used, unlocks all difficulties arising from contemporary medical ethics and law.

2.3.3. Right to Equality

The concepts of equality and dignity are associated in both constitutional texts as well as constitutional jurisprudence. The connection between the two, however, is not always apparent. At times equality is held to incorporate dignity; at other times, dignity is held to incorporate equality.[226] Nonetheless, when interpreting rights, such as the right to equality, courts use dignity to clarify what the rights protect. For this chapter, understanding the already established link between the right to equality and dignity is imperative.[227]

Equality in law takes on the form of one of two approaches, namely formal and substantive equality. Formal equality refers to the sameness of treatment, whereas substantive equality infers the sameness of result. The Constitution was built on a nation divided by inequality. The courts' interpretation regarding the right to quality is made so that substantial equality is given effect.[228]

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224 Rudman A. 'The protection against discrimination based on sexual orientation under the African human rights system' (2015) 15AHRLJ pp 1-7. See further the United Nations Human Rights Committee which has described human dignity as 'the supreme right from which no derogation is permitted even in time of public emergency which threatens the life of the nation'.

225 Currie I. and De Waal J. *supra* 181 pg 805.

226 Daly E. 'Dignity Rights: courts, constitutions, and the worth of the human person' (2013).

227 Refer back to subchapter 2.3.2 for a full discussion on the right to dignity.

228 Currie I. and de Waal J. *supra* 184 pg 233. See further the Constitution *supra* 2, section 1(a).

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In contemporary constitutional law, equality operates under the guise of discrimination, such that notional freedom without equality does not advocate for democracy.[229] The Bill of Rights seeks to protect against a violation of the principle of equality in instances where the violation causes degradation, identifiable as unfair discrimination.[230]

The majority of jurisprudence which governs equality is contained within section 9 of the Bill of Rights, which places pre-emptive value on equality as follows:[231]

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

As referred to above, section 9 of the Constitution provides for the enactment of national legislation to prevent or prohibit unfair discrimination and promote equality. Be that as it may, discrimination continues to find its way into the daily lives of many South Africans.

On the occurrence of unfair discrimination being suspected, a two-step analysis must be followed by the courts. Firstly, it must be established whether a differentiation between people or categories of people exists, and in such a case where it exists, whether it be connected to a legitimate government purpose or not. Even if a rational connection has been established, the differentiation may nevertheless amount to discrimination.

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229 Daly E. *supra* 226.

230 The Constitution supra 2, section 7(1) read together with section 39.

231 The Constitution *supra* 2, section 9. See further the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 which contains provisions on ensuring that the right to equality specific to the provision of health care services. The schedule pertaining to section 29 includes the protection against: (b) Unfairly denying or refusing any person access to health care facilities or failing to make health care facilities accessible to any person. (c) Refusing to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds.

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Secondly, the court needs to establish whether the differentiation in itself amounts to unfair discrimination.[232] In *Harksen v Lane*, the Constitutional Court tabulated a three-stage enquiry to be followed in determining whether the differentiation amounts to unfair discrimination as follows:[233]

> (b) (i) Firstly, does the differentiation amount to 'discrimination'? If it is on a specified ground, then discrimination will have been established. If it is not on a specified ground, then whether or not there is discrimination will depend upon whether, objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner.
>
> (b) (ii) If the differentiation amounts to 'discrimination', does it amount to 'unfair discrimination'? If it has been found to have been on a specified ground, then unfairness will be presumed. If on an unspecified ground, unfairness will have to be established by the complainant. The test of unfairness focuses primarily on the impact of the discrimination on the complainant and others in his or her situation. If at the end of this stage of the enquiry, the differentiation is found not to be unfair, then there will be no violation.
>
> (c) If the discrimination is found to be unfair, then a determination will have to be made as to whether the provision can be justified under the limitations clause (section 36 of the Constitution).

This test, as formulated, categorises conduct into numerous different forms of inequality, including differentiation, discrimination that is fair, and discrimination that is unfair.

Discrimination must be proven on a balance of probabilities, with the burden of proof resting on the complainant.[234] The complainant must prove that they were treated less favourably than another, in addition to proving the existence of a causal connection between the act or omission and the discrimination. In order to establish whether or not such discrimination is unfair, it must be further proved that the conduct was intended to be discriminatory.[235]

When considering the application of equality in view of euthanasia, withholding the opportunity to execute end-of-life decisions with the outcome of death amounts to differential treatment of persons who no longer deem their lives worth living. Labuschagne submits that the right to equality encompasses an accompanying right to equal social-moral

232 *Harksen v Lane supra* 200.
233 *Ibid.*
234 Landman A.A. and Landman W.J. 'A Practitioner's Guide to the Mental Health Care Act' (2014) pg 40.
235 Currie I. and de Waal J. *supra* 184 pg 263.

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stigmatisation.[236] Finding a person who commits voluntary active euthanasia and a person who tortures another to death both guilty of the same crime of murder amounts to a human rights violation.

Albeit the discrimination in this instance falls within an unlisted ground of section 9, the failure in decriminalising euthanasia undoubtedly amounts to substantive inequality, with a severe impact on a person's wishes to decide upon their end-of-life choices. A presumption of unfair discrimination becomes apparent and will remain until this issue is brought before the Court's whereby the contrary is proven.[237]

2.3.4. Right to Freedom of Security of the Person

Section 12 of the Constitution regarding the right to freedom and security of the person provides that:[238]

1) Everyone has the right to freedom and security of the person, which includes the right –
   (a) not to be deprived of freedom arbitrarily and without just cause;
   (b) not to be detained without trial;
   (c) to be free from all forms of violence from either public or private sources;
   (d) not to be tortured in any way; and
   (e) not to be treated or punished in a cruel, inhuman, or degrading way.

2) Everyone has the right to bodily and psychological integrity, which includes the right
   (a) to make decisions concerning reproduction;
   (b) to security in and control over their body; and
   (c) not to be subjected to medical or scientific experiments without their informed consent.

Section 12(2)(b) is divided into two distinct components, the first relating to the 'security in' and second to 'control over' a person's body.[239] 'Security in' refers to the protection of bodily integrity against the intrusion of others, including that of the state. This provision includes the right to be left alone and unmolested.[240] 'Control over' is submitted as the inclusion of

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236 Labuschagne J.M.T 'Dodingsmisdade, sosio-morele stigmatisering en die menseregtelike grense van misdaadsistematisering' (1995) pg 34.

237 Currie I. and de Waal J. *supra* 184 pg 248.

238 The Constitution *supra* 2, section 12.

239 This provision extends to include the protection of both the right to bodily and psychological integrity. For purposes of this study, only that of bodily security will be considered.

240 Currie I. and Woolman S. 'Freedom and Security of the Person' in 'Chaskalson *et al* Constitutional law of South Africa Revision Service 2' (1998) pp 39-43.

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protecting one's bodily autonomy or self-determination, free from the interference of others.[241] This component ensures that a person can live their life according to their own volition, within reason.[242]

Prescribing to the idea that each person has the right to determine what can be done to their own body has found expression through the doctrine of informed consent.[243] Once given, informed consent does not account for the agreement to a lapse in bodily integrity or self-determination.

Moreover, it has been discussed previously by the Constitutional Court that in such instances, a positive obligation is imposed upon the state in order to prevent violations of physical integrity where possible.[244] These positive obligations are explicated further, as noted by Watermeyer J in *Stoffberg v Elliot*:[245]

> A man, by entering a hospital, does not submit himself to such surgical operations as the doctors in attendance upon him might think necessary…by going into hospital, he does not waive or give up his right of absolute security of the person…he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and unless consent to an operation is expressly obtained, any operation performed on him without his consent is an unlawful interference with his right of security and control of his own body.[246]

As expressed by Watermeyer J, the positive obligation requires informed consent to be obtained for each prescribed medical treatment, regardless of whether the refusal of such treatment will undoubtedly result in the patient's death. The right of a patient to decide what medical treatment they are willing to receive or refuse recognises not just the right to bodily integrity but that of the right to self-determination, such that it falls within the ambit of section 12(2).

The right to freedom and security of a person becomes obscured in the instance whereby a person's informed consent can no longer be obtained. Such a scenario is evident in the case of *Clarke v Hurst* whereby Dr Clarke lapsed into a persistent vegetative state, and the Court had

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241 *Ibid*.
242 The Constitution supra 2, section 36.
243 National Health Act *supra* 30. Refer to chapter 1.5 for an in-depth analysis detailing the doctrine of informed consent.
244 *Carmichele supra* 162. See also *NK v Minister of Safety and Security* 2005 14864 (CC).
245 *Stoffberg v Elliot supra* 102.
246 *Stoffberg v Elliot supra* 102. See also Carstens P.A and Pearmain D. *supra* 9 pg 500.

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to decide whether or not to give effect to the refusal of treatment as contained in his advanced directive. Dr Clarke's curator ad litem argued as follows:[247]

> An adult of complete legal competence has, while of sound mind, an absolute right to the security and integrity of his body. In the exercise of that right, he is entitled to refuse to undergo medical treatment, irrespective of whether such refusal would lead to his death … Where, as in the present case, such a person, while he is of sound mind, has directed that should he lapse into a persistent vegetative state with no prospect of recovery, he should be allowed to die and that he should not be kept alive by artificial means, then if he does lapse into such a state, there is no reason why a curator appointed to his person should not have the power to give effect to his direction.

The line of the argument within the submission of Dr Clarke's curator ad litem correctly advocates that a person's right to freedom and security remains enforceable, even though they can no longer provide consent concerning the acceptance or refusal of medical treatment. It is submitted that the last known wishes of the patient should be effected in the form of an advanced directive.

Although not a prescribed right in the Constitution, the value of individual autonomy is pertinent when considering applying the right to freedom and security of a person. The extent of freedom that should be provided within the ambit of this right requires interpretation to be given in a broad sense rather than a restrictive one.[248]

2.3.5. Right to Privacy

Due to the nature and importance of the right, the right to privacy acquires protection from several sources in law. In South Africa, the right to privacy is safeguarded by the common law, the Constitution, and legislation.[249]

The common law maintains a broad application regarding the right to privacy of every individual. The right as provided for includes personality rights, such as the rights to physical integrity, freedom, reputation, dignity, and privacy.[250] Privacy is therefore established by

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247 *Clarke v Hurst supra* 26.
248 Devenish *supra* 212 pg.120.
249 Neethling J. 'Neethling's Law of Personality' (1996) chapter 8.
250 Neethling J. *supra* 250 chapters 3-9.

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common law as not only the seclusion of information of a person but instead that it incorporates valuable aspects of a person's personality.[251]

Moreover, the right to privacy is set down by section 14 of the Bill of Rights as formulated by the Constitution. In the context of the Constitution, the right is indicative of a limiting slant, whereby the right relates to the articles of a person as opposed to the intangible indemnity of oneself. Section 14 of the Bill of Rights thereby provides that:[252]

> Everyone has the right to privacy, which shall include the right not to have –
> (a) their person or home searched;
> (b) their property seized;
> (c) their possessions seized; or
> (d) the privacy of their communications infringed.

In essence, the application of the right to privacy, given both common law and the Constitution, insinuates that a person is not obligated to make known anything about themselves to another.[253] In concert with the application thereof, the duty owed toward the right to privacy is relative and not absolute in its explication.[254] No absolute privilege relating to disclosure of information exists; if justifiably required by law, there will be no breach in terms of professional ethics.[255]

Ackerman J considered the confines owing to the right to privacy in *Berstein v Bester*. Herein it was stated by Ackerman J that "it would be reasonable to expect privacy to extend to the inner sanctum of a person . . . which is shielded from erosion by conflicting rights of the community".[256]

Furthermore, Ackerman J took the Council of Europe's view of the right to privacy into consideration, namely that " the right consists essentially in the right to live one's own life with

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251 South African Law Commission Act 19 of 1973.
252 The Constitution *supra* 2, section 14.
253 Bennett R. and Erin C. 'Hiv and Aids: testing, screening and confidentiality' (1999) pg 210.
254 HPCSA *supra* 49, Rule 13 stipulates instances owing to a breach in confidentiality on behalf of a medical practitioner wherein it states the following: (1) A practitioner shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only (a) in terms of a statutory provision; (b) at the instruction of a court of law; or (c) where justified in the public interest. (2) Any information other than the information referred to in sub-rule (1) shall be divulged by a practitioner only (a) with the express consent of the patient; (b) in the case of a minor under the age of 12 years, with the written consent of his or her parent or guardian; or (c) in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate.
255 The Constitution *supra* 2, section 36.
256 *Bernstein v Bester 1996* (2) SA 751 (CC).

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a minimum of interference".[257] Following the views of Ackerman J, the right to privacy is restricted to a person's intimate aspects of life.[258]

The conception of privacy is often used interchangeably with that of confidentiality. The National Health Act defines confidentiality, which consists of "all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential".[259] This definition, as set out by the Act, accentuates the correlation between confidentiality and privacy. Taitz furnishes a perspicuous formulation regarding the workings and understanding of confidentiality within the domain of medical law:[260]

> The duty cast upon a medical practitioner, by reason of his calling and his special relationship with his patient, to keep secret and confidential all, and any, information, whether relating to a patient's ailment or otherwise, which information was obtained directly or indirectly by the practitioner as a result of the doctor-patient relationship.

Taitz has described the onus placed upon a medical practitioner when considering confidentiality as a burdensome one. Ensuring that confidentiality of all privy information is maintained rests upon the medical practitioner and not on the patient. This legal duty eventuates out of the relationship which exists among the parties involved. The duty seeks to protect all rights that vest in the patient, including the right to privacy.[261]

Protecting the privileged relationship between a medical practitioner and a client concerns far more than merely treating the person. It is intrinsic to how the law operates in the field of medicine. Once a person's right to privacy has been infringed, the adverse consequences that

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257 *Ibid*.

258 See further *NM v Smith* 2007 (50) SA 250 (CC) where the court held that, "The right to privacy recognises the importance of protecting the sphere of our personal daily lives from the public. In so doing, it highlights the interrelationship between privacy, liberty and dignity as the key constitutional rights which construct our understanding of what it means to be a human being".

259 National Health Act *supra* 30, section 14 (1). See further subsection 2 which stipulates: 'Subject to section 15, no person may disclose any information contemplated in health status, treatment or stay in a health establishment, is confidential. unless- (a) the user consents to that disclosure in writing; (b) a court order or any law requires that disclosure; or (c) non-disclosure of the information represents a serious threat to public health'.

260 Taitz J. 'The rule of medical confidentiality v the moral duty to warn an endangered third party' (1990) pg 78 SAMJ 29.

261 *Jansen van Vuuren NNO v Kruger* 1993 (4) SA 842 (A). Harms, A.J.A deduced the duty in regard to confidentiality as follows, 'The duty of a medical practitioner to respect the confidentiality of a patient is one that is not exclusively ethical but is also a legal duty recognised by the common law and legislation'.

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flow from this cannot be retracted to reinstate the person's dignity to that prior to the privacy infringement.[262]

2.3.6. Right to Access to Healthcare

Section 27 (1)(a) of the Constitution provides that everyone has the right to have access to health care services.[263] The second component of section 27 imposes specific positive obligations upon the state to 'achieve the progressive realisation' of the right to access to healthcare and that all measures applicable to it must be reasonable.[264]

It has yet to be determined as to what is considered a reasonable yardstick in such a situation within the Bill of Rights. The reasonable approach has been ascribed to being one that falls short of providing adequate recognition of socio-economic rights.[265] The final aspect regarding the right of access to healthcare determines that no person may be refused emergency medical treatment.[266]

The subsections of section 27, when read together, propose that there is no right to health guaranteed by the Constitution, but rather a qualified right of having access to health services. Furthermore, a right of access to health care entails having access to health care that is affordable, available, and effective.[267]

When considering the nature and level of care applicable under sections 27(1)(a) and 27(3), it is apparent that access to healthcare is largely dependent upon the extent of resources

262 In *Afrika v Metzler and Another* 1997 SA 531 (NM). The Namibian court derived the consequences of infringing a person's *dignitas in lieu* of the right to privacy, 'It is in my view, humanly speaking virtually impossible for one to restore another's good name and reputation to its former glory'.

263 The term 'health services' defined in section 1 of the National Health Act *supra* 30 prescribes: (a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution; (b) basic nutrition and basic health care services contemplated in section 28(l)(c) of the Constitution (rights of children); (c) medical treatment contemplated in section 35(2)(e) of the Constitution (in regard to the rights of arrested, detained and accused persons); and (d) municipal health services.

264 The Constitution *supra* 2, section 27(2) provides for as follows: 'The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights'.

265 Bilchitz D. 'Chaskalson *et al* Constitutional law of South Africa' (2005) pp 56A-19.

266 The Constitution *supra* 2, section 27(3). See further the National Health Act *supra* 31, section 5, 'A health care provider. health worker or health establishment may not refuse a person emergency medical treatment'.

267 Carstens P.A. and Pearmain D. *supra* 9 pg 41. See also Ngwena C. 'The recognition of Access to Health Care as a Human Right in South Africa: Is it enough?' (2000) pg 5.

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available. This is confirmed in the *Soobramoney* case, where the patient suffered from kidney failure and required emergency dialysis treatment. The patient claimed that the failure to receive the required treatment violated his right to life by not having access to healthcare services and receival of emergency healthcare treatment.

The ordinary meaning of 'emergency treatment' does not cater for the ongoing treatment of chronic illnesses. However, the right to emergency treatment should come into effect the moment a chronic illness transitions into a terminal diagnosis that requires immediate medical intervention, as evident in the case of *Soobramoney*.[268]

Notwithstanding this contemplation, failure to provide access to healthcare and emergency healthcare treatment is considered justifiable in a select number of instances.[269] However, the State requires a high burden of proof to prove that all constitutional obligations have been performed diligently without delay.[270] Thus, it is paramount that a balance is struck between constitutional objectives set out by the Bill of Rights and the means available to reach these goals.[271]

The Constitutional Court confirmed in *Soobramoney* that the obligations imposed under section 27 are, in fact, dependent on the availability of resources. Correspondingly, the rights themselves held to be justifiably limited due to the lack of resources available at the time.[272] *Soobramoney* serves to highlight that the availability of healthcare services is crucial to consider when determining the enforcement of a socio-economic right against the state.

The state is therefore in the position to justify how healthcare resources are distributed. Attesting to this notion, Currie and De Waal indicate how the wording of section 27(1) operates as a procedural safeguard. When healthcare resources become available, the positive obligation imposed upon the state regarding the distribution thereof renders it "difficult for the state to justify its failure to devote those resources to the fulfilment of the rights".[273]

268 *Soobramoney supra* 80. See further Pearmain D.L. *supra* 187 pg133. Pearmain presupposes that terminally ill patients who cannot benefit from curative care are to be afforded a right to palliative care services.
269 The Constitution *supra* 2, section 36.
270 The Constitution *supra* 2, section 237.
271 *Government of the Republic of South Africa and Others v Grootboom and Others 2001* (1) SA 46 (CC).
272 *Soobramoney supra* 80.
273 Currie I. and de Waal J. *supra* 184 pg 575.

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The pretext of section 27(1) must therefore be read in line with section 9 to ensure that all persons have equal access to the rationing of healthcare services and the benefit thereof, without any discriminatory actions.[274] Human rights thus function as powerful instruments sought to protect marginalised persons by demanding accountability from those responsible for the service delivery of healthcare.[275]

When considering the right to healthcare in light of euthanasia, insufficient resources are often not the problem at hand. Pearmain argues that for as long as euthanasia is criminalised as a means of achieving death, the availability of resources required to achieve such means is a futile argument as there is no right to their use.[276]

The national healthcare system in South Africa is overburdened with persons actively seeking medical treatment. With the inadequacy of resources to furnish treatment as required, Pearmain raises a hard to answer question regarding persons already receiving treatment, but instead rather wish to die:[277]

> In a country in which there is a shortage of health care personnel to treat a patient, how can one justify keeping such a patient 'alive' when the nursing staff and possibly the bed may be required for the purpose of the delivery of health care services to other patients who have a good chance of recovery.

Therefore, it is submitted that in recognising the right to die, the State would be in a better position to achieve the positive obligations imposed by section 27, detailing the right to access to health. Such that, the redistribution of resources within the healthcare system would improve the lives of many and further the values enshrined within the Bill of Rights.

2.4. Limitation clause

The limitation clause is provided for in the Bill of Rights.[278] The clause sets out the relationship between all rights entrenched in the Bill of Rights and the extent to which they might be limited provided that the relevant factors are considered. The two central concepts applied when applying the limitation clause is that of reasonableness and proportionality.

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274 Pieterse M. 'Can rights cure?: The Impact of human rights litigation on South Africa's health system' (2014).

275 *Ibid.*

276 Pearmain D.L. *supra* 187 pg 146.

277 *Ibid.*

278 The Constitution *supra* 2, section 36.

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The requirement of reasonableness is elucidated by test within the general limitation clause. On the other hand, proportionality remains to be open to interpretation when applying the limitation clause under the South African Constitution.[279] The following statement of Klatt and Meister is regarded as appropriate with reference to understanding the proportionality segment of the limitation clause:[280]

> All in all, proportionality is a structured approach to balancing fundamental rights with other rights and interests in the best possible way. It is a necessary means for making analytical distinctions that help in identifying the crucial aspects and considerations in various cases and circumstances and ensuring a proper argument.

The concept of 'limitation' is therefore considered overbroad when analysed in the context of the Bill of Rights. Constitution makers set bounds as a pretext for the abuse of power on both vertical and horizontal application. Contained within section 7(3) of the Constitution is the governing principle to which these preventative measures apply.[281] Rautenbach describes the power to limit all rights prescribed by the Constitution as a 'limited power'[282] subjugated by several provisions in the Bill of Rights.[283]

As discussed by the court in *S v Walters*, rights deemed capable of limitation are to follow a two-stage process when applying section 36. Firstly, it must be determined whether the

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279 *S v Makwanyane supra* 172. Consideration of legitimacy and proportionality in view of the limitation clause, as highlighted by the interim Constitution, "The limitation of Constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of section 33. The fact that different rights have different implications for democracy, and in the case of our Constitution, for an open and democratic society based on freedom and equality, means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case-by case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question. In the process, regard must be had to the provisions of section 33, and the underlying values of the Constitution".

280 Klatt M. and Meister M. 'The Constitutional Structure of Proportionality' (2012) pg 170.

281 The Constitution *supra* 2, section 7(3) 'The rights in the Bill of Rights are subject to the limitations contained or referred to in section 36, or elsewhere in the Bill.

282 Rautenbach I.M. 'The limitation of rights in terms of provisions of the bill of rights other than the general limitation clause: a few examples' TSAR 4 (2001).

283 In re Certification of the Constitution of South Africa, 1996 10 BCLR 1253 (CC) par 43 'No specific limitation provision in the South African bill of rights may be interpreted in such a way as to empower parliament or anybody else to limit rights as if no bill of rights exists'.

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conduct had infringed upon a right in the Bill of Rights. This is done by determining the scope and ambit of the right and the effect of the infringement.[284]

After this has been established, it must be determined whether the violation was justifiable in terms of section 36 of The Constitution.[285] Attributable to this notion, as set out by the court, the limitation clause makes provision for the following terms:[286]

1. The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality, and freedom, taking into account all relevant factors, including
   a) the nature of the right;
   b) the importance of the purpose of the limitation;
   c) the nature and extent of the limitation;
   d) the relation between the limitation and its purpose; and
   e) less restrictive means to achieve the purpose.
2. Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

As seen above, the limitation clause contains no detail in respect of the protective ambit of rights. The limitation clause does not limit rights but instead sets the rules for which the limitations of rights are to take place.[287]

This, in turn, invokes a balancing act, with limitation analysis within the confines of the final Constitution.[288] Balancing refers to the 'head-to-head' comparison of competing rights, values, or interests.[289] Balancing may also be interpreted in the guise of 'striking a balance' between competing rights or interests.[290]

The balancing of rights takes on more than one configuration insofar as the ambit of the limitation clause. Balancing sometimes means that one right (or interest or value), when

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284 *Ex Parte Minister of Safety and Security:* In re *S v Walters* 2002 4 SA 613 (CC).
285 The Constitution *supra* 2 section 36.
286 The Constitution *supra* 2, section 36(1).
287 Rautenbach I.M. *supra* 282.
288 Woolman S. 'Out of Order? Out of Balance? The Limitation Clause of the Final Constitution' (1997).
289 Alienikoff T.A. 'Constitutional Law in the Age of Balancing' (1987).
290 *Dotcom Trading D 121 (Pty) Ltd t/a Live Africa Network News v The Honourable Mr Justice King NO* 2000 (4) All SA 128 (C). Wherein the application of section 36 was deliberated as follows 'Section 36 involves a process of the weighing up of competing values and ultimately an assessment based on proportionality which calls for the balancing of different interests. Inherent in this process of weighing up is that it can only be done on a case-by-case basis with reference to the facts and circumstances of the particular case'.

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compared to another, will simply 'outweigh' the other. This is evident in the *Makwanyane* case, whereby the Court held that the applicants right to life simply outweighed the state's interest in the death penalty.[291] The death penalty in itself will not survive constitutional scrutiny; euthanasia, however, is exhibiting an alternative outcome.

Balancing can moreover be interpreted by way of contrasting competing rights or interests. In the judgement of *Holomisa v Argus Newspapers Ltd*, Justice Cameron held that rights would be afforded constitutional protection unless acted upon unreasonably.[292] However, the undertaking to balance constitutional rights, values or interests in this regard is often deemed to be an impossible task due to terminological confusion.[293]

It can be seen that the limitation clause advocates for a more precise interpretation by the courts insofar as the fundamental rights applicable to the consideration of legalising voluntary active euthanasia. Therefore, given the limitation clause, reasonableness and proportionality are allowed to be applied more concisely.

2.5. Recommended developments

Apart from recognising and giving effect to fundamental rights when considering the decriminalising of voluntary active euthanasia, it has been adopted that an exigency exists to widen the basis of the legislation of not only the act of euthanasia but concepts concerning it.

Recommendations relating to the development of legislation within South Africa's legal framework do not explicitly fall within the scope of this study. It is to be noted that a basic outline of recommended legislative provisions will be made available in this subchapter. No in-depth analysis nor a critique of these recommendations, as mentioned, will, however, take place. The South African Law Commission has provided a detailed list of recommendations for consideration in the hopes of achieving legislative clarification.

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291 Woolman S. *supra* 288.
292 *Holomisa v Argus Newspaper Ltd* 1996 (2) SA 588 (W).
293 Sunstein C. 'Conflicting Values in Law' Fordham Law Review 1661 (1994) pg 62.

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2.5.1. Voluntary passive euthanasia

Passive euthanasia remains to be a taboo topic by many. Nonetheless, provision is made for the termination of life-prolonging treatment in line with both common law and constitutional provisions.[294]

The Commission has suggested that all persons should be afforded the enjoyment to terminate life-prolonging treatment, regardless of the extent to a person's mental competency.[295]

2.5.2. Voluntary active euthanasia

The Commission devised a proposal concerning the implementation of voluntary active euthanasia by submitting three possible solutions.[296] The aim of which is to deter the manner in which the courts currently dispose of mercy killings. Each suggestion recognises the ambivalence towards mercy killings under the contemporaneous application of South Africa's law.

Furthermore, as contained within the submissions, the Commission appreciates the noteworthiness in allowing persons who gravely suffer from terminal illness the right to decide whether they wish to end their own lives with assistance from their medical practitioners.[297]

The first option stipulates that no legislation be implemented for the governance of voluntary active euthanasia. Thereby, the focus is drawn to recognising fundamental human rights surrounding the decision to self-regulate end-of-life decisions, as already contained within the Bill of Rights.

The second option is more structured, whereby the choice to end one's life is afforded to a patient, accompanied by the approval of their relevant medical practitioner. Although heavily

294 The Constitution *supra* 2, section 12(2).
295 Mahomed I. *supra* 53. See further Appendix E for the proposed clauses pertaining to voluntary passive euthanasia, as drafted by the Commission.
296 Mahomed I. *supra* 53. See further Appendix E for the proposed clauses pertaining to voluntary active euthanasia, as drafted by the Commission.
297 McQuoid-Mason D. and Sneiderman, B. *supra* 86.

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burdensome on the patient, the rationale of this option recognises the right of choice, giving effect to the notion of patient autonomy.[298]

As a final recommendation, the Commission submits an option to be homogenised with a naturalist *modus operandi*. The Commission proposes implementing an ethics committee to oversee and decide upon all requests of voluntary active euthanasia. Although this recommendation provides many safeguards to the medical profession, it is considered inherently paternalistic. The placement of 'bureaucratic obstacles' continues to erode the autonomy of the patient.[299]

It is submitted that implementing legislation to decriminalise euthanasia is not contrary to constitutional principles.[300] The Constitution is not to be seen as an obstacle to legislation on the condition that the rights being advocated for are not exercised in a harmful manner to society.

2.5.3. Advanced Directives

The legal position of advanced directives in South Africa has previously been made known in this study, such that no legislative provisions regulate the implementation of advanced directives.[301]

It is submitted by the Commission that medical practitioners ought to respect the living wills of patients in instances whereby the prior intentions of the patient have been made known and validified. As prescribed by the patient, the living will is to reflect the current wishes of the said patient and conveyed whilst being mentally competent.[302]

As set out by the Commission, these recommendations seek to negate the continuation of uncertainties encountered by medical practitioners concerning the difficulties and enforceability of living wills, specific to the lapsing of power of attorney immediately when the maker is deemed mentally incompetent.[303]

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298 Giesen D. 'From paternalism to self-determination and shared decision-making' (1988) *Acta Juridica* pg 107.
299 McQuoid-Mason D. and Sneiderman, B. *supra* 86.
300 Allan A., Department of Psychiatry, University of Stellenbosch.
301 Refer back to chapter 1.8 for more information in this regard.
302 Mahomed I. *supra* 53. See further Appendix E for the proposed clauses pertaining to advanced directives, as drafted by the Commission.
303 Strauss S.A. *supra* 157 pg 344.

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2.6. Concluding remarks

This chapter, as envisaged, sought to challenge the constitutional framework that underpins the contentious discourse owing to decriminalising voluntary active euthanasia. It remains glaringly apparent that the Constitution and protection of rights that it bestows impart ample safeguards in regulating the practice of voluntary active euthanasia.

This serves as confirmation that the Constitution is instrumental in balancing both the horizontal and vertical application of the law in a just and equitable manner. Nevertheless, unsettling sentiments of irresolute legislators have been attributed toward the repudiation of euthanasia as a valid means to end one's life.

The Court is by no means embellished with the prerogative to reject the advancements of deeply rooted human rights and freedoms. The rule of law provides that the Court is at no time endowed with the first nor last word on the Constitution; the text does. This conception of supreme law is elucidated by Rawls as follows:[304]

> The Constitution is not what the court says it is. Rather it is what the people acting constitutionally through the other branches eventually allow the Court to say it is. A particular understanding of the constitution may be mandated to the court by amendment or by a wide or continuing political majority.

Vacillating perceptions toward euthanasia continue to invoke long-standing moral and ethical dilemmas. Complete objectivity is imperative when explicating the matter of personal choice under constitutional principles. Decriminalising voluntary active euthanasia is indispensable to consistently apply the constitutional framework and retain the epitome of what it means to be human, equipped with the ability of choice-making.

[304] Rawls J. 'Political Liberalism' (1993) pg 237.

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CHAPTER 3: FORMULATION AND ANALYSIS OF EUTHANASIA AMONG ALTERNATIVE LEGAL SYSTEMS

3.1. Introduction

This chapter undertakes a divergent perspective, whereby the structure of which is in the form of a comparison, rather than one that is positivist in nature. Judicial comparativism, in conjunction with the recognition of fundamental human rights, is ostensibly the premise upon which this study is founded. The duty to consider foreign law establishes the necessary framework for this chapter in light of The Bill of Rights.

Hereafter, the focus shifts to the current legal stance of voluntary euthanasia on a global scale, gleaning insight and understanding as to how decriminalising euthanasia has been integrated into current legal practices. This chapter, therefore, includes a list of foreign countries, each with its unique contribution to the euthanasia debate. The particular importance of selecting each country compared to South Africa has been identified in light of decriminalising euthanasia and physician-assisted suicide.[305]

Specific focus will be drawn to both legislation and the precedent case law of each country to deduce which defining factors led to the decriminalising of voluntary euthanasia in each instance. Furthermore, an in-depth discussion will follow to deduce whether the existing legal framework of each specified country provided for seamless integration of voluntary euthanasia into their legal system.

3.2. Duty to consider foreign law within the ambit of the Constitution

International and foreign law have impacted policymaking in South Africa both direct and indirectly. The Constitution functions as the point of departure for determining the role of both

305 The practice of voluntary euthanasia and/or physician-assisted suicide is currently either afforded protection within the ambit of each country's legal regime or processes have been put in place for its implementation in the foreseeable future.

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international and foreign law domestically. The interpretation clause, as set out in section 39 of the Constitution, is noteworthy in this regard, which stipulates:[306]

> When interpreting the Bill of Rights, a court, tribunal, or forum-
>
> a) *must* promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
> b) *must* consider international law; and
> c) *may* consider foreign law.

Thereby, the wording provided by the interpretation clause suggests a different stance be taken when dealing with international law compared to foreign law. The clear distinction between the two is that the courts are obliged to give due consideration in international law. In contrast to this, foreign law imposes no such obligation upon the courts.[307]

Given the interpretation clause, several scholars have construed the implementation thereof as the pivotal point of judicial comparativism in South Africa.[308] Ackerman recognizes this misconstruction in consideration of foreign law and suggests that:[309]

> I have not the slightest doubt that, because of the comparative law ethos in South Africa, the Court would have placed the same reliance on foreign law even had there been no such provision in the Constitution.

The outlook of Ackerman considers the inherent application of section 39(1), which extends far beyond what is provided for in the Bill of Rights. This point of argument by Ackerman was confirmed and furthered by Chaskalson J in the case of *S v Makwanyane*:[310]

> In dealing with comparative law, we must bear in mind that we are required to construe the South African Constitution, and not an international instrument or the constitution of some foreign country and that this has to be done with due regard to our legal system, our history and circumstances, and the structure and language of our own Constitution. We can derive assistance from public international law and foreign case law, but we are in no way bound to follow it.… The international and foreign authorities are of value [to the judges]

306 The Constitution *supra* 2, section 39 (1). See further the discussion of Dugard J. 'Kaleidoscope: International Law and the South African Constitution'(1997) EJIL pg 85, regarding the role of international law in view of the Constitution.

307 For purposes of this chapter focus will be drawn to the consideration of foreign law, rather than that of international law, insofar as it encompasses voluntary active euthanasia.

308 Lollini A. 'Legal Argumentation Based on Foreign Law: An Example from Case Law of the South African Constitutional Court' (2007) pp 60-74.

309 Ackermann L.W.H. 'Constitutional Comparativism in South Africa' (2006) SALJ pg 500.

310 *S v Makwanyane supra* 172 para 34.

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because they analyse arguments for and against the death sentence and show how courts of other jurisdictions have dealt with this vexed issue. For that reason alone, they require our attention.

On more than one occasion, it has been made clear that decriminalising euthanasia should not be considered secluded but rather on a basis of comparison. For the most part, this is attributed to the nature of rights circumscribed by life-ending measures, including both voluntary active euthanasia and physician-assisted suicide alike.

For purposes of this chapter, foreign law is considered a cardinal tool in assessing the interpretation of these fundamental human rights, as identified, within the context of decriminalising euthanasia. In summary, it has been postulated that the withholdment of euthanasia practices unjustifiably infringes upon the rights of these constitutional freedoms.

3.3. Netherlands

3.3.1. A history of the Dutch law on end-of-life practices

Although the Netherlands exhibited no early efforts to adopt end-of-life practices, as other nations did in the early decades of the twentieth century, a pro-euthanasia society was founded in due course.[311]

The Dutch Association for Voluntary Euthanasia advocated for legalising euthanasia and physician-assisted suicide before implementing the Netherland's Penal Code.[312] Despite the slow onset, the Netherlands took to the forefront of legalising these end-of-life practices in the modern world.[313]

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311 Griffiths J., Bood A., and Weyers H. 'Euthanasia and law in the Netherlands' (1998) pg 53. The Dutch Association for Voluntary Euthanasia (Nederlandse Vereniging voor Vrijwillige Euthanasie) was founded in 1973. See also Hendin H. 'The Dutch Experience' (2002) wherein it is stipulated that the Voluntary Euthanasia Legalisation Society was founded in Britain in 1935.

312 Griffiths J. et al *supra* 311, pg 16. Since 1984 the Royal Dutch Medical Association has viewed euthanasia and physician-assisted suicide as being synonymous, with no distinction between the two. See also The Criminal Code (Wetboek van Strafecht) of 1886.

313 Lara L. 'Is There a Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States)' (2002).

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Since the implementation of the Criminal Code, which took place in 1886, euthanasia and assisted suicide were both explicitly criminalised within independent articles. Article 293 prohibited euthanasia in the context of Dutch law, which provided:[314]

> A person who takes the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.

This article was introduced to the Dutch Penal Code to dispel any uncertainty surrounding the legality whereby a person kills another upon their express request.[315] The application of Article 293 differentiates killing upon request from that of murder, contained within Article 289.

Although both these actions deal with the intentional killing of a person, leniency is attributed to the crime of euthanasia, which yields maximum imprisonment of 18 years less than that of murder.[316]

Alongside the prohibition of euthanasia, criminal liability was established for assisted suicide within Article 294 of the Criminal Code, which provided:

> A person who intentionally incites another to commit suicide assists in the suicide of another or procures for that other person the means to commit suicide is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where a suicide ensues.

Furthermore, an overarching provision was introduced within the Criminal Code, which regulates criminal liability where violations of Articles 293 and 294 took place by medical practitioners. Article 40 functions as a defence of necessity, which yields a pivotal role in absolving medical practitioners from criminal liability during euthanasia and physician-assisted suicide.[317]

The legislation mentioned above indicates that euthanasia and physician-assisted suicide were considered illegal within the constraints of Dutch law, requiring specific conditions to be complied with to justify these criminalised actions legally. However, Dutch jurisprudence

314 The Criminal Code *supra* 312, Article 293.
315 Otlowski M. 'Voluntary Euthanasia and the Common Law' (1997).
316 The Criminal Code *supra* 312, Article 289 prescribes the sanction for murder as follows: "Any person who intentionally and with premeditation takes the life of another person shall be guilty of murder and shall be liable to life imprisonment or a determinate term of imprisonment not exceeding thirty years or a fine of the fifth category".
317 Termination of Life on Request and Assisted Suicide Act of 2001. Article 40 states, "a person who commits an offense as a result of a force he could not be expected to resist is not criminally liable". See also *Schoonheim: Nederlandse Jurisprudentie* 1985 No. 106. The Court in Schoonheim ruled that medical practitioners who engage in euthanasia now have the available defense of necessity.

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reveals that even when defendants were found guilty of contravening Article 293 or 294, the court showed ambivalence in their sentencing.[318]

3.3.2. Common law developments of euthanasia in the Netherlands

3.3.2.1 Adopting conditional requirements for euthanasia: Postma

The societal debate regarding end-of-life practices in the Netherlands was prompted by the '*Postma case*' in 1973.[319] Ms Postma, a medical practitioner, helped terminate her dying mother's life, who was recovering from a cerebral haemorrhage. The deceased made her desire to die known through the repeated and explicit request to her daughter.

At trial in Leewarden's District Court, the Medical Inspector advocated that accelerating the onset of death of a patient through the administration of pain relief medication was a widely accepted practice, so long as specific requirements are met:[320]

a) the patient must be incurably ill;
b) the patient's suffering must be physically or mentally unbearable;
c) the patient is in terminal stages of illness;
d) the patient must explicitly express their wish to die; and
e) the person who accedes to the patient's request must be a medical practitioner.

Given the Medical Inspector's conditional requirements, it was adopted by the Court that a medical practitioner who assists a patient in ending their own life, at that patient's explicit request, may do so when specific substantive and procedural requirements are met.

The Court held further that although Postma had satisfied the abovementioned conditions, the administration of a morphine injection was unreasonable as a means of ending the

318 *Nederlandse Jurisprudentie* (1952) no. 275.

319 *Postma: Nederlandse Jurisprudentie* 1973 DC Leeuwarden No. 183. See further Sheldon T. 'Obituary: Andires Postma' BMJ 334: 320 (2007). Although the normal citation convention in Dutch law is to reference the Court and not the party name, for ease of understanding I have referenced cases by party names.

320 *Postma supra* 319. The Court adopted all but one of the conditions posed by the Medical Inspector. The Court rejected the proposition that the patient must be in the terminal stages of illness. See further *Wertheim: Nederlandse Jurisprudentie* 1982 No. 63:223, where the Court further developed these conditional requirements to include: the decision to die was made voluntarily; the patient was capable of understanding the situation; the attending physician must consult at least one other competent independent medical practitioner; and assistance by a medical practitioner must be in accordance with utmost care.

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deceased's suffering. Postma received a conditional jail sentence of one week, along with a year's probation.[321]

The landmark case of *Postma* offered an opening to regulate better euthanasia practices within the jurisprudential landscape of the Netherlands. As a result, raised awareness transgressed medical practitioners regarding the limitations of medical care and patients' rights to self-determination.

3.3.2.2 Requirements of careful practice: Admiraal

The significance of the *Admiraal* case lies in the fact that it set legal precedent in the Netherlands since medical practitioners who performed euthanasia would avoid prosecution if the 'requirements of careful practice' were complied with.[322]

The 'requirements of careful practice' were issued in a report one year before the case of *Admiraal* by the Executive Board of the Royal Dutch Medical Society. The report prescribed certain conditions that ought to be met by medical practitioners in order for euthanasia practices to be considered acceptable, which included:[323]

a) the request for euthanasia must be voluntary;
b) the request must be well-considered;
c) the patient's desire to die must be a lasting one;
d) the patient must experience his suffering as unacceptable for him;
e) the doctor concerned must consult an independent medical practitioner.

These 'requirements of careful practice' were judicially adopted in the case of *Admiraal*. Admiraal was an anaesthesiologist who euthanised a patient that had multiple sclerosis. The Court acquitted Admiraal on the basis that due care was given to the abovementioned 'requirements of careful practice' during the euthanasia process, which resulted in the accelerated death of the patient.[324] Therefore, the case of Admiraal established the necessary

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321 Postma *supra* 319.
322 Executive Board of the Royal Dutch Medical Society 'Position on Euthanasia (Standpunt inzake euthanasia) 31 (1984) pp 990-998. See also Griffiths J. et al *supra* 308.
323 Griffiths J. et al *supra* 311 at 66. An additional requirement was added in 1992 which required that medical practitioners maintain a fully-documented written record.
324 *Admiraal: Nederlandse Jurisprudentie* 1985 No. 709. See further *Nederlandse Jurisprudentie* 1988, no. 157, the Court considered whether all 'requirements of careful practice' had to be fulfilled in order to avoid criminal liability. The Appeal Court held that failure to consult another independent practitioner in itself is an insufficient ground to establish criminal liability.

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criteria by which medical practitioners might be 'justified' before the law to perform end-of-life procedures.

3.3.3 Decriminalising euthanasia under Netherland's revised Criminal Code

In April 2002, legislation regarding the decriminalisation of euthanasia and physician-assisted suicide became effective in the Netherlands. The inception of this legislation resulted in the Netherlands becoming the first country ever to decriminalise end-of-life practices.[325]

Continued developments took place within the jurisprudential framework, adopting standards previously developed from case law. The result of which bridged the gap between moral convictions of society and the former legislative provisions.

Judicial exceptions to euthanasia were created, envisaged by amendments to the Criminal Code. The most significant amendment to the criminal code took place in terms of Article 293, which now reads:[326]

1) A person who terminates the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.
2) The offence referred to in the first paragraph shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide Act and who informs the municipal autopsist of this in accordance with the Burial Act.

Article 294 was also amended to include legally accepted means to physician-assisted suicide; the newly founded wording prescribes:[327]

1) A person who intentionally incites another to commit suicide is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues.

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325 Termination of Life on Request and Assisted Suicide Act *supra* 317. See also Hendin H. et al. 'Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons From the Dutch.' JAMA 278 (1997) pp 1720-1722.

326 Termination of Life on Request and Assisted Suicide Act *supra* 317 at 20A. See also The Burial and Cremation Act of 2002, Article 8 states: "1) The committee assesses on the basis of the report referred to in Article 7 second paragraph of the Burial and Cremation Act whether the physician who has terminated a life on request or assisted in a suicide has acted in accordance with the requirements of due care, referred to in Article 2. 2) The committee may request the physician to supplement his report in writing or verbally, where this is necessary for a proper assessment of the physician's actions. 3) The committee may make enquiries at the municipal autopsist, the consultant or the providers of care involved where this is necessary for a proper assessment of the physician's actions".

327 Termination of Life on Request and Assisted Suicide Act *supra* 317 at 20B. Article 293 second paragraph applies mutatis mutandis.

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2) A person who intentionally assists in the suicide of another or procures for that other person the means to commit suicide is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues.

In light of these amendments to the Criminal Code, medical practitioners acting within the revised requirements of due care and who report the death properly can avoid legal sanction.[328]

Controversy exists as to whether the procedures of euthanasia and assisted suicide were governed by legislation in itself or whether it functions in a more technical aspect of complying with constructed guidelines.[329]

Paradoxically, the Dutch government appointed a review committee that oversaw physician-assisted suicide and euthanasia in the Netherlands, following the guidelines mentioned above.[330] The Termination of Life on Request and Assisted Suicide Act provides a framework of oversight for the exculpatory conditions to be met by medical practitioners when terminating a person's life through euthanasia.[331]

The reasoning for such a committee to be appointed remains questionable. The commission focused on medical malpractice immunity rather than effecting the rights of those exposed to potential malpractice.[332]

The lingering question is whether the newly founded legislative developments will function *de facto* notwithstanding Netherland's participation within the European Convention on Human Rights.[333]

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328 Termination of Life on Request and Assisted Suicide Act *supra* 317 Article 2 section 1. The State Commission formulated the criteria for due care, initially developed through case law. The requirements prescribed by section 1 of Article 2 mean that the physician: a) holds the conviction that the request by the patient was voluntary and well-considered, b) holds the conviction that the patient's suffering was lasting and unbearable, c) has informed the patient about the situation he was in and about his prospects, d) and the patient hold the conviction that there was no other reasonable solution for the situation he was in, e) has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a – d, and f. has terminated a life or assisted in a suicide with due care. See also de Haan J. 'The new Dutch law on euthanasia' MLR 10 (1): pp 57–75 (2002). See further The Burial and Cremation Act *supra* 326, Article 7 and 8.

329 Quill T. and Kimsma G. 'End-of-life care in The Netherlands and the United States: a comparison of values, justifications, and practices.' (1997) pp 189-204.

330 Termination of Life on Request and Assisted Suicide Act *supra* 317 Article 3. "The committee is composed of an uneven number of members, including at any rate one expert on ethical or philosophical issues. The committee also contains deputy members of each of the categories listed in the first sentence".

331 Termination of Life on Request and Assisted Suicide Act *supra* 317, Chapter 3.

332 Jochemsen H. 'Legalization of Euthanasia in the Netherlands' 16 (2001).

333 See further Chapter 3.5 for an in-depth discussion on the European Convention on Human Rights.

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3.4. Canada

3.4.1. Overview of the Canadian Charter

The legal system to which Canada is bound is akin to that of South Africa's. The similarity in legal frameworks emanates by employing the Canadian Charter of Rights and Freedoms[334] as a template of inspiration throughout the drafting process of South Africa's Constitution.[335]

The Charter was designed primarily to protect all citizens' fundamental rights and freedoms against impingement per the vertical and horizontal application.[336] In doing so, the passing of the Charter precipitated the protection of fundamental human rights governed by the rule of law.[337]

The Charter has proven to be grounded in fertile jurisprudential soil, capable of reinterpretation and realignment.[338] This conception was reaffirmed in the course of public debates concerning the controversial issue that is euthanasia.

3.4.2. Intolerable stance to mercy killings: *R v Latimer*

In Canada, as in most other countries, the practice of euthanasia along with other life-ending measures are considered violations of the sacrosanct right to life, incapable of unjustifiable infringement.[339] This is demonstrated in the case *R v Latimer* where the accused asphyxiated his teenage daughter with the exhaust fumes from his truck. Latimer's daughter was severely mentally and physically disabled and suffered from inextricable pain.[340]

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334 The Candaian Charter of Rights and Freedoms, 1982. Hereinafter referred to as 'the Charter'.

335 Phooko M. R. 'Evaluating Canadian and South African Collaborative Human Rights Initiatives: A Preliminary Analysis and Research Agenda' The Transnational Human Rights Review 4. (2017). See further Hornsby D.J. 'Canada's (Dis) Engagement with South Africa'(2013) in Medhora R. and Samy Y. 'Canada-Africa Relations: Looking Back, Looking Ahead' (2013) pg 43.

336 Jackman M. 'The Application of the Canadian Charter in the Health Care Context' (2001) pg 22.

337 Gratzer T.G. and Matas M. 'The Right to Refuse Treatment: Recent Canadian Developments' (1994) pg 249.

338 Neumann P. 'Charter Justice in Canadian Criminal Law' (1993) pg 351. See further *Edwards v Attorney-General for Canada,* 1930 A.C. 124 at 136, wherein Sankey referred to the Charter as a 'living tree capable of growth and expansion'.

339 The Charter *supra* 334, section 7 which reads as follows, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. Section 7 is to be read along with section 15, such that '(1) Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination'.

340 *R v Latimer* (1995) 99 CCC (3d) 481.

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The court held the fact that he had killed out of compassion to be irrelevant.[341] Subsequently, Latimer was convicted of second-degree murder and sentenced to 10 years imprisonment, consistent with the mandatory minimum sentencing by denouncing murder as 'a completely unacceptable offence'.[342]

Aside from the Latimer case, only two other cases dealing with mercy killings went to trial. Neither resulted in the offender receiving sentencing congruent with that of Latimer but instead resulted in jury acquittals.[343]

Moreover, assistance in suicide has proven to be no different from mercy killings when considering the legality of such end-of-life measures. Although suicide nor attempted suicide are capable of being criminalised, assisting another to commit suicide amounts to the indictable offence of 'aiding suicide' under Canadian law.[344] Aiding and abetting a person to commit suicide refers to a situation whereby the patient functions as the 'agent of death', yet the assistance of another is required for the specific purpose of helping the person commit suicide.[345]

3.4.3. Justifiable limitations of fundamental human rights: *Rodriguez v Attorney General*

When considering assistance in suicide, the constitutionality of section 241(b) was upheld by the court in the case of *Rodriguez v Attorney General of Canada et al*.[346] In this particular case, the appellant Sue Rodriguez was suffering from a neurological disease and sought a judicial declaratory order.

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341 Regardless of whether Latimer's daughter was a mentally competent adult who pleaded for assistance in dying, the result would have been no different as consent does not function as a defence to the charge of murder as per section 14 of the Canadian Criminal Code, Revised Statutes of Canada (1985), c C-46 'No one is entitled to consent to have death inflicted on him and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent'.

342 *R v Latimer* supra 340. See also the Charter *supra* 337, section 12.

343 These cases are *S v Ramberg* (1941) (unreported) discussed in Sneiderman B., Irvine J.C. and Osborne P.H. 'Canadian medical law: an introduction for physicians, nurses and other health care professionals (2ed 1995) at 538–9, and *R v Davis* (1942) (unreported) as discussed in Sneiderman B. 'Mercy killing: an old debate' (1998) at pg 15.

344 Criminal Code *supra* 341, wherein section 241 reads as follows: Everyone who (a) counsels a person to commit suicide or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

345 Minister of Supply and Services 'Canada Report of the Special Senate Committee on Euthanasia and Assisted Suicide: Of Life and Death' (1995) at pg 51.

346 *Rodriguez v Attorney General of Canada et al* (1993) 3 SCR 519.

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The order, as submitted, was based upon the unjustifiable limitation of the right to liberty in conjunction with the right against discrimination, to the effect that she could be assisted by a physician to die as her situation had become unbearable.[347]

Although the majority judgement acknowledged that the provisions of section 241(b) breached the right to liberty and amounted to discrimination, the court further held that the reasonable limits, as contained in section 1, sufficiently justified the limitation of these abovementioned rights.[348] The court noted that the scope of the declaration was specific for the factual circumstances for the case at hand, and the particular judgement is not to function as a blanket ruling for all situations dealing with physician-assisted suicide.[349]

3.4.4. Declaration of invalidity: *Carter v Canada*

After the judgement handed down in *Rodriguez*, the prohibited acts of assistance in suicide and euthanasia were once again constitutionality challenged in *Carter v Canada*.[350] The Criminal Code provisions at issue were section 241(b), which prohibits assistance in suicide, and section 14, which provides that no person may consent to death. Together, these provisions bar acts of medical assistance in dying within Canada.

In the case of *Carter v Canada*, after being diagnosed with a fatal neurodegenerative disease, Ms Taylor challenged the constitutionality of the Criminal Code insofar as the prohibition of physician-assisted dying.[351] Ms Taylor was joined in her claim by Ms Carter and Mr Johnson, who had previously assisted Ms Carter's mother in dying with dignity outside the jurisdiction of Canada.[352]

The trial judge declared that the laws prohibiting assistance in terminating ones' life infringed upon the right to life, liberty, and security of the person in an unjustifiable manner.

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347 The Charter *supra* 334, sections 7 and 15.
348 The Charter *supra* 334, section 1 guarantees 'the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'.
349 *Rodriguez supra* 346.
350 *Carter v Canada* (Attorney General) SCC 5 (2015).
351 Criminal Code *supra* 341, sections 14 and 241(b).
352 Kay Carter, the appellants mother, suffered from spinal stenosis, a progressive disease coupled with intractable pain.

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Moreover, the infringement of these rights was incapable of reasonable limitation under section 1 of the Charter.[353]

The matter was appealed on the ground that the trial judge was unable to develop the law but somewhat bound to follow the courts previous decision as set out in *Rodriguez*, in accordance with the principle of *stare decisis*. The trial judge was nonetheless entitled to revisit the ruling of *Rodriguez* as per the fact that the law relating to the principles of 'overbreadth and disproportionality' had progressed considerably since. Moreover, the evidence before the court in *Carter* differed substantially from that of *Rodriguez*.[354] In consequence of this, the decision of the trial judge was upheld.

Within the ruling of *Carter*, the court held that a freestanding constitutional exemption in this particular matter does not amount to being an appropriate remedy. Instead, the court issued a declaration of invalidity insofar as section 241(b) and section (14).[355] Upon doing so, the court declared that:[356]

> Section 241(b) and section 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease, or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

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353 The Charter *supra* 334, section 7.

354 *Carter v Canada supra* 350. The rulings of higher courts may be reconsidered by trial courts in two situations, namely: (1) where a new legal issue is raised; and (2) where there is a change in the circumstances or evidence that fundamentally shifts the parameters of the debate. In the case of *Carter* when compared to *Rodriguez*, both conditions were met. See further Singleton T. J. 'The Principles of Fundamental Justice, Societal Interests and Section 1 of the Charter' (1995) for an in-depth analysis of 'overbreadth' and 'gross disproportionality'.

355 *Carter v Canada supra* 350. In contrast to the judgement of *Rodriguez*, the court held in *Carter* that these sections were not saved by section one of the Charter.

356 *Carter v Canada supra* 350. The court made no attempt to define physician-assisted suicide nor euthanasia in their decision but rather presupposed these definitions, as prescribed by the Canadian Medical Association contained within 'Euthanasia and assisted death' (2014). In terms of which, physician-assisted death is classified as, "a physician knowingly and intentionally provides a per-son with the knowledge or means, or both required to end their own lives, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs". Furthermore, euthanasia has been defined by the C.M.A as, "the practice of knowingly and intentionally performing an act, with or without consent, that is explicitly intended to end another person's life and that includes the following elements: the subject has an incurable illness; the agent knows about the person's condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain".

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The declaration of invalidity was suspended for twelve months to allow for Parliament and provincial governments to properly administer safeguards through legislative and regulatory amendments.[357]

3.4.5. Legislative recognition of 'Medical Assistance in Dying'

Following the judgement of *Carter v Canada*, the legal stance surrounding end-of-life decisions in Canada experienced a paradigm shift. In June 2016, the Criminal Code was amended to include further provisions pertaining to these practices.

The proposed amendments to sections 227 and 241 sought to clarify the indispensable factors to be complied with during physician-assisted suicide and euthanasia to avoid legal sanction.[358] Sequentially, these necessary legislative changes brought about the decriminalising of both euthanasia and physician-assisted suicide in Canada.

Although these end-of-life practices differ in their application, they are both distinguished by the participation of a medical practitioner. These procedures require the intercession of medical practitioners to fulfil a patients' end-of-life request by interceding in the ending of their patients' own lives.[359]

Whilst the aid of a medical practitioner is ordinarily required, no provision compels practitioners to provide assistance in dying. Nevertheless, these two distinct practices have since been referred to collectively as 'Medical Assistance in Dying' under the confines of Canadian jurisdictions.[360]

Subsequently, in October 2020, federal legislation classified MAID as a health care right, proposing changes to Canada's legal framework in view of end-of-life practices.[361]

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357 *Carter v Canada supra* 350.

358 Criminal Code *supra* 341, section 14 which prohibits consenting to one's own death, at present allows for rules of exclusion when read in conjunction with section 227. The application of section 227 extends to situations whereby a person consents to have death inflicted on them with the aid of medical practitioners, in accordance with section 241.2 In addition, section 241 which previously prohibited physician-assisted death has since been amended to include legalised assistance in dying under certain prescribed conditions. Refer to Appendix F for a full description of sections 227 and 241 of the amended Canadian Criminal Code.

359 *Carter v Canada supra* 350. See further Van der Maas P.J., van Delden J.J.M., and Pijnenborg L. 'Euthanasia and other medical decisions concerning the end of life' (1991).

360 Hereinafter referred to as MAID.

361 The Criminal Code *supra* 341. Bill C-7 titled 'Medical Assistance in Dying' (2021).

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3.4.6. Redefining current guidelines in view of 'Medical Assistance in Dying'

Since the inception of MAID, continuous developments of the federal health law have taken place within Canada's legislative bodies. These proposed amendments set out to further recognise fundamental human rights during the end stages of one's life.[362]

During March 2021, a newly revised assisted dying Bill was assented to, which became enforceable law with immediate effect.[363] This Bill, driven by compassion and a desire for personal autonomy, reconsiders which persons are eligible to obtain medical assistance in dying. The Bill prescribes further processes and regulations to be followed in considering the assessment thereof.

The amended eligibility criteria now provide that MAID is available to all persons whose deaths are not reasonably foreseeable yet are burdened with a medical condition that is considered 'grievous and irremediable'.[364] In addition to revisiting the eligibility requirements of MAID, the administration of procedural safeguards have become overlayed with stringent requirements, endeavoured to protect vulnerable persons against potential abuse and error.[365]

This newly founded legislation serves as a legal impetus in recognising Canada as a pluralistic liberal society, encompassing all citizens of differing values and positions.[366] Consequently, the value of individual autonomy and self-determination have been recognised as paramount when considering one's own end-of-life decisions. The trials and tribulations experienced by Canada, given decriminalising euthanasia and physician-assisted suicide, have assisted in further developing the legal basis of Canada's health laws.

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362 The Charter *supra* 334, sections 7 and 15.
363 Criminal Code *supra* 341. Bill C-7 titled 'Medical Assistance in Dying' (2021). See further *Truchon v. Attorney General of Canada* 2019 QCCS 3792.
364 Criminal Code *supra* 341. Bill C-7
365 *Ibid.*
366 Hogg P.W. 'Constitutional Law of Canada (ed 2)' (1985).

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3.5. Austria

3.5.1. Historical uncertainty surrounding end-of-life practices

End-of-life decision making in Austria has been a controversial topic in both public discourses and legislation.[367] In recent years, debates surrounding end-of-life decision-making processes have intensified, arousing public interest.

Societal changes and increased appreciation of individual liberties call for escalated recognition of freedoms insofar as end-of-life decisions are concerned.[368] The multitudes of these freedoms, liberties, and ideals functioned as the driving force to reconsider the legality of both euthanasia and physician-assisted suicide.

3.5.2. Corresponding legal frameworks

The Austrian Constitution is akin to that of South Africa's in many aspects. The Constitution establishes Austria as a democracy in which national constitutional law is regarded as the supreme law, subject to the separation of powers as a protective measure to curtail abuse of process.[369]

Contained within the 'fundamental principles' of the Constitution are the most sacrosanct laws in the Austrian legal hierarchy, including the democratic principle, the principle of the rule of law, and the principle of the separation of powers. These fundamental principles, therefore, form the basis of the constitutional legal system of Austria.[370]

3.5.3. Multifacet jurisprudence: Pertinence of the right to life

The Constitution of Austria is distinguished from South Africa's in the sense that it does not contain a coherent catalogue of fundamental human rights; instead, a broad approach has been

367 Stolz E. et al. 'Determinants of acceptance of end-of-life interventions: a comparison between withdrawing life-prolonging treatment and euthanasia in Austria' (2015).

368 Stolz E., Burkert N., Großschädl F., Rásky É., Stronegger W.J., and Freidl W. 'Determinants of Public Attitudes towards Euthanasia in Adults and Physician-Assisted Death in Neonates in Austria: A National Survey' (2015).

369 Albi A. and Bardutzky S. 'National Constitutions in European and Global Governance: Democracy, Rights, and the Rule of Law' (2019) pg 1283.

370 The Federal-Constitutional Law of 1920.

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developed and held separate from the core Constitution.[371] The State Basic Law was adopted as an independent document that protected the rights of citizens before the enactment of the Constitution.[372]

The human rights catalogue of Austria was expanded in 1958 when the European Convention on Human Rights[373] was adopted into Austrian Law.[374] These rights contained within the ECHR became formally recognised rights in 1964 when the constitutionalisation of the ECHR took place.[375]

As contained in the current democratic society of Austria, 'life' is considered to be an inalienable and legally protected right. Article 2 of the ECHR confirms this, prescribing the right to life as follows:[376]

> 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
> (a) in defence of any person from unlawful violence;
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

Pursuant to the abovementioned provision, whereby the sanctity of life in Austria is affirmed, there is an implied notion that Austrian law prohibits any infringement of the right to life.[377]

The protection of the right to life is categorically provided for within the Criminal Code (*Strafge-setzbuch – StGB*), whereby the legal corpus extends to include the prohibition of euthanasia pertaining to the request of mercy killings as well as assisting in suicide.[378] As a

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[371] Albi A. and Bardutky S. *supra* 369.
[372] Stelzer M. 'The Constitution of the Republic of Austria. A Contextual Analysis' (2011) pp 209-210.
[373] Hereinafter referred to as the 'ECHR'.
[374] Stelzer M. *supra* 372 pp 211-215.
[375] Federal Law Gazette 59 (1964). See also Öhlinger T., Eberhard H. 'Verfassungsrecht, 11th ed' (2016) para. 681.
[376] European Convention on Human Rights Protocol No.15 (2021).
[377] The State Basic Law on the Rights of Citizens 1867, affords no general constitutional provision on the limitation of rights. See further Jahn-Kuch et al 'End-of-life decision making by Austrian physicians - a cross-sectional study' (2020).
[378] Criminal Code of Austria, 1998. In regard to killing on request, section 77 prescribes "Anyone who kills another person upon their serious and emphatic request is to be sentenced to a prison term of between six months and five years". Moreover, in relation to the assistance to suicide section 78 stipulates

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substitute measure, in an effort to maintain the dignity of persons living in intractable pain, the onus is placed upon all medical practitioners to provide legalised assistance to dying patients in the form of palliative care.[379]

An inconsistency of the prohibition towards euthanasia contained within section 1(2) of the Criminal Code is predicated on the right of a person to refuse medical treatment, irrespective of whether such refusal accelerates the onset of death.[380] In any circumstance, the presupposition is that the person concerned is of sound mind, capable of discernment and judgment.

3.5.4. Legislative development concerning end-of-life decisions

In recent times there has been a transition in Austria with the focus on the freedom and individual autonomy of a person in the form of self-determination. This shift of mindset is determinative of an increased acceptance of euthanasia practices; it also serves to recognise the right to die with dignity.[381]

Although euthanasia practices in Austria remain to be criminalised, the unconstitutionality of provisions relating to the prohibition of assisted suicide was brought before the Constitutional Court in the December of 2020.[382] Pursuant to Article 140 of the Constitution, the Constitutional Court was tasked to decide upon the unconstitutionality of sections 77 and 78 of the Criminal Code after a public oral hearing in September 2020.[383]

When considering the wording of section 78 of the Federal Law regarding the assistance of suicide, the Court held the phrase 'or assists them in doing so' to be unconstitutional and is

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"Anyone who induces another person to kill themselves or assists them in doing so is to be sentenced to a prison term of between six months and five years".

379 Criminal Code of Austria *supra* 378, section 49(a) whereby it stipulates, "(1) Physicians have to provide assistance to dying patients taken over for treatment, while respecting the patients' dignity. (2) Within the meaning of paragraph 1, measures taken within the framework of indications of palliative medicine, in particular for dying patients, the benefit of which in relieving the most severe pain and suffering outweighs the risk of an accelerated loss of vital functions, are permitted".

380 Criminal Code of Austria *supra* 378, section 1(2) sets out "A patient's will to refuse medical treatment can be laid down in a living will with binding effect".

381 Seale C. 'Doctors' attitudes surveyed' BMJ (2009). See further Jaspers E., Lubbers M., and de Graaf N.D. 'Horrors of Holland': explaining attitude change towards euthanasia and homosexuals in the Netherlands' IJPOR (2007).

382 Verfassungsgerichtshof, A-1010 Wien, G 139/2019-71 (translated to The Constitutional Court, A-1010 Vienna, G 139/2019-71).

383 The Federal-Constitutional Law *supra* 370, Article 140 (1)(c).

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therefore repealed.[384] Whilst the act of 'inducing someone' to commit suicide remains to be an offence.[385] These changes to the Federal Law are scheduled to enter into force as of the end of December 2021.

The Court held further that the application of unconstitutionality as far as it refers to killing on request as contained in section 77 of the Criminal Code is rejected.[386] Thereby the Constitutional Court once more confirmed the prohibition against euthanasia, yet the restrictions insofar as assistance in suicide are set to be eased.

While noting the reasons for its decision, the court stated that the clause so contained in section 78 subjugated a blanket ban on assisting a person in dying. For this reason, the court held that the provision violated one's right to self-determination.

It is submitted that the ruling of the Constitutional Court contemporaneously appreciates the freedoms rooted in the dignity of the person. Moreover, dying at the hands of suicide, and consequently, vesting the right to request assisted suicide, accentuates the right to self-determination, ensuring the right to a dignified death.[387]

3.6. Concluding remarks

This subchapter set out to analyse euthanasia by comparing foreign countries to South Africa, considering the contrasting viewpoints of alternative foreign jurisdictions. A parallel was drawn between the foreign legal systems mentioned above concerning their current regulatory legal frameworks pertaining to voluntary active euthanasia and physician-assisted suicide.

Though the application of foreign law is not considered binding on South African judiciaries, the consideration can still subscribe to the moulding and development of legislative frameworks, specifically regarding recognising fundamental human rights.

[384] Criminal Code of Austria *supra* 378, section 78 reads, "Anyone who induces another person to kill themselves or assists them in doing so is to be sentenced to a prison term of between six months and five years". Additionally, section 64 (1) provides that section 78 remains to be valid despite 'the act' taking place abroad, outside the Republic of Austria.

[385] Verfassungsgerichtshof G 139/2019-71 *supra* 382. See further the Criminal Code *supra* 375, section 64 (1).

[386] Criminal Code *supra* 378.

[387] Minelli L.A. 'DIGNITAS- To live with dignity- To die with dignity' (2020).

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In considering properly developed foreign jurisprudence, the independence of the Constitutional Court is not brought into dispute nor tainted but instead reaffirms inferences already drawn by transnational contextualisation.

It is submitted that the focus of arguments pertinent to end-of-life decisions in South Africa have been misplaced on ethics and morality rather than the fundamental human rights, which continue to be unjustifiably limited.

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CHAPTER 4: APPLICATION OF VOLUNTARY ACTIVE EUTHANASIA THROUGH CASE LAW IN SOUTH AFRICA

4.1. Introduction

A turning point was introduced since the inception of the Constitution regarding the practical implementation of human rights within South Africa. Demarcated by the expedited development of legislation, the judiciary has been tasked with the cumbersome duty of interpreting and enforcing fundamental human rights and freedoms as set out by the Bill of Rights. These duties, accompanied by the subsequent responsibilities, involve one of the most onerous tasks found in law to date.

As previously mentioned, the constitutional democratic system imposed by South Africa's government is characterised by a 'checks and balances' system. The doctrine of separation of powers recognises autonomy insofar as divisional functionalities are concerned, among the executive, legislature, and judiciary.

The reason for doing so prevents the usurping of powers from one to another, in conjunction with ensuring the balancing of interest on a horizontal level.[388] By asserting the functions attributed to the judiciary, tension may arise as it is conceivable that courts be required to encroach upon the duties of the legislature, executive, and governmental policies.[389]

There are exceedingly limited applications of judgements pertaining to euthanasia found within the legal framework of South Africa. A broad approach will thus be taken for purposes of this chapter to deconstruct and evaluate the judgements handed down by the relevant courts in view of euthanasia. The function is to determine the practical application of euthanasia within South Africa whilst giving effect to the determinants of constitutional law.

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388 De Klerk F.W. 'Checks and balances, Reflections on the development of the doctrine of separation of powers under the South African Constitution' (2005).

389 *National Director of Public Prosecutions and Others v Freedom Under* Law 2014 SCA (Unreported case). The SCA explained that, "The doctrine of separation of powers precludes the courts from impermissibly assuming the functions that fall within the domain of the executive'. See further, the judgement by the SCA whereby it was held that 'The court will only be allowed to interfere with this constitutional scheme on rare occasions and for compelling reasons". See further *Speaker of the National Assembly v De Lille and Another* 1999 SCA.

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4.2. Voluntary active euthanasia in South Africa[390]

Voluntary active euthanasia, as already discussed in-depth, refers to an act of inducing the death of a person for several reasons. This form of euthanasia is considered to be a criminal offence under current South African law. Protection is sought from section 11 of the Constitution in this regard, where it provides that everyone has the right to life. The right to life is regarded as the most basic human right. Despite this, the right to life forms the foundation on which all other rights are premised.[391]

When considering voluntary active euthanasia, an intrinsic link exists between the right to life and the right to dignity. The Court described these two rights in *S v Makwanyane* as the most important of all human rights, whereby the right to life is antecedent to all other rights in the Constitution.[392] Consequently, the right to life serves to be the source of all other personal rights as stipulated in the Bill of Rights.

As previously mentioned, the act of voluntary active euthanasia in current South Africa would undoubtedly be considered an unlawful action. Instances whereby a person aids in the intentional killing of another constitutes the crime of murder. This remains true regardless of whether such a killing takes place with the intention to alleviate the pain and suffering of a patient, amounting to a 'mercy killing'. The following cases of active euthanasia thereby are to be discussed to provide further clarity on this position as set out by the judiciary.[393]

4.2.1. S v Hartmann[394]

This case deals with one of the most controversial aspects of active euthanasia in its voluntary form. Both the accused and the deceased were enrolled as medical practitioners within South Africa. The elderly father of the accused was suffering ongoing agony from an incurable form of stomach cancer. Since there were no prescribed treatment methods, the only relief available

390 This subchapter incorporates physician-assisted suicide as well as physician-assisted euthanasia under the ambit of voluntary active euthanasia.
391 *S v Makwanyane supra* 172.
392 The right to life insofar as it relates to the abolishment of the death penalty as ruled in *S v Makwanyane*, is outside the scope of this study.
393 The following cases involve judgements regarding both voluntary and involuntary active euthanasia. The reason for including judgements whereby involuntary active euthanasia has been established, is to contextualise the approach of courts and their judgement during instances of mercy killings.
394 *S v Hartmann supra* 53.

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to ease the pain was in the form of palliative care.[395] The accused, Dr Hartmann, injected his father, at his father's request, with a fatal level of sodium pentothal[396] to alleviate his father's suffering through a certain death.[397] The lethal overdose of sodium pentothal accelerated the onset of Dr Hartmann's father's death to one that was almost immediate.[398]

Dr Hartmann was convicted of murdering his father; however, the court took into consideration the presence of decisive mitigating factors. The court brought the quality of life into question to deduce whether the deceased's life had become meaningless. The court held the following in this regard:[399]

> The general picture of such a patient is one of extreme misery due to bodily wasting […] There comes a time when the patient's quality of life becomes meaningless to himself through the misery of his pain and physical disability, which results from the potent drugs used to free him of it. At this stage, the patient presented a problem to his medical attendant, which brings about a conflict in ethical principles, namely, to save lives and to relieve pain and suffering.

Taking this into account, the accused was sentenced to one year's imprisonment. Dr Hartmann was detained until the rising of the court, whereby the remainder of the imposed sentence was suspended. Subsequent disciplinary measures were incurred by Dr Hartmann whereby he was struck off the roll of medical practitioners by the Medical and Dental Council, although reinstatement has taken place since.[400]

Liability by Dr Hartmann could not be escaped, even though a case for good motive was argued.[401] Motive, however, was factored into the sentencing phase whereby a lenient sentence

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395 Palliative care measures in this instance included the use of morphine as a means to alleviate the pain suffered by the patient.

396 Sodium pentothal is an ultra-short acting depressant of the central nervous system that induces hypnosis and anaesthesia, but not analgesia.

397 *S v Hartmann supra* 53.

398 An unnatural death ensued in the form of a *conditio sine qua non,* as a result of injecting the Sodium Pentothal. Judgement given in *S v Hartmann supra* 53, reads as follows, "It is true that the deceased was in a dying condition when this dose of pentothal was administered and that there is evidence that he may very well have died as little as a few hours later. But the law is clear that it nonetheless constitutes the crime of murder even if all that an accused has done is to hasten the death of a human being who was due to die in any event . . . Here the state has proved that but for the accused's actions, the deceased would not have died when he did. That such action, if wilfully undertaken, constitutes murder".

399 *S v Hartmann supra* 53.

400 Strauss S.A. *supra* 157 pg 342.

401 This case serves to determine whether a person holds the functional capacity to enact the very freedom of choice as contained in Chapter 2 of the Bill of Rights.

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was awarded. It is thus evident that cases in which mercy killing takes place, under current practices, seem to result in a lesser sentence when compared to that of a conventional murder.[402]

4.2.1. S v Grotjohn[403]

This case emanates from a distraught domestic environment whereby the accused engaged in an extramarital affair after being refused conjugal rights from his wife. On the day in question, an argument ensued, which resulted in Mrs Grotjohn threatening to shoot herself.

Due to Mrs Grotjohn being partially paralysed and bipolar, the act of killing herself was encouraged by her husband as he saw her as nothing but a burden. Mrs Grotjohn proceeded to take the gun and killed herself with a fatal shot to the head. The accused was charged with the murder of his wife. After that, the accused was acquitted based on the basis that the chain of causation was independent of the act of suicide.

Upon the acquittal being taken on appeal, the court posed the following two questions, whether encouraging, providing the means for or helping a man or woman commit suicide was a crime? Moreover, if so, what crime was committed? The Court failed to provide an overarching decision in this regard as each case is to be dealt with in terms of the specific circumstances present. This stance was committed by the court where Steyn CJ stated:[404]

> I would not subscribe to a general proposition that the final 'voluntary and independent' act of suicide must always result in the acquittal of the accused without reservation in regard to the independence of that act.

The basis remains that, although suicide and attempted suicide are not criminalised within South Africa, not every subsequent event that leads to a particular consequence is to be viewed as an intervening cause. Legal principles surrounding a *novus actus interveniens,* in this instance, are required to be completely independent of the prior acts of the accused.

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402 *S v Marengo* 1990 WLD (Unreported case), the accused was given a suspended sentence after being found guilty of murdering her terminally ill and suffering cancer-ridden father in order to end the ongoing suffering that he was being subjected to.

403 *S v Grotjohn supra* 71.

404 *S v Grotjohn supra* 71 at 363H. Translated from the original passage which reads: "Ek sou egter nie 'n algemene stelling dat die laaste 'vrywillige en selfstandige' handeling van die selfmoordenaar altyd op vryspraak van die beskuldigde moet uitloop, sonder voorbehoud ten aansien van die selfstandigheid van die handeling wil onderskryf nie".

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4.2.2. S v De Bellocq[405]

The accused in this case was a young woman who had given birth to a premature baby. After a short time, it became evident that the baby was suffering from a disease known as toxoplasmosis.[406] The accused had some previous medical knowledge of the disease due to the fact that she was a medical student. She was, therefore, aware of the severity of the disease, inclusive of the fact that her baby would be unable to live everyday life.[407] De Bellocq took it upon herself to end her baby's life by drowning the baby in the bath.

De Belloqc was eventually charged and found guilty of murder. The Court found extenuating circumstances, for which she was sentenced in terms of section 349 of the old Criminal Procedure Act.[408] This section allowed the accused to be discharged on the condition that she would be required to appear if summoned by the court within the following six months. The court, however, never acted by resummoning De Bellocq before the court for sentencing. Within the judgement, De Wet JP stated the following:[409]

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

What is of concern in this particular case is the relative ease in the treatment of a disease, such as toxoplasmosis. Treatment options have been made available since before the case of De Belloqc. These treatment methods should have been explored before acting upon a self-diagnosis, although De Belloqc was a medical sciences student.[410]

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405 *S v De Bellocq* 1975 (3) SA 538 (T).
406 A disease resulting from infection with a common paraite (Toxoplasma gondii).
407 The life expectancy of the baby was minimal. The baby was unable to drink and had to be fed via a naso-gastric tube. In addition to this, the babies' mental capabilities were severely restricted.
408 Criminal Procedure Act 56 of 1955.
409 Labuschagne J.M.T 'Dekriminalisasie van eutanasie' (1998) Tydskrif vir die Hedendaagse Romeins-Hollandse Reg pg 175.
410 Torok E., Moran E., and Cooke F. 'Oxford Handbook of Infectious Diseases and Microbiology' (2009) pg 6.

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Treatment for toxoplasmosis can be administered during both the prenatal and postnatal stages of pregnancy. Prenatal treatment has been proven to be ineffective against already established foetal infections.[411] However, the option of postnatal treatment in the form of trimethoprim/sulfamethoxazole (TMP/SMX) makes for what is now considered to be a commonly prescribed medication.[412]

TMP/SMX finds its application on the World Health Organizations' list of essential medicines, attributed to the success it has had for diseases such as toxoplasmosis.[413] The long-term benefits ascribed to postnatal treatment are, however, still extensively debated.[414] However, the use of TMP/SMX for babies less than two months of age is not recommended due to the adverse side effects. It can be argued that a quality filled life can still be led despite thereof. This raises the question as to whether the measures taken by De Belloqc were considered to be justifiable, and subsequently, whether the court erred in failing to explore all options available to De Belloqc.

The traditional view of the law has since been altered within South Africa. Cessation of treatment may, under certain prescribed circumstances, be permissible. Life-sustaining measures may thus be withdrawn from the patient, allowing for patients to die from natural causes. Under the current application of the laws surrounding euthanasia, patients cannot be actively killed in the way De Belloqc ended her child's life.

4.2.3. R v Davidow[415]

This case serves to be one of the earliest cases involving the practice of active euthanasia in South African law. In this case, Davidow's mother was suffering from a terminal illness whereby she was subjected to extreme measures of pain and suffering. Davidow exhausted all other options to acquire medical treatment for his mother. However, her condition was incurable, and her overall health was worsening.

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411 Robert-Gangneux F. 'The placenta: a main role in congenital toxoplasmosis?' (2011) pp 530–536.
412 *Ibid*.
413 World Health Organisation: List of essential medicines 'https://list.essentialmeds.org/?query=Trimethoprim' accessed 2 August 2021.
414 Petersen E. 'Prevention and treatment of congenital toxoplasmosis' (2007) pp 285-293.
415 *R v Davidow* 1955 WLD unreported.as discussed in Van Dyk 'Die Dawidow saak' (1956) Tydskrif vir die Hedendaagse Romeins-Hollandse Reg pg 286.

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Davidow's mother had expressed her wishes to be relieved of her suffering on prior occasions. Davidow attempted to satisfy his mother's wishes by requesting a friend to give his mother a lethal injection, but the friend refused. As a result, the accused was found to be in an emotional state of turmoil and let Davidow shoot and kill his mother in her hospital bed.

Davidow was not convicted by the court on the charges of murder. The particular reason for circumstance was that the court found Davidow lacked the necessary capacity. The unlawfulness of the act was not put before the court as a result of the incapacity of Davidow during the perpetuation of the deed.

4.2.4. S v McBride[416]

McBride and his wife were aware of the likelihood that she had cancer, although this was never formally diagnosed. Along with the deterioration of McBride's wife's health, so was their financial position in decline. McBride decided to take both their lives by first shooting his wife, killing her, and attempting to take his own life after that. The accused was saved due to a *novus actus*, whereby bystanders intervened with his suicide attempt.

The accused was charged with the murder of his wife. The court, however, dismissed the charge on the ground of criminal incapacity. Once again, the ground of incapacity has been adapted by the court in instances of mercy killings. This infers current judicial practices to fall along the slippery slope of active euthanasia occurrences in South Africa.

4.2.5. S v Marengo[417]

The deceased, an 81-year-old man who had cancer, was shot and killed by his daughter. The accused acted on the account that she could no longer bear her father's suffering. Upon being charged with murder, the accused pleaded guilty. Marengo was convicted of murder and sentenced to three years imprisonment, suspended for five years.

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416 *S v McBride* 1979 4 SA 313 (W).
417 *S v Marengo supra* 402.

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Once again, the court imposed a lesser sentence as this fell under the classification of mercy killing. Emphasis is to be drawn to the fact that Marengo shot her father because *she* could no longer endure *his* suffering. There is no mention of whether the deceased requested his life to be ended or if he was in a position of insurmountable pain.

Regardless of this, the court still deemed a lesser sentence to that of ordinary murder to be appropriate. This instance is borderline non-voluntary active euthanasia, as there seems to be no clear intention on behalf of the now-deceased as to his unwillingness to continue living.

4.2.6. S v Smorenburg[418]

The accused in this case was a nursing sister, who on more than one occasion, attempted to end the lives of suffering terminally ill patients. The accused, driven by compassion, injected the patients with insulin in an attempt to put an end to their pain and suffering.

The accused was found guilty by the court on the ground of attempted murder. She was sentenced to three months imprisonment, suspended in its entirety. The court once again exhibited leniency in sentencing, for which the accused's motive of mercy killing was considered.

4.2.7. Stransham-Ford v Minister of Justice and Correctional Services and Others[419]

The case of *Stransham-Ford* encapsulates the most recent application of physician-assisted suicide and that of voluntary active euthanasia within the context of South African courts.

Mr Stransham-Ford was suffering at the hands of a progressive form of terminal cancer. Whilst being close to death, an urgent application was brought to the court on Mr Stransham-Ford's behalf. The application sought to authorise a lethal dose of medication by a medical practitioner to be administered by either the practitioner or himself.

Two hours following the death of Stransham-Ford, the High Court granted an order whereby a medical practitioner was substantially authorised to administer the lethal dose of medicine to Stransham-Ford, as requested, with the intention to relieve his pain and suffering. This order

418 *S v Smorenburg* 1992 CPD (Unreported case).
419 *Stransham-Ford supra* 47.

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enabled the said medical practitioner to act without incurring any criminal or professional consequences.

As previously mentioned, the High Court ruling as set out by Fabricius J provided an order to be granted, enabling physician-assisted suicide on constitutional grounds.[420] This served as an audacious and progressive judgement by Fabricius J, which was considered in light of the recommendations in the report on 'Euthanasia and the artificial preservation of life' by the South African Law Commission in November of 1998.

The High Court held that a terminally ill patient and suffering is nonetheless entitled to commit suicide with the assistance of their doctor. The Court further held that the doctor's conduct (which ordinarily would be deemed to satisfy the requirements of physician-assisted suicide) would not amount to being unlawful.[421]

The *ratio decidendi* provided by Fabricius J, in this case, suggests that this instance of voluntary active euthanasia should not be used as a blanket tool for all instances of euthanasia but should instead be decided on a case-by-case basis. Any furtherance of legislation or development of the common law should bear this principle in mind.[422]

This revelatory High Court ruling was met with discontent by the Supreme Court of Appeal, such that it was appealed by several parties, inclusive of the HPCSA. The order provided for by Fabricius J was overruled and set aside by the Supreme Court of Appeal based on the following three interrelated grounds:[423]

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420 *Stransham-Ford supra* 47. Fabricius J. sets out requirements to be met prior to voluntary passive euthanasia being considered: "a) Patient has to be terminally ill and subjected to extreme pain but mentally competent, b) a second independent medical practitioner would have to confirm the diagnosis and the findings- these must be recorded in writing, c) the request must be based on informed and well-considered decisions, and d) the request must have been made repeatedly".

421 Judgement of Fabricius J. in *Stransham-Ford supra* 47, "The common law 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 the Applicant's constitutional rights to human dignity, (section 10) and freedom to bodily and psychological integrity (section 12 (2) (b), read with sections. 1 and 7), and to that extent are declared to be overbroad and in conflict with the said provisions of the Bill of Rights. Except as stipulated above, the common law crimes of murder and culpable homicide in the context of assisted suicide by medical practitioners are not affected".

422 Fabricius J. in *Stransham-Ford supra* 47, "In the absence of legislation, which is the government's prerogative, any other court will scrupulously scrutinize the facts before it and will determine on a case-by-case basis, whether any safeguards against abuse are sufficient".

423 *Stransham-Ford supra* 47.

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(i) When Mr Stransham-Ford died, his cause of action ceased to exist, such that the High Court no longer had the prescribed authority to make an order on his urgent application, which rendered the order impermissible. The correct procedure that should have been followed upon becoming aware of the death of Mr Stransham-Ford, includes the rescindment of the order as made in error;

(ii) There was an improper and incomplete evaluation of the current state of the law in view of the Constitution. At the time of writing, no ruling has been made which governs this situation. Broader development in the sphere of criminal law is required by the legislator whereby the implications could be determined in light of the circumstances of each particular case at hand;

(iii) The case had been conducted on the precept of an urgent application which amounted to an incorrect and restricted factual basis. The lack of evidence brought before the court prohibited a full consideration of the law from taking place.

The commentary within the decision, held by the Supreme Court of Appeal, failed to address the legality surrounding any prospective misconduct of a medical practitioner who aids in the practice of voluntary active euthanasia.[424] The court emphasised that such decisions and rulings fall outside the ambit of the court's scope, duty, and powers.

Thus, it was concluded that the matter is better suited for the legislator to address. The Courts were correct in giving effect to the principle of separation of powers. The onus now lies on Parliament, as the national legislature, to develop legislation required to apply voluntary active euthanasia.[425]

To sum up, everything stated so far, the case of *Stransham-Ford* has served a paramount role in the development of euthanasia within South Africa's legal system. The judgement given has enabled the concept of euthanasia to be largely debated, bearing emphasis on a number of aspects, including legal, political, sociological, religious, and cultural.[426]

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424 As it stands, there are a number of pending cases which are prepared to challenge the decision as set out by the Supreme Court of Appeal. Should this materialise, it would amount to an unprecedented case, whereby a case dealing in euthanasia is to be heard in front of the Constitutional Court.

425 *Stransham-Ford supra* 47.

426 Koenane M.L.J. *supra* 12.

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4.3. Current development of voluntary active euthanasia within the judiciary

Presently, there have been numerous advances in human rights movements across the globe, with euthanasia continuously proving to be at the forefront of these. South Africa has been revealed to be no different. As of the beginning of 2021, the courts have once again set in motion to tackle the crux surrounding the decriminalisation of voluntary active euthanasia. The last time this issue was brought before a court was during the matter of *Stransham-Ford*, which took place in 2015.

Application has since been made to the Johannesburg High Court to allow for physician-assisted suicide and physician-assisted euthanasia.[427] The applicant in this matter is Suzanne Walter, a palliative care specialist who has been previously diagnosed with multiple myeloma, a terminal type. The applicant is accompanied by her patient, Diethelm Harck, who suffers from a motor neuron disease of which treatment is yet to be discovered.

The relief sought by the applicants in this matter is for the High Court to establish a judgement, whereby current professional rules and laws barring medical practitioners from aiding their patients to end their own lives as an unjustifiable infringement of the Constitution. The Centre for Applied Legal studies has been appointed by the court to bring forth evidence in the form of legal arguments to address these issues so raised:[428]

> The Centre for Applied Legal Studies sought to extend the legal arguments on the rights to dignity and life, to include the right not to be treated in a cruel, inhumane, or degrading way, and not to be tortured, with reference to international law: that the absence of a right to assisted dying can amount to torture or cruel and unusual punishment.

Further relief sought by the applicants includes the provision for Parliament to enact legislation, giving effect to the right to self-determination and other fundamental human rights as contained in the Bill of Rights. Swemmer identifies the importance of this landmark case by stating, “this ultimately determines the cornerstone of our rights, which is the right to life, the right to live with dignity but also the right to die with dignity”.[429]

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427 *Suzanne Walter and Others v Minister of Health and Others supra* 182. Whereby the medical practitioner is responsible for administering medication to the patient with the intent to end the life of the said patient.

428 Swemmer S. ‘Centre for Applied Legal Studies’ (2021).

429 *Ibid*.

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As currently conceived, evidence continues to be led by virtual proceedings, with a trial set to take place before the end of this year with judge Keightly presiding over the matter. However, delays are expected due to the tragic passing of retired judge Claassen who was overseeing this matter as chair.

At the time of writing, the matter mentioned above has not been consummated yet; hence, no in-depth analysis has taken place. Therefore, the outcome of this matter will not be made available or discussed any further within this study.

4.4. Concluding remarks

Given the case law, as discussed in this chapter, there appears to be an ambivalence towards euthanasia within South Africa. Several identifiable judgements have attempted to address and redress the issue that is the justifiability of euthanasia in the context of the right to life.

Subsequently, these judgements have served a paramount role in developing arguments related to euthanasia within South Africa's judiciary. However, this is but a trifling step in the underlying issue, namely, the unfair limitation of fundamental human rights with specific reference to all forms of voluntary euthanasia.

As highlighted by the case law mentioned above, the main arguments advanced in support of euthanasia include the advocation for human autonomy, a concept that does not function in isolation. Autonomy is privy to the right to dignity, which indirectly incorporates the right to end incurable pain and suffering, although this is not explicitly a right in itself. The ability for persons to make decisions regarding their own lives should be underscored, resultant from the adverse impacts that stem from withholding such a procedure.

The courts have passed judgments, presented by counter-arguments in support of defying the decriminalising of euthanasia. The concentration of which is placed for the most part on morals, concerning both personal and religious views.

The premise upon which these judgements were handed down serves a fundamental role in determining which areas of South African law require further development prior to any future incorporation of voluntary active euthanasia therein. There are currently several limiting

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factors attributed to the unjustifiable infringement of fundamental human rights when considering euthanasia.

Due consideration is needed to be given by the State in an effort to raise the protection of fundamental human rights in line with the international standards as identified in Chapter 3. To put it differently, integrated compliance of the legislature, judiciary, and executive is required to address the challenges currently facing euthanasia. Without the presence of which, an anticipated usurping of powers is in order. It is evident that euthanasia holds no easy solution in remedying its application within the South African legal system.

This chapter has confirmed that case law in South Africa stands in dire need of further development. The end goal should be to protect the fundamental human rights as identified and address the unequal standpoint that persons seeking euthanasia currently face. Euthanasia as a whole is an ongoing concern that needs to be addressed with the seriousness and urgency that it warrants.

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CHAPTER 5: OBSERVATIONS AND CONCLUSION

5.1. Scope and purpose of the study

This study evaluated the feasibility of South Africa's legislative and regulatory framework to incorporate voluntary active euthanasia against the backdrop of fundamental human rights.

The focus of this study fell mainly on South Africa's current legal framework, in particular the Bill of Rights, as prescribed by the Constitution. In addition to this, various alternative legal jurisdictions were considered and compared, including the Netherlands, Canada and Austria. Furthermore, this study incorporated several relevant regulations insofar as their applicability to euthanasia as a whole is concerned. These regulations include the National Health Act 61 of 2003, South African Law Commission Act 19 of 1973, and Health Professions Act 56 of 1974.

The main goal of this study also included the analysis of decriminalising voluntary active euthanasia in South Africa through the application of fundamental human rights. In doing so, the following encapsulating statement was borne in mind throughout this study, namely that life is dependent on the will of others, whereas death should be on ours.

An in-depth study took place to ascertain whether fundamental human right infringements within the realm of euthanasia are prevalent under the current dispensation of South Africa. Possible solutions were advanced to mitigate the extent to which this potential miscarriage of justice might extend. This was done by way of considering the South African legislative framework that regulates the right to life. Several other closely related rights were taken into consideration to further this objective and consider the effectiveness thereof concerning voluntary active euthanasia.

These rights are afforded protection due to the multi-layered dimension of South Africa's legal system. Patients wishing to exercise individual choice in respect of their end-of-life decisions should feel confident in seeking medical advice as to the option of euthanasia without fear or prejudice. Not only does this safeguard the individual directly, but it also promotes the wellbeing of society and the furtherance of public interest as a whole.

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Since an analysis of current legislation in South Africa on its own does not portray an accurate reflection of societal construction revolving around the concept of euthanasia. Conceptualisation was necessitated due to the fact that the law is dynamic and ever-changing.

The deprecation surrounding decriminalising voluntary active euthanasia in South Africa was objectified against a contrast of legislative doctrines whereby euthanasia is legalised. Of particular significance were the foreign jurisdictions identified and discussed in Chapter 3. Areas of South African law in which current practices lack recognition of fundamental human rights pertaining to euthanasia, clarity and critique were provided by these alternative legal systems. Continued development within the bounds of case law will further aid in the realisation that calls for voluntary active euthanasia to be legalised through recognising fundamental human rights as identified and discussed.

It is therefore submitted that the proverbial door has been left open when considering prospects associated with the decriminalising of voluntary active euthanasia within the context of South African law. As such, this study, in its completeness, delivers a unique perspective with the aim to facilitate further topical debates regarding euthanasia and provides a means for such participation.

5.2. Synopsis

5.2.1. Preface

The central hypothesis of this study, along with the research questions, outline of the study, and methodology, served as a precursor to Chapter 1.

5.2.2. Chapter 1: Deconstructing euthanasia and other concepts

The discourse of this study was introduced in Chapter 1, and principles relevant to the central tenet of decriminalising voluntary active euthanasia were addressed. A causal link was established between each concept and the inter-relationship that exists, vested within voluntary active euthanasia.

Important issues considered in this chapter include the various forms of euthanasia, a defined interpretation of what constitutes death, the applicability and importance of consent and privacy, patient autonomy, palliative care, living wills and their application when

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considering euthanasia. This serves as further confirmation that no topic in law can be considered in isolation but requires the incorporation of a multitude of doctrines, concepts, ideologies, and the application of rights.

It has been established that the supportive structure and measures required to implement voluntary active euthanasia have already been made available. It should be further noted that these measures referred to encompass both medicine and law jointly. Additionally, numerous outstanding requirements require compliance, including medicolegal ethics approval and the correct application of already bestowed fundamental human rights.

Pre-conditional requirements to euthanasia have not only been established in South Africa's law, but they have already found application by way of practical implementation.[430] In addition to this, it has been made apparent that some concepts regarding both medicine and law are required to be met prior to euthanasia being considered a viable procedure.

This, in turn, confirmed the checks and balances system, which is transparent throughout South Africa's legal system and medical profession alike. This thorough process sequentially ensures due procedures are complied with, guaranteeing that the patient's best interests are maintained at all times.

The concatenation of these prerequisites coupled with immense physiological evaluations places a heavy burden on the patient and the medical fraternity as a whole when considering euthanasia. Although never omitted, the presence of these concepts related to euthanasia reduces the risk of an abuse of process, one that is ever important considering the fact that it serves as a literal determinant between life and death. This discussion regarding euthanasia and other concepts thus served its purpose in paving the journey for the remainder of this study.

5.2.3. Chapter 2: The constitutional dispensation and current legislation in South Africa

Voluntary active euthanasia is predicated by constitutionalism and constitutional supremacy. As such, this chapter undertook an in-depth study of South Africa's legal framework, with specific reference to that of euthanasia. This included an overview of the Constitution and the

[430] See the judgement as set out in *Clarke v Hurst supra* 26, for an example concerning living wills.

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fundamental human rights prescribed by it and the consultation of numerous other primary sources applicable to the euthanasia debate.

By incorporating these primary legal sources, a point of reference was established through a benchmark. The function of which determined whether the current application of the Constitution, along with other applicable legislative provisions, are sufficient in themselves to provide the necessary basis whereby voluntary active euthanasia may be decriminalised.

Against which, it would be established whether legislation, regulations, or conduct as discussed potentially infringe upon any fundamental rights guaranteed in the Bill of Rights when considering euthanasia. The prime focus was placed on the following protected rights: the right to life, the right to dignity; the right to equality; the right to privacy; the right to freedom and security of the person; and the right to access to healthcare services.[431]

The content, scope, and application of these aforementioned rights and principles were assessed in terms of the manner in which they unjustifiably limit a person's choice regarding the preservation of life and the inaptitude to die legally.

Furthermore, it was established that certain forms of conduct potentially infringe upon a person's fundamental human rights, as specified by the Bill of Rights. The factors contained within section 36 of the Constitution were considered to determine the reasonableness and justifiability of such an infringement.[432]

Where such an infringement was held to be unjustifiable in light of section 36, recommendations were made to identify the steps required to amend the applicable legislation or rectify the conduct to attain constitutional compliance.

The combination of the Constitution and current legislation provides ample means and protection to facilitate the integration of euthanasia into South Africa's legal framework. Albeit decriminalising euthanasia in both its active and passive forms would require additional measures, the foundation has already been provided for the decriminalisation thereof,

[431] The Constitution *supra* 2, Chapter 2 Bill of Rights.

[432] The Constitution *supra* 2, section 36. The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including: the nature of the right; the importance of the purpose of the limitation; the nature and extent of the limitation; the relation between the limitation and its purpose; and less restrictive means to achieve the purpose.

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emphasising the fundamental human rights entrenched within the Bill of Rights. When interpreting voluntary active euthanasia, further development must take place following the constitutional framework.[433]

It is to be noted that the continued disregard of arguments that further, the implementation of voluntary active euthanasia pose a risk of hindering the application of the Constitution. The goals outlined in the Constitution, with particular reference to the notion of fairness, prescribe that the quality of life of all citizens is guaranteed.[434] This is a non-specific statement and, as such, should not be excluded in light of euthanasia.

Arguments were advanced regarding the influence and effect that legal protectionism may impose on rights vested by patients, with specific reference to that of their end-of-life decisions. The intricate nature of such an argument, in which the favouring of medical practitioner rights to those of the patient serves as a contributing factor, indicates the many restraints that might afflict current euthanasia viewpoints.

Governance by the rule of law requires corrective measures to circumvent these identified issues. Failing to do so will result in these constitutional provisions serving to be nothing but empty promises. The importance thereof should not be overlooked, as it brings into question the integrity of the Constitution as a whole.[435]

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433 The Constitution *supra* 2, section 39(2).

434 The Constitution *supra* 2, the Preamble guarantees the following: We, the people of South Africa, Recognise the injustices of our past; Honour those who suffered for justice and freedom in our land; Respect those who have worked to build and develop our country; and Believe that South Africa belongs to all who live in it, united in our diversity. We therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to:
   i) Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights;
   ii) Lay the foundations for a democratic and open society in which government is based on the will of the people and every citizen is equally protected by law;
   iii) Improve the quality of life of all citizens and free the potential of each person; and
   iv) Build a united and democratic South Africa able to take its rightful place as a sovereign state in the family of nations.

435 The Constitution *supra* 2, section 2.

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5.2.4. Chapter 3: Formulation and analysis of euthanasia among alternative legal systems

In Chapter 3, the research approach deviated from the systematic positivist approach applied throughout all other sections of this study. A comparison was undertaken whereby three foreign legal systems were compared to that of South Africa's.[436] A discussion was presented in which each country was dissected into three main constituents: current legal provisions, accompanying case law, and future development in the law. This provided the means to thoroughly assess and understand the legal perspective of end-of-life decisions in each of these foreign jurisdictions.

The reasons associated with the selection of each foreign legal system for this study were identified. By doing so, the legal background of each country regarding euthanasia was elaborated upon, including their applicable legal frameworks, relevant legislation, and policies implemented to regulate any matters related to euthanasia. Each country contributed a unique stance to the argument of decriminalising euthanasia in South Africa, as identified as follows.

The Netherlands was selected as the predominant foreign jurisdiction for the comparison segment of this study. The Netherlands took to the forefront of legalising physician-assisted suicide and euthanasia, which has had legal sanction in the country for over two decades. Since euthanasia and physician-assisted suicide have been sanctioned in the Netherlands for a lengthy duration, a more objective study could be achieved. This made it possible to assess the long-term effects of policies, detailed guidelines, and compliance with specific conditions to determine the viability of euthanasia moving forward.

What was of particular interest in this study of comparison was the appointment of a commission by the Dutch government to oversee the implementation of euthanasia and physician-assisted suicide. This redirection of resources allows for strict regulation of the respective guidelines and further contributes to the ongoing success of euthanasia in the Netherlands. An approach attributed to governance rather than the explicit recognition and upholding of fundamental human rights.

Canada was chosen as a foreign jurisdiction comparison for several reasons. Emphasis was placed on the Canadian Charter for being comparable with the Constitution of South Africa.

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[436] The Constitution *supra* 2, section 39. Courts may consider foreign law when interpreting the Bill of Rights.

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The Canadian Charter of Rights and Freedoms protects several fundamental rights and freedoms quintessential to preserving Canada as a free and democratic country. These rights and principles served as the basic framework when drafting the Constitution of the Republic of South Africa.

The legal position regarding euthanasia and physician-assisted suicide in Canada experienced a paradigm shift when the judgement of *Carter v Canada* was handed down, whereafter amendment of the Canadian Charter took place.[437] These changes resulted in Canada's legal framework adaptation to incorporate physician-assisted suicide within the ambit of their newly amended Charter. The amalgamation of the Charter and the judgment as handed down in *Carter v Canada* serve as a blueprint for the South African Constitutional Court regarding euthanasia, focusing on the infringement of fundamental human rights.[438]

Austria's legal jurisdiction was selected as a comparison for this study since Austria is among the most recent countries to decriminalise euthanasia practices. Since the onset of this study, Austria had not yet finalised the internal processes in legislating the decriminalising of end-of-life practices. Although the door had been left open regarding the legalisation thereof, Austria actively pursued the enactment of voluntary active euthanasia as a lawful way to end one's life. Whilst completing this study, Austria successfully proclaimed the necessary legislative basis required to ensure legal compliance with voluntary active euthanasia as a medical procedure.

Reiteration has taken place by using these foreign legal systems, as mentioned, that the right to life does not function as an absolute right within the field of euthanasia. Sequentially, it has become apparent that human life may be legally extinguished through the means of a person choosing to end their own life. Albeit, the exercising of this choice requires stringent compliance with regulatory controls and procedures.

Therefore, in drawing insight from Chapter 2 and in concluding the comparison nature of this chapter, evidence suggests that South Africa's constitutional dispensation provides ample protection of fundamental rights pertaining to the procedure of voluntary active euthanasia.

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437 *Carter v Canada supra* 350.

438 With specific reference to the unjustifiable infringement of the right of freedom and security of the person in conjunction with the right to equality.

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5.2.5. Chapter 4: Application of euthanasia through case law in South Africa

Chapter 4 considered the application of voluntary active euthanasia within the ambit of South African case law. Emphasis continues to be deflected by the courts to the underlying act of ending a life, in the form of euthanasia, through the establishment of wrongfulness.

Application of the law in this regard forms part of one of the many inherent requirements of the judiciary. However, the judgement that follows ensures a narrow interpretation should the courts continue to view 'the act' in isolation rather than contextualise the concept of euthanasia using the relevant fundamental human rights cited in the Bill of Rights.

Euthanasia is in no way unrevealed by South African courts as a life-ending measure; however, it has never indeed been brought to completion in its understanding nor application. The ongoing notion rests on the legislature that voluntary active euthanasia ought to remain criminalised in law. Nonetheless, sentences imposed by the courts in instances of active and passive euthanasia have shown ambivalence. The continuation of this mindset only problematises arguments surrounding euthanasia, and as a result, clarification needs to be provided by the courts in this regard.

There is a dire need for courts to further apply the law by promoting the enactment of the fundamental rights prescribed by the Constitution as a tool in achieving constitutional democracy. Resultant from which flows a holistic approach, rather than disregarding and often obscuring a judgement through cognitive biases. The prevalence of cognitive biases is embodied within what it means to be human, specifically in instances where the discontinuation of human life is questioned.

That being said, there remains to be a higher burden of proof placed upon the judiciary. The onus requires the appointed judges to exercise their duties without imparting bias within their judgement. The presence of bias fails to produce correct judgement in the case at hand. Utmost care thus needs to be taken by the judiciary to damper the effects of potential cognitive biases. This may, in turn, have caused quiescence in the development of decriminalising euthanasia, as courts transpire a far more reserved approach than expected. By doing so, the courts exhibit restraint as a preventative measure of crossing a line that can never be uncrossed.

The future of the South African legal system includes euthanasia as a going concern that needs to be strengthened in law from the basis of all relevant fundamental rights. Further

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development in case law will aid in addressing the unequal relationships that exist among persons wishing to engage in end-of-life measures and the restraints they face due to the current skewed legal disposition.

5.3. Future research

5.3.1. Suggested approaches for future research include:

- Methods of improving palliative care measures to ensure comfort in living, rather than delaying the onset of death in a way that is devoid of all quality of life;
- Placing the application of fundamental human rights, as provided for in the Constitution, on par with international standards;
- The development of voluntary active euthanasia within the Constitutional Court, easing the ongoing administrative burden placed on the courts;
- Adaptation of legislative frameworks to confer the decriminalising of euthanasia in accordance with various rights as contained in the Bill of Rights;
- Further research into the National Health Act and its regulations in accordance with the preamble of the Act.[439] Furthermore, institute a regulatory system to govern this framework, impose guidance for future voluntary euthanasia applications, and ensure administrative fairness during voluntary euthanasia matters.

5.4. Concluding remarks

Voluntary active euthanasia is peremptory to living a life that is not devoid of all quality. In conjunction with being autonomous, the cognitive ability to reason instils the surety of living a life rather than merely surviving. However, this is not entirely the case concerning the topic of euthanasia currently in South Africa. Fundamental human rights in this regard are being overlooked and unjustifiably restricted rather than being afforded the protection they so require.

Implementing regulatory controls in light of voluntary active euthanasia would serve as a foundational requirement to foster purposeful change. As a result, decriminalising voluntary

[439] National Heath Act *supra* 30. The preamble reads as follows, "To provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local government".

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active euthanasia will contribute to the recognition and enforcement of these fundamental human rights as pronounced.

It is consequential that by doing so, the spirit, purport and objects of the Bill of Rights must be considered. This, in turn, will result in a more prosperous South Africa, one that is truly built on democracy and one that can boast a constitution that protects the very rights prescribed by it.

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Appendix A: The Physician's Pledge[440]

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

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440 Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 68th WMA General Assembly, Chicago, United States (October 2017).

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Appendix B: Modern Hippocratic Oath (Declaration by Wits Graduands)[441]

I do solemnly declare:

That I will exercise my profession to the best of my knowledge and ability for the safety and welfare of all persons entrusted to my care and for the health and well-being of the community.

That I will not knowingly or intentionally do anything or administer anything to them to their hurt or prejudice.

That I will not permit consideration of religion, nationality, race, politics, or social standing to intervene between my duty and my patient.

That I will not improperly divulge anything, I have learned in my professional capacity.

That I will endeavour at all times to defend my professional independence against improper interference.

That I will not employ any secret method of treatment, nor keep secret from my colleagues any method of treatment that I may consider beneficial.

That in my relations with patients and colleagues, I will conduct myself as becomes a member of an honourable profession.

I make this declaration upon my honour.

Appendix C: Modern Hippocratic Oath (Declaration by University of Pretoria Graduands)[442]

I declare solemnly that:

I will continue the ancient tradition of health care and service to humanity.

I will respect human life.

I will practise my profession diligently, with dignity and with professionalism.

I will respect my colleagues, and together we will strive to maintain high professional standards.

I will maintain and protect patient confidentiality and, in all cases, will conduct myself in an ethical way towards my patients.

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441 Hippocratic Oath declaration by Wits Graduands, "https://www.wits.ac.za/bioethics/about-us/hippocratic-oath/" (Accessed 08/06/2021).

442 Hippocratic Oath declaration by University of Pretoria Graduand, "Declaration Ceremony" (2018).

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I will continue the high standards of training received from my university through life-long learning in order to remain a competent practitioner.

Appendix D: Hippocratic Oath (Translated)[443]

I swear by Apollo, the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgement, I will keep this Oath and this contract:

To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfil his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan, and similarly, I will not give a woman a pessary to cause an abortion.

In purity and according to divine law, I will carry out my life and my art.

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.

So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

443 Translated by Michael North, National Library of Medicine (2002).

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Appendix E: Recommendations as per the South African Law Commission Report in regard to mercy killings in South Africa.[444]

Proposed clauses in relation to voluntary passive euthanasia:

3(1) Every person-

(a) above the age of 18 years and of sound mind, or

(b) above the age of 14 years, of sound mind and assisted by his or her parents or guardian, is competent to refuse any life-sustaining medical treatment or the continuation of such treatment with regard to any specific illness from which he or she may be suffering.

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

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

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

Proposed clauses in relation to voluntary active euthanasia:

Recommendation 1:

The first option is that no legislation be introduced.

Recommendation 2:[445]

(5)(1) Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of

[444] Mahomed I. *supra* 53. The recommendations as set out are taken directly from the Report.
[445] Mahomed I. *supra* 53 at xvii–xix.

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administering or providing some or other lethal agent, the medical practitioner shall not give effect to the request unless he or she is convinced that–

(a) the patient is suffering from a terminal or intractable or unbearable illness;

(b) the patient is over the age of 18 years and mentally competent;

(c) the patient has been adequately informed in regard to the terminal illness from which he or she is suffering, the prognosis of his or her condition and of any treatment or care that may be available;

(d) the request of the patient is based on a free and considered decision;

(e) the request has been repeated without self-contradiction by the patient on two separate occasions at least seven days apart, the last of which is no more than 72 hours before the medical practitioner gives effect to the request;

(f) the patient, or the person acting on the patient's behalf in accordance with subsection (6), has signed a completed certificate of request asking the medical practitioner to assist the patient to end the patient's life;

(g) the medical practitioner has witnessed the patient's signature on the certificate of request or that of the person who signed on behalf of the patient;

(h) an interpreter fluent in the language used by the patient is present in order to facilitate communication when decisions regarding the treatment of the patient are made where the medical practitioner, as contemplated in this section, does not share or understand the first language of the patient;

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

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

(2) A medical practitioner who gives effect to a request as contemplated in subsection (1) shall record in writing his or her findings regarding the facts as contemplated in that subsection and the name and address of the medical practitioner with whom he or she

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has conferred as contemplated in subsection (2) and the last-mentioned medical practitioner shall record in writing his or her findings regarding the facts as contemplated in subsection (2).

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

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

(5) If a patient who has orally requested his or her medical practitioner to assist the patient to end the patient's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in subsection (2) above may, at the patient's request and in the presence of the patient and both the medical practitioners, sign the certificate on behalf of the patient.

(6) (a) Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner without regard to his or her mental state;

(b) Where a patient rescinds a request, the patients' medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.

Recommendation 3:[446]

5(1) Euthanasia may be performed by a medical practitioner only, and then only where the request for euthanasia of the patient has been approved by an ethics committee constituted for that purpose and consisting of five persons as follows:

(a) two medical practitioners other than the practitioner attending to the patient;

(b) one lawyer;

(c) one member sharing the home language of the patient;

(d) one member from the multi-disciplinary team; and

(e) one family member.

(2) In considering and in order to approve a request as contemplated in subsection (1), the Committee has to certify in writing that:

446 Mahomed I. *supra* 53 at xx–xxi.

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(a) in its opinion, the request for euthanasia by the patient is a free, considered and sustained request;

(b) the patient is suffering from a terminal or intractable and unbearable illness;

(c) euthanasia is the only way for the patient to be released from his or her suffering.

(3) A request for euthanasia must be heard within three weeks of it being received by the Committee.

(4) (a) The Committee which, under subsection (2), grants authority for euthanasia must in the prescribed manner and within the prescribed period after euthanasia has been performed, report confidentially to the Director-General of Health, by registered post, the granting of such authority and set forth–

(i) the personal particulars of the patient concerned;

(ii) the place and date where the euthanasia was performed and the reasons therefor;

(iii) the names and qualifications of the members of the committee who issued the certificates in terms of the above sections; and

(iv) the name of the medical practitioner who performed the euthanasia

(b) The Director-General may call upon members of the Committee required to make a report in terms of subsection (4) or a medical practitioner referred to in subsection (1) to furnish such additional information as he or she may require.

Proposed clauses in relation to advanced directives:

6(1) Every person above the age of 18 years who is of sound mind shall be competent to issue a written directive declaring that if he or she should ever suffer from a terminal illness and would, as a result, be unable to make or communicate decisions concerning his or her medical treatment or its cessation, medical treatment should not be instituted, or any medical treatment which he or she may receive should be discontinued and that only palliative care should be administered.

(2) A person as contemplated in subsection (1) shall be competent to entrust any decision-making regarding the treatment as contemplated in that subsection or the cessation of such treatment to a competent agent by way of a written power of attorney, and such power of attorney shall take effect and remain in force if the principal becomes terminally ill and as a result, is unable to make or communicate decisions concerning his or her medical treatment or cessation thereof

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(3) A directive contemplated in subsection (1) and a power of attorney contemplated in subsection (2) and any amendment thereof shall be signed by the person giving the directive or power of attorney in the presence of two competent witnesses who shall sign the document in the presence of the said person and in each other's presence.

(4) When a person who is under guardianship, or in respect of whom a curator of the person has been appointed, becomes terminally ill and no instructions as contemplated in subsection (1) or (2) regarding his medical treatment or the cessation thereof have been issued, the decision-making regarding such treatment or the cessation thereof shall, in the absence of any court order or the provisions of any other Act, vest in such guardian or curator.

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Appendix F: Criminal Code amendments (medical assistance in dying)

The act has been amended by adding the following after section 226:

227 (1) No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241.2.

(2) No person is a party to culpable homicide if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

(3) For greater certainty, the exemption set out in subsection (1) or (2) applies even if the person invoking it has a reasonable but mistaken belief about any fact that is an element of the exemption.

(4) Section 14 does not apply with respect to a person who consents to have death inflicted on them by means of medical assistance in dying provided in accordance with section 241.2.

(5) In this section, medical assistance in dying, medical practitioner and nurse practitioner have the same meanings as in section 241.1.

Section 241 of the Act is replaced by the following:

241 (1) Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

(a) counsels a person to die by suicide or abets a person in dying by suicide; or

(b) aids a person to die by suicide.

(2) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.

(3) No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

(4) No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the

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substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.

(5) No person commits an offence under paragraph (1)(b) if they do anything, at another person's explicit request, for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assist-ance in dying in accordance with section 241.2.

(5.1) For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying.

(6) For greater certainty, the exemption set out in any of subsections (2) to (5) applies even if the person invoking the exemption has a reasonable but mistaken belief about any fact that is an element of the exemption.

(7) In this section, medical assistance in dying, medical practitioner, nurse practitioner and pharmacist have the same meanings as in section 241.1.

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